

THE UNIVERSITY OF HULL

**ACCEPTANCE AND UTILISATION OF PRIMARY HEALTH CARE IN
JEDDAH CITY, SAUDI ARABIA.**

being a Thesis submitted for the Degree of Doctor of Philosophy in Sociology,

in the University of Hull

by

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Abstract:

The provision of health services to all the population is one of the highest priorities in many governments' agenda, because the health system, education and social security are important indicators of the level of development of a state. However, the provision of health services to cover all the population is not easy, particularly in many developing countries, which lack human and financial resources. In 1978, at Alma - Ata WHO and UNICEF jointly declared the primacy of the primary health care (PHC) approach for achieving the WHO's social goal, " health for all the people by the year 2000". Since then, PHC has become a major concern on national and international levels. Saudi Arabia one of the countries which has adopted and implemented the PHC approach.

This study explores the implementation of the PHC approach, the utilisation of health services delivered at the health centres and health awareness in Jeddah, a major urban centre in Saudi Arabia, where public and private health services co - exist and compete, and where traditional medicine is still used and practised. A sample comprising both utilisers of the PHC centres and non - utilisers were questioned about their health practices, beliefs and attitudes, and an attempt was made to determine whether socio - economic and demographic characteristics were significantly related to utilisation and health awareness. No single pattern of attitude or behaviour was found to be consistently related to socio - economic or demographic characteristics. However, the findings indicate the general significance of education.

The nature of service provision was found to affect satisfaction and a need was found to improve the quality of the health service and to remove bureaucratic barriers which impede utilisation. Although many aspects of PHC are successfully implemented, there is evidence of misunderstandings of the approach by both consumers and providers, which limits both utilisation and satisfaction. In particular providers and users still prioritises curative above preventive medicine, health education is still neglected, and the potential of the media in this respect is under - exploited.

Finally, traditional medicine was found to be used and practised, but the findings indicate there is not necessarily a conflict between the two systems. They appear to be used in a complementary way, and there may be scope for integration.

Dedication

To all who have taught me: those who taught me directly knowing they were doing so, and those who taught me indirectly and were unaware of their influence. I shall be in debt to them all my life - without their teachings I would not have been able to write this thesis or to hold a degree. I begin with my family, where I learnt the first lesson, then my people, then to everyone who has influenced me, wherever he or she is in this world. Al hamdulillahi wa shukrulillah.

To my Parents

My wife Um Abdulkareem

My children Abdulkareem, Abdulaziz and Abeer, and the twins' Abdulrahman and Abduraheem, who were born on 28th November 1993, in Jeddah while I was in Hull, and whom I have not yet seen.

I also dedicate this work to the memory of my grandmother who passed away 29 May, 1994, during my study at Hull,

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Introduction

The provision of comprehensive health services to cover all the population is in itself a major challenge to any government. Health policies have been formulated in many developing countries by imitating the health system model of the industrialised world, regardless of whether this health system suits their health problems and conditions, or whether it is practical and cost - effective within their socio - economic conditions and socio - political systems. The health systems of the industrial world were developed within particular socio - political and economic systems, which are entirely different from those in developing countries; moreover, the health situations and health problems that are prevalent in the industrial world also differ from those in the developing world. For this reason, it is necessary to think again about existing health care systems and to develop different approaches that can be implemented in the developing world. These approaches must meet the criteria of practicality and cost - effectiveness in the context of the huge health problems, socio - cultural structures and resource constraints of developing countries. Many governments have been trying to establish health systems which would work within their political systems and be economically cost - effective, which providing a reasonable level of health coverage.

The philosophy of development in many developing countries has been to achieve high economic growth; thus, resources have been allocated to productive sectors. Health has been considered by many governments, development planners, donor organisations and governments as a non - productive sector. Thus, it used to get very low priority in development planning. However, health is one of the most important aspects of social development, and the position of health in the development process is a very crucial one.

A number of authors in different disciplines have outlined different models of health care systems, in both developed and developing worlds, though they have mainly concentrated on the developed world (Seham 1969; Shannon and Dever 1974; Newell 1975; Djukanovic and Mach 1975; Gesler 1984; Joseph and Phillips 1984; and Rosenberg

1986). Little has been reported about the health care systems in the Arab world in general and Saudi Arabia in particular.

Delivery of the health care service is a reflection of the socio - political and economic conditions and ideology of the country. For example, American health services reflect the economic market ideology, or enterprise economy. In the former socialist countries, health services were provided for the people free of charge, financed, planned and controlled by the state. Patients had no choice which physician to consult. This approach made one writer consider it as a means for social control in the society (Werner 1983). In UK the National Health Service (NHS), a socialised health service (Klein 1989), is controlled by the government but decentralised in its planning and administration.

The shortage of studies on health care systems in developing countries has many reasons, including imitation of the industrialised countries' health systems, lack of data concerning operational policy, and financial constraints. Researchers of health care systems in the developing world usually face many difficulties in obtaining up - to - date data on health organisation, health professionals, capacity of hospitals, numbers of health institutions, or even basic information on the general socio - demographic characteristics of the population, let alone level of utilisation of the health services and the coverage of the population. These problems have been highlighted by many commentators (MacPherson 1982; Joseph and Phillips 1984; Gesler 1984; MacPherson and Midgley 1987 and Stephen 1991).

Health care systems in most developing countries are often characterised as centralised, with uneven distribution usually in favour of urban areas, lacking in co-ordination, and with inadequate record - keeping systems. They are often unable to provide reasonable health care for their population due to the lack of resources available, increased cost of medicine and medical technology and shortage of trained health personnel. Furthermore, most developing countries suffer from a high rate of infectious preventable diseases; high mortality rates, especially in childhood and infants; malnutrition; shortage of

clean drinking water and poor sanitation. Generally, the health policy is hospital - oriented and focuses on curative rather than preventive care.

All of these deficiencies have led many concerned individuals and non - governmental organisations to try to look for other alternatives. In 1975 WHO and UNICEF sponsored two studies to investigate different approaches and experiments were practised in many countries with different economic systems, different socio - cultural backgrounds and social structures as well as different political system. (Newell 1975; Djukanovic and Mach 1975). The positive findings of these two studies and others encouraged WHO and UNICEF and other non - governmental organisations to call for change in health policy and strategies in order to achieve a reasonable health coverage for most of the population, particularly for rural and peripheral areas and urban slum dwellers, by the year 2000. In 1978, WHO declared in its conference the emergence of the Primary Health Care (PHC) approach, which is the main vehicle to achieve the WHO's social goal of providing health care for everybody by the year 2000.

Saudi Arabia as a member state of WHO adopted the PHC approach and formulated policies compatible with the new strategy of health care. By the year 1991 there were 1692 PHC centres in the country (MOH 1991).

During the past three decades, Saudi Arabia has experienced rapid social and economic changes due to the improvement in the economy. These changes have led to improvements in living standards and an increase in the provision of social services, including health and education. As a result, the number of hospitals, hospital beds, health personnel, and health centres has grown. It is the policy of the government of Saudi Arabia to make health services available and free as far as possible, not only in every city and town, but even in remote areas. Thus, the budget of the Ministry of Health has increased rapidly in the attempt to keep pace with the social and economic changes in the country. In 1960, the budget was SR 58.4 million; in 1991, it was SR 8,597,000, 6 % of the total budget.

Such an expansion of health service facilities should have brought improvement and change in the overall health conditions of the population. Unfortunately, there is no

documented information available to show whether or not this has happened. Personal impressionistic evidence suggests that the overall situation is far better than before but, with such expenditure, perhaps it could be better still. The general trend in Saudi Arabian, health policy is still toward curative care rather than preventive, although the PHC approach is, in theory, basically preventive rather than curative.

This study is concerned with the implementation of PHC in Saudi Arabia and more specifically the utilisation of PHC services in a major city of Saudi Arabia, Jeddah. No research has been carried out in the implementation of the PHC and utilisation of the health services provided through the health centres in Jeddah since the government adopted the new strategy of PHC. Jeddah is the most populated city in Saudi Arabia and two medical systems, public and private, operate there. Therefore, it is important for research to be carried out in this city. The competition between the two systems is very strong. The private system offers attractive facilities and accommodation, and provides extra services which are not available in the public sector. This is likely to have an impact on the utilisation of the PHC centres in general. The concern of this study is to investigate people's attitudes to and satisfaction with the health services tendered through the health centres.

The structure of the thesis

The study is divided into twelve chapters. The first chapter is mainly concerned with the health situations and problems facing developing countries. It highlights the scarcity of health resources as well as the problem of urbanisation and its effects on health conditions. These conditions and problems in the third world led to the emergence of PHC which is the main topic of Chapter Two. The main components of the approach and its implementation in rural and urban areas are discussed. Examples of the implementation of the programme in two Arab states are analysed. The role of women in PHC is also explored in this chapter.

Also Chapter Two explores traditional medicine, its types, schools, utilisation and the characteristics of the folk healers, as well as the general characteristics of the utilisers of this type of medicine. Its potential relationship with PHC is also highlighted.

Chapter Three explores the main approaches studying the utilisation of the health services, and outlines the main characteristics of the health delivery system, and their implications for the rate of utilisation of the health services. This chapter also discusses previous studies and their findings on the utilisation of the health services.

Chapter Four is divided into two main sections. The first provides general background about Saudi Arabia, its people, its social and economic development and its political economy; the second describes the development and main characteristics of the country's health policy and organisation. Chapter Five discusses, in more detail, previous studies of the provision and utilisation of the health service facilities, health conditions and traditional medicine in Saudi Arabia.

Chapter Six provides a general description of the study site, Jeddah, and health organisation in the city, as background to the field work. Chapter Seven discusses the methodology used to carry out this study, the sampling and the difficulties encountered during the fieldwork as well as the general characteristics of the respondents. Chapters Eight to Ten present and discuss the collected data both descriptively and analytically. Chapter Eight describes the attitudes of the sample and knowledge of PHC as well as explores their general use of the health centres. It provides a description of those registered with the health centres, and the findings about general use of its facilities, as well as the difficulties facing them. Chapter Nine analyses and discusses the use of the health centres for child care, maternity and dentistry care. Chapter Ten discusses the health awareness and practices of the whole sample, both those who registered with the health centres and the non - registered. It also discusses the use of traditional medicine, the patient - doctor relationship and the role of the mass media in raising the level of health awareness.

Chapter Eleven draws conclusions from the study. It brings the major themes of the study into focus, considers the limitation of the study and draws attention to scope for further research, as well as making some recommendations.

CHAPTER 1 Health Conditions and Problems in the Third World:

1.1 Introduction

Developing countries cannot be considered as a single group: they include small countries in the Gulf region and Caribbean, and large countries like China and India. Some are torn apart by civil war and famine, e.g. Afghanistan, Ethiopia, Sudan, Mozambique, Somalia, Angola, Nicaragua, Sri Lanka and Cambodia; others, such as Singapore, Taiwan and South Korea Malaysia and Hong Kong are rapidly industrialising (Stephen 1992), still others are oil exporting countries with high oil revenues. A single label cannot take account of all these differences. However, characteristics which are common to many developing or "Third World" countries are generally low levels of income and widespread poverty, a large proportion of rural population and nomads, recent and rapid growth in urbanisation, and high illiteracy rates.

This chapter will attempt to discuss and analyse in some detail the various aspects of the health conditions and problems in developing countries. The present health conditions of the people in most developing countries require urgent efforts on the part of governments and non - government organisations to plan and implement new health strategies. For decades, developing countries have copied western models of health and medical education. Even so, they still face formidable health problems which affect the productive capacities of their populations, and therefore impede national development as well as causing untold individual suffering which can not be measured in quantitative terms. Although the discussion is mainly concerned with the health conditions in developing countries, comparison with and reference to the developed world will also be made to provide additional insights into the problem.

The main causes of morbidity and mortality in the industrialised societies and in the developing countries at present are different. In the former, the so-called modern life style diseases and degenerative diseases such as cancer, heart disease, obesity, diabetes and hypertension together with alcoholism, drugs, road accidents and suicide, are the main causes of death. In developing countries, in contrast, preventable and curable infections such as malaria, parasitic diseases, dysentery, tuberculosis, pneumonia and measles, are the main causes of death. Such diseases were major causes of death in developed countries such the US one hundred years ago (Gesler 1984), but are now controlled.

The historical development of health services is another factor which needs to be considered. Health services in the developing countries have been introduced through colonialism or in the case of non - occupied states copied from the west. The result has been a tendency towards hospital - based medical care and concentration of services in urban areas. Poor transport and communications in rural areas often compound the problem.

Another significant difference between developed and developing countries is that in the former, traditional medicine is often practised and accepted by a large proportion of the population in both urban and rural areas, while in developed countries traditional medicine has been superseded by modern medicine, and alternative therapies are not widely recognised, either by the medical profession, or by the population at large.

As long as these differences and others such as resource allocation to the health system, population size and structure, and the strategy for health development, exist between the developing and developed countries, the appropriate solutions to health problems will necessarily differ. However, there are lessons to be learnt from the experience of the developed countries, in respect both of their successes , and of their limitations.

At the beginning of the nineteenth century Britain, for instance, encountered diseases caused by infection such as tuberculosis, cholera, smallpox, diphtheria and dysentery. Among these infectious diseases which killed the poor in such vast numbers, smallpox and cholera are often assumed to have been the more deadly (Doyal 1972). Infant and maternity mortality rates were high. For instance, in 1898 Rowntree found infant mortality in York to be 247 per 1,000 amongst the poorest classes and 94 per 1,000 amongst the richest (Office of Health Economic 1972), and life expectancy at birth was much lower than it is now. Britain's experience in eradicating many diseases by preventive measures, as much as by medical intervention, may provide valuable insights for developing countries, with regard to health policy and planning. Abel - Smith demonstrates more explicitly the concrete effect of preventive measures and public health policy:

" Improvements in mortality rates in the nineteenth century were mainly due to higher standards of nutrition and personal hygiene and introduction of clean water and sewage disposal in cities." (Abel - Smith 1972, P. 2.)

Furthermore, he points out that improved environmental health services rather than the isolation of cases in hospitals, conquered cholera, typhoid, and plague in Europe and North America. However, new scientific evidence shows two important factors which might have contributed to the increase in the incidence of tuberculosis: the standard of nutrition, which would effect the level of resistance of the victim, and overcrowding at home and in the workplace, increasing the possibility of contracting the bacillus (Doyal 1972). Thus, personal hygiene, sanitation and improved nutritional standards were major factors in improving health conditions and saving the lives of many young and middle aged people in the nineteenth century (Abel - Smith 1976).

1.2 Health and Development

The relationship between health and development is a very close one, because both are concerned with raising the living standards of the population. Improvement in the living standards of the people entails improved health standards, health facilities and health awareness, good housing conditions, better education and social justice. Unfortunately, health services and the health conditions of the population, in the past, and even today to some extent, have not received the attention or consideration they deserve on the part of development planners and economists (Agbonifo 1983). This is because development and health care were perceived as separate issues. Development was viewed as being entirely concerned with economic growth, measured by increases in per capita income or Gross National Product (GNP), and health care, on the other hand, was seen as a non productive factor; indeed it is viewed widely as a consumption element in the development process. Perhaps because of these different views of the two topics, few attempts have been made to explore the relationship between them (Doyal 1979). Furthermore, insufficient information is available on the impact of ill - health on economic and social activities (MacPherson 1982).

The effect of health on economic growth is a complicated issue. Abel - Smith and Leiserson (1978) argued that:

" The precise relationship between expenditure on health services ... and improvement in health is hard to establish" (P. 22).

However, they indicated that there is much evidence to show that ill - health is economically wasteful. According to Golladay (1980):

" Illness disrupts normal activities for roughly one - tenth of people's time in most developing countries. Many illnesses are intermittent with recurrent acute episodes; these illnesses disrupt economic activity, often at critical times, such as the planting and harvesting seasons in the case of malaria. Chronic and debilitating diseases impair people's ability to concentrate, students' ability to learn and adults' productivity" (P. 11).

Abel - Smith and Leiserson (1978) describe how illnesses weaken people's health and thus lower their productivity, and also cause the abandonment of land where vector - borne diseases are endemic. In the Volta River basin, for example, large cultivatable areas have been deserted because of disease. Eradication of diseases would enable such land to be cultivated, producing additional capital and improving the living standards of the people on both micro and macro levels.

Economically, modern medicine, which is curative in emphasis, is increasingly expensive and goes beyond the available limited resources of many developing countries. Usually, social policy planners emphasise the government's responsibility to provide health care for all the population, whereas many economists believe that expenditure on health care services is a diversion of scarce resources from productive factors needed for economic growth and development, to a consumptive element in the development process (Hardiman and Midgley 1982). For many developing countries, therefore, social policy must incorporate a health and medical strategy which includes preventive and promotive health measures in order to minimise the high cost of curative medicine and at the same time, to assure maximum coverage to reach the largest number of people, particularly the most vulnerable ones. If people's health and well - being is improved, they are more likely to be able to participate more effectively in the overall development process, whereas poor health is likely to impede social and economic productivity.

The measurement of development in terms of economic growth alone is misleading. Increases in the GNP do not reveal much about the quality of life or the health of the people. Some oil - exporting countries, for example, have a high GNP but poor health status, such as high infant and child mortality rates, low life expectancy and high rates of maternity mortality. On the other hand, some countries with low per capita income or GNP, such as Sri Lanka and Cuba, enjoy good health conditions and low mortality rates. In this regard, Morris and Liser (1978) argue that " It (GNP) can not satisfactorily measure the extent to which the human needs of individuals are being met. Nor should it be expected to do so , since there is no automatic relationship between any particular level or

rate of growth of GNP and improvement in life expectancy, death rates, infant mortality, or literacy". Furthermore, Agbonifo 1987, confirms that the great rise in per capita does not necessarily imply significant improvements in the quality of life of the masses.

On the other hand, a case can be made that improvement in the health conditions of the population will lead to economic growth and consequent increase in the per capita GNP. Carin (1984), argues that health status can be a factor contributing to economic growth and supports his view by citing the life expectancy and real GNP of the twelve fastest - growing countries for the period 1960 - 1977. These countries all had a life expectancy of 61 years or above. In turn, improvement in economic growth or GNP means more money can be allocated for the social services, including health care services, which will help bring about an improvement in health conditions.

Another aspect of the relationship between health conditions and level of development can be seen in the environment. If the environment is healthy and clean, people will be more likely to be healthy mentally and physically, and able to contribute to the national economic growth (Agbonifo 1983). Conversely, ill - health often stems from and flourishes in a bad environment. The role of environment will be discussed in more detail in a later section.

1.3 Health Conditions and Problems:

The health situation in many developing countries is unacceptable, and there are wide discrepancies in health status between industrialised and developing countries, between one developing country and another, and between different regions within the same country. Usually, in order to measure the health situation of any society, various quantitative indicators and qualitative descriptive measures have been used (Hardiman and Midgley 1982). However, these instruments have some disadvantages. For instance, descriptive reports are usually subjective and biased, whereas statistical records are frequently inaccurate and unreliable. Data on developing countries, in particular, are often fragmentary and under - estimated. Obtaining reliable information on the health patterns in the third world is a problematic issue (Doyal 1979) . Bryant (1969) pointed out that variations in reported mortality rates between countries may to some extent be reflections of variations in effectiveness of the methods of collecting and reporting vital data. Nonetheless, mortality and

morbidity rates, and ratios of physicians, nurses and hospital beds to population do provide some understanding of health conditions (Hardiman and Midgley 1982).

In 1981 the General Director of the World Health Organisation summarised the world health situation as follows:

- 1 - A newborn child in some African countries has only a 50 % per cent chance of surviving to adolescence.
- 2 - Four fifths of the world's population have no access to any permanent form of health care.
- 3 - Only one in three persons in developing countries has reasonable access to safe water and adequate sanitation.
- 4 - Infant mortality rates remain high in all developing countries, and the rate of improvement has begun to slacken.
- 5 - Over five million children defecate themselves to death annually.
- 6 - More than half of all child deaths can be traced to the vicious complex of malnutrition, diarrhoeal and respiratory diseases. All these deaths are unnecessary and it is the failure to control such diseases of poverty that is holding back further reductions in mortality rates (Mahler 1981).

Similarly, in 1982, the Executive Director of the UNICEF concluded on a report about the state of the world's children that:

" the optimism of the 1960's which gave ground to the realism of the 1970's has now receded even further to make room for the doubt and pessimism which seems to be setting into the 1980's " (Grant 1982, p. 13).

1.3.1 Predominant Diseases:

The most prevalent diseases in the developing world are mainly infectious and communicable.

They can readily be classified into three categories as follows:

- 1 - Faecal diseases: this group of diseases is transmitted through human faeces. They are: typhoid, cholera, poliomyelitis, intestinal parasitic, diarrhoea and dysentery.

Diarrhoeal diseases are most prevalent in the developing countries. They are mainly transmitted by human faecal contamination of water, soil and food. MacPherson and Midgley (1987) claim that

" More than 500 million children suffer diarrhoeal infection, three or four times a year. It is so common that it is seen as both a normal part of childhood, and indeed of adulthood too." P. 150

It is estimated that in 1975, diarrhoeal diseases accounted for the deaths of between 5 million and 18 million people in Africa, Asia and Latin America (MacPherson and Midgley 1987).

2 - Air - borne diseases, such as pneumonia, bronchitis, tuberculosis, diphtheria, whooping cough, meningitis, influenza, measles and chickenpox.

Tuberculosis, leprosy, pneumonia and other air - borne infections have been a major cause of morbidity and mortality throughout the world from time immemorial. In this century, the infection rate has fallen significantly in the developed world, but in developing countries, tuberculosis and leprosy have continued to be major causes of concern, particularly in South East Asia. The overcrowded and inadequate living conditions in third world countries facilitate the rapid spread of such air - borne diseases. The problem is particularly severe in urban areas, where the population concentration is greater.

3 - Vector - born diseases: these are transmitted to human beings through a third party, which carries the disease, such as mosquitoes, water snails and tsetse flies. Examples of such diseases are malaria, bilharzia, and sleeping sickness. Most so called " tropical diseases" fall into this group.

The global incidence of malaria has not improved and there are continuing downward trends in some countries and worsening or fluctuating situations in others. It is believed that around 100 million cases occur annually. Levels of mortality due to malaria vary considerably and, unfortunately, information is generally lacking (WHO 1989 a). In spite of the fact that, theoretically, malaria can be prevented by inexpensive drugs or by insecticide spraying to kill the mosquito and its larvae, WHO has pointed out that around 850 million people live in areas where malaria has been only partially controlled, and some 350 live in areas which have inactive control measures (WHO 1981). Some 500 to 600 million people are vulnerable to the risk of infection with bilharzia and a similar number are probably infected (Webb 1981).

The diseases in all three categories are related to poverty, or manifested in malnutrition, poor environmental conditions, contaminated drinking water and poor housing conditions.

1.3.1.1 Nutrition:

The effect of nutrition on health is recognisable and very strong, particularly among children. For example, chronic undernutrition of both calories and protein food is usually associated with poor

health conditions. Several studies have shown the relationship between malnutrition and increased susceptibility to disease: in the case of tuberculosis, infectious diarrhoeal diseases and measles, for example, the malnourished have a mortality rate 400 times higher than the well nourished. Malnutrition not only increases the exposure to infection, but also reduces the body's ability to resist the invading disease, which accounts for the high mortality rate in the developing world (Hardiman and Midgley 1982). The relationship between malnutrition and infection is that one precipitates and aggravates the other (Fendall 1972).

Several international reports and studies show that children and women are the most vulnerable groups of the population to malnutrition. Malnutrition is an associated cause in child mortality and is a contributory factor in as much as 60 per cent of all infant deaths in the developing world (Hardiman and Midgley 1982). Twenty - five per cent of childhood deaths under age five in African countries are due to some form of malnutrition, while in over 50 per cent, malnutrition may be a contributory factor.

It is worth mentioning that the terms malnutrition and undernutrition are often used interchangeably, and are so here, but strictly speaking, the terms should be differentiated. Undernutrition means a deficit in calorie intake or quantity of food, while malnutrition does not necessarily mean low intake in quantity terms, but that the food taken does not provide the necessary range of nutrients. Thus, it is correct to use the term undernutrition, when the discussion concerns people who live in absolute poverty. The number of these in Africa rose from 101 million in 1969 -71 to 168 million in 1988 - 90, and in Latin America the number increased from 54 million to 59 million. In contrast, the number in Asia dropped from 941 million to 786 million during the same period. Therefore, in 1990, 72 million more Africans and Latin Americans were chronically starving than at the end of the 1960s (Harrison 1993). Famine resulting from drought was a cause of malnutrition for millions of people.

Such malnutrition in the developing countries may be contrasted with the position in the developed world and some oil - exporting countries, particularly the Gulf States and Saudi Arabia, where overeating leads to obesity and dental caries, and is associated with metabolic and cardio - vascular disorders (Fendall 1972).

1.3.1.2 Environmental conditions:

Poor environmental conditions constitute another aspect of poverty and underdevelopment, characterising both cities and rural areas in developing countries. These conditions are usually associated with poor housing conditions, lack of potable water and inadequate, ineffective sanitation systems. In many urban areas of the developing countries, for example, it is common for sewerage to run openly through the streets and accumulate in pathways and open spaces between buildings (Hardiman and Midgley 1982).

Many faecal diseases are spread by use of contaminated water for drinking, bathing or washing kitchen utensils, while vector - borne diseases proliferate in and around open water such as dams, lakes and rivers. Inadequate water supplies lead to insufficient attention to personal hygiene, which is also linked with transmitted diseases such as trachoma, which flourishes in many developing countries. Table 1 - 1 shows the percentage of people in selected countries who have access to safe drinking water, showing urban and rural groups separately.

Table 1 - 1 Percentage of Population with Access to Safe Drinking Water in Selected Countries of Third World, 1990.

Country	Urban	Rural	Total
Mozambique	44	17	18.9
Djibouti *	50	21	43.2
Ethiopia	70	11	18.1
Guinea	55	24	23.9
Guinea Bissau	18	27	25.3
Somalia	58	22	33.3
Pakistan	83	38	49.9
Bangladesh	25	66	60
Democratic Yemen	86	35	..
Kenya *	61	21	28.4
Uganda	45	12	15.2

Sources: UN The Least Developed Countries (1990), UNICEF (1988), The State of World Children, and WHO (1992). * Data for year 1983- 1985

It is noticeable that in almost all the countries featured in the table, those living in rural areas fare worse than those in the urban areas. In some countries, the rural population is more than 70 % per cent, of the total population, and the majority of those have no access to regular sources of safe

drinking water. These poor conditions, along with others, contribute to the increase of illness in the developing countries.

History and experience show that improvement in the health condition of any population is not only a matter of providing hospitals with advanced technology and specialised medical personnel. Many communicable diseases now widespread in developing countries were once endemic in the industrialised countries, but improvement in housing conditions, the provision of safe drinking water and improvement in environmental conditions contributed significantly to the eradication of communicable diseases in the developed world (Abel - Smith 1976). Several experiences have shown a positive correlation between improvement in health conditions and the introduction of public health measures such as provision of safe drinking water and disposal of excreta (Abel - Smith 1976; Hardiman and Midgley 1982; MacPherson and Midgley 1985). In Kenya, at Zaina, for example, where a rural community of more than 6,000 persons was provided with safe water and sewage disposal systems, there was a greater improvement in the health conditions of the population of this community than in the neighbouring areas where no such facilities were introduced (Fendall 1972).

1.3.2 Health Indicators:

Health - related indicators such as mortality, morbidity rates and life expectancy are believed to be useful instruments in understanding the health conditions of the people, despite the limited data in many developing countries, referred to above. Also, there are health services indicators which provide information regarding the number of medical facilities such as hospitals and the percentage of health personnel to the population. Again, these can not give a full picture of the health conditions of a population, but they do give interested researchers an idea of the extent, balance and location of facilities. There follows a discussion on the health - related demographic indicators and health service indicators:

1.3.2.1 Life Expectancy

The World Bank (1975), has suggested that life expectancy is the most reliable measure of health status available. The life expectancy of a population at a given age is the average number of years lived beyond that age by all those who have the same age (WHO 1981). Life expectancy in general has improved and increased dramatically throughout the world since the Second World War,

in both developed and developing countries. Before this, life expectancy at birth in developing countries was very low, only about 32 years; it has subsequently improved till the average is 51 for inhabitants of low income countries (World Bank 1991). In these countries, children under five years are twelve to fifteen times more likely to die than those the same age group born in the developed world, and those who survive beyond the age of five years in the developing countries have a life expectancy six to eight times lower than their counterparts in the developed countries (MacPherson 1982). In term of regions, African countries have recorded the lowest life expectancy, while Latin American countries have reported high life expectancy at around 70 years. In the Middle East, life expectancy varies considerably between countries. For instance, Kuwait has reported a life expectancy comparable to that of the developed world, while Yemen has reported a low life expectancy. Nevertheless, there are variations within regions and within individual countries (WHO 1981 and World Bank 1980).

Table 1 - 2 gives some indication of the variation in life expectancy between developing countries in four regions: Africa, Latin America, Asia and the Middle East. The table also shows that there tends to be a relationship between infant mortality rate and life expectancy. Countries with high infant mortality rates have a lower life expectancy and conversely, countries with high life expectancy have low mortality rates.

1.3.2.2 Mortality Rate:

The infant mortality rate is one aspect of the mortality data which is believed to be useful in measuring the health conditions. Infant mortality rate is defined as the number of deaths of infants under one year of age in a given year per 1,000 live births in that year (World Bank 1984). Another indicator, which measures the number of deaths of women due to complications of pregnancy and childbirth per 100,000 live births in a given year, is called "maternity mortality rate" (World Bank 1984). It has been reported that in the 1970s, mortality rates in the developing world were five to six times higher than in industrialised countries. In 1990, the highest mortality rate in developed countries, reported in Italy and United States, was 9, while the average rate in sub - Saharan Africa was 107 (World Bank 1992).

Table 1 - 2 Infant Mortality Rate (IMR) and Life Expectancy at Birth in Selected Developing Countries in Comparison with Selected Industrialised Countries.

Country	Infant Mortality Rate 1986 - 87	Life Expectancy 1990
Africa		
Ethiopia	141	43
Chad	134	45
Malawi	153	47
Tanzania	108	53
Nigeria	107	-
Latin America		
Argentina	33	70
Cuba	15	75
Mexico	44	69
Venezuela	37	70
Asia		
Bangladesh	121	50
Sri Lanka	30	70
Indonesia	78	59
Middle East		
Afghanistan	174	-
Saudi Arabia	74	64
Kuwait	19	74
Yemen	124	50
Egypt	66	60
Sudan	102	50
Morocco	67	62
Syria	43	66
Jordan	51	67
Iran	88	63
Tunisia	44	67
Turkey	60	67
Developed World		
Italy	9	-
UK	8	76
USA	9	76

Sources: WHO (1992); and World Bank Report (1992).

Table 1 - 2 reveals that mortality rates in most of the featured countries are very high, with the highest rates in Afghanistan and the African countries. In the Arab world, there is dramatic variation, with Yemen having one of the highest rates at 124, while Kuwait, on the other hand, reported the

relatively low rate of 19. These variations can be attributed to many factors: economic, demographic, socio - cultural and political.

As well as differences in infant mortality from one country to another, there are different recorded rates between rural and urban areas, between different income groups and different levels of literacy. For example, in 1970, a study in Thailand showed differing infant mortality rates between different residential areas, in relation to education. The rate varied from 87 per thousand live births for mothers with no schooling to 16 for mothers with secondary or university education (Lee and Mills 1983). The relationship of income, quality of housing and level of education to infant mortality rate was explored in Saudi Arabia, and the findings suggested strong association. Two groups in Riyadh city were studied. The highest infant mortality rate was reported to be among families with low income, poor quality housing and mother with low educational level. The study showed that infant mortality rate was 25 % higher in this group than in the second group, which had higher income, better education and better housing (Al - Obeidy 1985).

Another indicator concerned with children is the "Under - five mortality rate (U5MR)", which shows the probability of a newborn baby dying before reaching the age of five. Children under five years of age in developing countries are twelve to fifteen times more likely to die than children in the same age group in the developed world (MacPherson 1982).

UNICEF has categorised under - five mortality rate as follows:

An under - five mortality rate (U5MR) of 170 and more is classified as a very high rate, from 95 - 170 as high, and from 26 - 94 as middle and under 25 as low (UNICEF 1988). Thus, according to this criterion, Kuwait and Cuba have low rates, while Argentina, Venezuela, Sri Lanka and Mexico, are all in the middle group with large variations among them; for example, 71 in Mexico and 39 in Argentina. Indonesia and Saudi Arabia are in the high category, while the various African states, Bangladesh, Afghanistan and Yemen have very high U5MR.

Table 1 - 3 Under - five Mortality Rate in Selected Countries.

Country	U5MR
Ethiopia	255
Chad	288
Malawi	270
Tanzania	179
Argentina	39
Cuba	19
Mexico	71
Venezuela	44
Bangladesh	193
Sri Lanka	46
Indonesia	122
Afghanistan	325
Saudi Arabia	105
Kuwait	24
Yemen *	204
Sweden	7
UK	11
USA	13

Source: UNICEF (1988)

* Yemen data prior to unification; however, both Yemens have the same rate.

It is essential, however, to emphasise that mortality rates as health indicators must be used with caution. High reported infant and under five mortality rates in one country may be due to accuracy of recording, as much as to high levels of disease, while low recorded rates may be due to lack of accurate recording, or data may be manipulated for political or economic reasons.

The third mortality indicator shows the number of female deaths that take place during childbirth per 100,000 live births (World Bank 1992). This rate comprises all the deaths which occur as a result of childbirth, complications of pregnancy or the period after delivery. This, like the others, reflects, but does not measure, both the availability of the health services and general welfare. Many pregnant women die because of shortage of suitable health services. Table 1 - 4 reveals the huge gap in maternity rates between developed and developing countries, and also differences among the developing countries themselves. However, it should be recognised that data on maternity mortality rate may not represent the actual numbers of deaths, because many developing countries do not

register the vital events in a systematic way. Often, the available data are limited to urban sites, and hospital records. Rural and remote areas are usually excluded because of shortage of logistic or feedback information within the health network. Moreover, deaths occurring other than in hospital may not be recorded. Other deaths are not recorded because they result from illegal abortions. Therefore, the true figures are likely to be much higher than those reported. Moreover, the reports do not explain whether deaths took place as a result of complications of pregnancy and childbirth or lack of nutrition.

Table 1 - 4 Maternal Mortality Rate in Selected Countries.

Country	Maternal Mortality Rate (per 100,000) 1980
Ethiopia	2,000
Chad	700
Tanzania	370
Argentina	85
Mexico	92
Bangladesh	600
Indonesia	800
Saudi Arabia	52
Kuwait	18
United Kingdom	7
USA	9

Sources: World Bank (1991, 1992)

Many factors affect women's health: care during pregnancy, nutritional status, obstetric care, woman's status, age at marriage and educational level. Moreover, whatever affects the mother's health is likely to affect that of the child too (Uyanga 1990).

1.3.3 Causes

Several writers have analysed the main causes of the poor health conditions in the developing countries, and some of them have attributed most of the predominant diseases in developing countries to climate and poverty (Gish 1971; Doyal 1979; MacPherson 1982 and Hardiman and Midgley 1982). Certainly, tropical climate provides the environment in which certain diseases flourish. However, climate is not the only factor. Doyal (1979) argues that many of the infectious diseases such as tuberculosis, leprosy, and venereal diseases were once unknown in Africa, but were spread rapidly in Europe in the eighteenth and nineteenth centuries, and brought to Africa during the

colonial era. Another related factor is literacy, which is known to help people to understand health issues and implement solutions. However, as Table 1 - 5 shows, literacy, particularly amongst women, is very low in many developing countries.

Table 1 - 5 Percentage of Illiteracy in Selected Developing Countries

Country	Female Illiteracy Rate in 1990	Total Illiteracy Rate in 1990
Mozambique	79	67
Somalia	86	76
Chad	82	70
Bangladesh	78	65
Burkina Faso	91	82
Pakistan	79	65
Saudi Arabia	52	38
Egypt	66	52
Sudan	88	73
Yemen	74	62

Sources: World Bank (1992).

It is estimated that more than 900 million adults in developing countries can neither read or write, and only 4 out of every 10 children complete more than three years of primary school (WHO 1981). Efforts, however, have been made to improve the level of literacy, particularly among women. In 1976, the Arab countries held a conference in Baghdad on Literacy Strategy, which emphasised the importance of improving adult (female) literacy. As a result, there has been some improvement in the rate of literacy in a number of Arab countries.

Population growth is another factor often held at least partly responsible for the poor health situation in most of the third world countries, though this is a controversial issue. Population growth may be considered in part as evidence of the success of modern medicine in reducing mortality; yet it is also considered to be a factor exacerbating problems of nutritional deficiency, overcrowding and poverty, which are detrimental to health. Population growth is a very complicated issue, as it involves cultural, religious, and economic as well as social aspects. Studies concerned with health conditions and population in third world countries usually view population growth in the underdeveloped world as a threat, because they frequently concentrate only on the scarcity of raw materials and food; in

other words they apply Malthus' theory, that the available nutritional resources are less than the increased number of the population. Enke states that:

" Economic resources used to reduce birth rates can be a hundred times more effective in raising per capita incomes in underdeveloped territories than if the same amount of resources were invested in traditional development projects to increase output." (Enke 1966, cited in Fendall 1972).

Socio - economic politics in Egypt present an illustration of this view in practice. Egypt has invested a huge amount of its income and consumes a great proportion of the external aid it receives, in reducing population growth and introducing family planning projects in rural as well as urban areas, rather than devoting these resources to productive developmental projects (Owais 1989).

An alternative view is that scientific breakthroughs can improve the quality as well as the quantity of agricultural resources, and can help in finding new nutritional resources (Fendall 1972). Thus, Saudi Arabia, for example, has been able to make productive use of its huge areas of desert, by using advanced agricultural technologies - green houses, irrigation systems, artificial fertiliser - so that, far from being dependent on others for its food, it has become an exporter of fruit, vegetables, grain and flowers (Hirst 1993). In contrast, Egypt, which is one of the most populated countries in the world and has a high rate of population growth, utilises only 4 % of its total area of 1,002,000 sq. km.

A less controversial effect of population growth as a result of a decline in mortality rates is the strain it has placed on health policy and health services. Most developing countries have a young population, with those under 15 years old constituting from 40 - 50 per cent of the population. This is significant, as these young people tend to be the main consumers of medical care, welfare, clothing, education, food, family support (Fendall 1972), requiring heavy investment. However, commentators on population and health issues who consider this age category as unproductive are not entirely correct. It is believed that such researchers look at developing societies in the third world in the light of preconceptions such as the status of children in their own societies, who enjoy many privileges such as the right to education, child benefit, etc. In most developing countries, children have a very short childhood because they enter into the labour market under 10 years of age. These children may

work as bread winners or on the family farm. In 1979, the ILO estimated at least 52 million children were at work (Harrison 1993).

Along with all these long - term problems, health is threatened by recurrent periodic famines brought on by droughts, floods and locusts.

1.3.4 Urbanisation

Many developing countries are undergoing rapid urbanisation and urban growth, and it is estimated that by the year 2000, over half the population of the world will be residing in urban centres with populations of 100,000 or more inhabitants (Ebrahim 1985). History shows that with the growth of many cities during the industrial revolution in the Western world, there were high rates of morbidity and mortality among the population of these cities, who were exposed to diseases because of the unhygienic environment. Urbanisation and urban growth are strongly related to health conditions and the input and output of the available health and medical care facilities.

In developing countries, social service facilities, such as medical and health care facilities are unevenly distributed between urban and rural areas, with concentration of these facilities in the former and relative neglect of the latter. The increased facilities available in cities have contributed to the migration of many ruralists from rural areas and small towns to urban centres. This, in turn, has put considerable pressure on the available health and medical care services, which were designed to serve a more limited population.

Secondly, the health and medical care services in the urban areas are based mainly on curative measures. Thus, an increasingly large proportion of the health budget is allocated to urban hospitals at the expense of other regions and types of care, such as health education and preventive care.

Thirdly, the percentage of the overall population of the urban areas who benefit from and utilise these facilities is very small as compared with the whole urban population. For instance, the urban poor have little access to medical and health care services; it is the urban elite who benefit from most of the available services. In many major cities of developing countries, the poor have high rates of infant mortality. For instance, in New Delhi the overall child mortality rate (0 - 5 years) is 221, but it reaches twice this number amongst the poor population. A study in Manila revealed that the infant mortality rate was three times higher among the slum population than among the rest of the

population of the city. The same study showed that the morbidity rates of several diseases were higher among the poor. For example, the incidence of tuberculosis was nine times higher, and of diarrhoeal diseases, twice as high. The poor were found to be twice as anaemic and three times more likely to suffer from malnutrition, as the rest of the city's population (Ebrahim 1985).

Fourthly, evidence has shown that poor housing, particularly in the urban areas, is usually associated with poor health. Therefore, urbanisation is considered a major factor in the spread of communicable diseases. Several studies have emphasised that the health conditions of the population of shanty towns and slum settlements are worse than those of any other parts of the urban centres due to overcrowding and lack of piped water and sanitation facilities.

1.4 Health Resources:

Another approach to exploring health conditions in developing countries is to review the health and medical care service statistics. These statistics provide researchers with data concerning the provision of medical and health care. However, ratios of population per physician, nurse and hospital beds do not offer any information regarding the geographical distribution, or level of utilisation of these facilities, or access to them. Bryant (1969) questioned the validity as well as reliability of these data, arguing that misleading conclusions may be drawn because of the variation in the definitions of terms such as "hospital beds", which might include mattresses on the floors of rural clinics, as well as hospital beds in urban hospitals. Similarly, population per nurse ratios may be misleading without a clear definition of "nurse", because health workers or auxiliaries might be included in the national health and medical statistics alongside qualified nurses. Furthermore, the availability of advanced medical technological facilities does not necessarily affect the health of the people who can not afford to purchase or utilise them (Hardiman and Midgley 1982). Therefore, national health statistics should be used with caution.

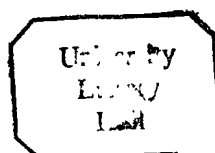


Table 1 - 6 Number of People to Medical Personnel in Selected Countries.

Index	Number of People to Medical Personnel 1990.	
	Physician	Nurse
Ethiopia	78,780	5,390
Tanzania	24,970	5,490
Chad	38,390	3,400
Malawi	11,340	3,110
Egypt	1,320	490
Sudan	10,190 **	1,260
Morocco	4,840	1,260
Argentina	2,340	300
Venezuela	700	...
Bangladesh	6,390	8,530
Indonesia	9,410	1,260
Saudi Arabia	730@	340
Kuwait	640	200
Syria	1,160	870
Jordan	860	980
Iran	3,140	1,150
Yemen	6,506*	1,940
Turkey	2,150	370
Sweden	390	100
United States	470	70
United Kingdom	...	120

Sources: World Bank (1990, 1992,1994) @ Ministry of Health (1991) Annual Medical Report 1411; * Stephen, W. J. (1992); ** data for 1984.

Despite these limitations, the ratios of population per medical personnel shown in Table 1 - 6 provide evidence of the substantial differences between developed and developing countries, and between individual developing countries. Generally, the average population per physician in the low income countries has improved and the number is recorded at 14,160 at 1984 while it was 26,500 in 1965. A similar decline took place in the average population per nurse from 9,760 in 1965 to 3, 540 in 1984 (World Bank 1992). Yet some countries have fared significantly worse than the average. Ethiopia, during the year in question, reported only one physician to 78,780 persons, and population per nurse was estimated at 5,390 (World Bank 1992). If other factors are borne in mind, such as communications from rural areas to urban centres where physicians usually reside, the ratio of population who have access to the medical personnel will be even lower. Information on the ratio of

population to other medical personnel such as dentists is not available. Data regarding the ratios of population to hospital beds are also not easily accessible

Health expenditure data are also considered in many studies and reports on health conditions (this issue will be discussed later in detail). These economic measures provide some information on general government spending on health and medical care. Unfortunately detailed data on each branch or facility of the medical and health care services by country are not available. Thus, the reports of international organisations such as WHO, UNICEF, or UN supply only basic information on health and medical expenditure by countries. However, most international reports present health and medical expenditure in terms such as percentage of the total allocation of the Ministry of Health, compared to overall government expenditure. Another measure in health expenditure per capita and this is probably the most useful indicator, but it is neither precise nor universal. Bryant (1969) and Abel - Smith (1976) discussed this point, and reported variation in expenditure in different countries. For example, Bryant showed that in the 1960s, per capita expenditure on health in Jamaica was 9.60 dollars, while in Nigeria, it was only 59 cents. Similar discrepancies were reported by Abel - Smith.

1.4.1 Financial Resources:

Many developing countries spend comparatively little on health and medical care services, (perhaps one to two percent of their GNP) compared with defence and physical infrastructure such as roads and dams. This pattern of expenditure implies that less priority has been given to the medical and health care sector and to the provision of medical care services by development planners who, as mentioned earlier in this chapter, often believe that economic development requires that investment be concentrated in the productive areas such as infrastructure. Table 1 - 7 shows expenditure patterns on selected sectors.

Table 1 - 7 Expenditures on Three Sectors: Defence, Health and Education of Selected Developing Countries, Compared with Three Industrialised Countries, in 1990.

Country	% of Total Expenditure		
	Defence	Health	Education
India	17	1.6	2.5
Pakistan	30.9	0.7	2
Korea	25.8	2.2	19.6
Oman	41	4.6	10.7
United Arab Emirates	43.9	6.9	15
Indonesia	8	2	8.4
Botswana	11.6	4.8	20.2
Peru	11.2	5.1	16.2
Thailand	17.3	6.1	16.3
France	6.7	15.2	6.8
Germany *	8.3	19.3	0.6
United Kingdom	12.2	14.6	3.2

* Data refers to Federal Republic of Germany before unification, Source: World Bank (1992)

Table 1 - 7 reveals that the proportion of total expenditures allocated for health services varied from 0.7 % in Pakistan to 6.9 % in United Arab Emirates. These allocation covers expenditure on hospitals, maternity and dental services, and on national health and medical insurance schemes as well as on preventive and family planning care. To put these figures in perspective, it is interesting to note that the United Kingdom's spending on health care is 14.6 %; France's, 15.2 %, and Germany's, 19.3 % (World Bank 1992).

Ironically, many countries desperate to improve their population's health status have limited resources, while countries with good health conditions, low infant and child mortality rates, high life expectancy, and high ratios of population to medical personnel and health facilities, spend more than the former on medical and health care services. Table 1 - 8 shows the level of expenditure assigned to health by governments of countries with different levels of income.

Table 1 - 8 Health Expenditure in Developing and Developed World, 1982.

Index	Health expenditure as % of total expenditure	Total expenditure as % of GNP
Low - income countries	3	16.3
Sub - Saharan Africa.	5.3	18
Lower middle - income countries	3.7	23.7
Upper middle - income countries	5.1	26.7
High - income oil - exporting countries	5.5	31.1
Developed countries with market economies	11.7	30.1

Source: World Bank (1985)

There are many patterns of health and medical expenditure, the differentiation in which reflect the socio - political, socio - cultural, socio - economic and ideological factors dominant in each country. In some countries, government assumes the responsibility of providing the population with comprehensive free medical care at all levels of the service. Another pattern is one in which governments share the cost of the services with the patients, or with other national and international organisations. In another, patients have to pay for the needed services, and the private sector flourishes. Similar to the latter pattern, but a little bit different, is the pattern in which people need to take medical insurance. In some countries, medical services can be obtained at nominal charges, e. g. Hong Kong, Jamaica, Kenya and Philippines; other countries impose compulsory social insurance schemes, as is the case in Cyprus and Netherlands (Abel - Smith 1967). In other countries, employers have to provide medical care for their employees, e. g. Peru, Costa Rica , Saudi Arabia, Kuwait, United Arab Emirates (Abel - Smith 1967; Stephen 1992).

1.4.2 Personnel

The shortage of medical personnel is an international issue, not confined to the developing countries alone. However, it is a more crucial matter to the developing than the developed world, because the latter enjoys far better medical standards and health conditions than the developing countries. Moreover, health awareness and education are far greater among the populations of developed countries than is the case with the developing countries.

Undoubtedly, the shortage of medical personnel has a strong influence on the delivery of health and medical services, and on health conditions. Where there are insufficient qualified medical personnel to serve the whole population, concentration tends to favour the capital and other large cities. Furthermore, shortage of medical personnel increases the burden on the available medical staff. Last, but not least, a large proportion of the health budget may be spent on employing expatriate doctors to compensate for the shortfall in indigenous personnel. For example over 30 % of doctors in Nigeria are expatriates (Uyanga 1990), and in Saudi Arabia, only 10.7 % of the total number of doctors who work with the MOH are actually Saudis (MOH 1991).

Table 1 - 9 Population Ratios to Medical Personnel According to Level of Income in 1984

Index	Number of Population to Medical Personnel	
	Physician	Nurse
Low and Middle Income	4,980	1,850
Sub - Saharan Africa	26,670	2,180
East Asia & Pacific	2,390	1,530
South Asia	3,460	2,650
Middle East & N. Africa	2,410	1,800
High Income Economies	470	150
OECD Members	460	150

Source: World Bank (1992)

It is estimated that in the world there is, on average, one doctor trained in modern medicine per 1250 people (Gesler 1984). However, as shown in Table 1 - 9, average population per physician and nurse varies considerably in regions of different economic income levels. Ratios for an individual country may, of course, be considerably higher or lower than the regional average. For example, the percentage of population per medical personnel in OECD members ranged from 140 population per physician in Portugal to 700 in Switzerland; for nurses, the average population ratio is 150, but individual ratios range from 60 in Denmark to 450 in Greece. There are even greater variations in the developing countries. In Saudi Arabia, for example, the World Bank Report 1992 shows that the ratios of population in 1984 were 730 per physician and 340 per nurse, compared with overall average for the Middle East and North Africa of 2,410 per physician and 1,800 per nurse. Africa has the poorest ratios, while Asia fares slightly better.

Another factor which contributes to and aggravates the shortage of qualified doctors in developing countries is what is known as "Brain Drain" emigration from their countries to the developed world because of better salaries abroad, good allowances and the available facilities, such as laboratories, research etc., which offer the opportunity to widen their experience (Gish 1971).

In many countries, the improvement is slow. Thus Uyanga argues that the doctor / population ratio in Nigeria stood at 1 / 22,000 in the 1970s and decreased only slightly to 1/ 17,000 in the early 1980s, in spite of government and medical school efforts to reduce the ratio, because of the rapid increase in population growth; and the aim of reaching a ratio of 1 / 14,000 under the third development plan was not achieved because of the increasing number of doctors leaving the country because of the good salaries abroad, as well as because of population growth (Uyanga 1990).

The shortage of skilled medical personnel is a chronic problem in Saudi Arabia and other countries of the region. However, the Saudi Arabian government is now exerting considerable efforts to overcome this problem, first, by establishing medical faculties to generate qualified doctors, and secondly, by establishing health institutes in various parts of the country, to train secondary school graduates as paramedics, nurses and laboratory technicians. There is, in particular, a great shortage of indigenous nurses in the Gulf region, because of the low esteem in which nursing is generally held, and efforts are being made to improve its status throughout the region. Despite such initiatives, however, Saudi Arabia, Yemen and United Arab Emirates still rely on foreign hospital management companies to administer and recruit personnel for their hospitals. The Gulf region will probably continue looking for the bulk of its health personnel from other Arabic speaking countries and South East Asia, with some consultants from Europe and North America, for some time to come (Ryan 1984).

Not only is there a shortage of qualified medical personnel in developing countries, but the uneven distribution of these personnel, as pointed out earlier, aggravates the situation, particularly in the rural and remote areas. Most doctors want to be located in cities where hospitals and other medical equipment and facilities are available, whereas rural areas often lack diagnostic facilities, drugs etc. In some developing countries human and material resources are concentrated to a large extent in and around the immediate vicinity of the capital city.

1.4.3 Facilities:

The availability and allocation of financial resources for medical and health care in developing countries is reflected in the statistics for numbers of hospitals and hospital beds, other medical organisations such as health centres, dispensaries and clinics, and the drug supply. Similar problems to those highlighted regarding the concentration of manpower in urban centres apply to the distribution of medical care facilities such as hospitals and clinics. Much has been written in respect of the distribution of medical facilities between urban and rural areas (Hardiman and Midgley 1982). Fendall (1972), for example, argued:

" Not only quantitatively is there a bias in favour of the urban dweller, but qualitatively as well there is a gross differential. The standard of service and facilities is much higher in the towns than in the rural areas. This applies to the ratio of staff / hospital beds, equipment and facilities, such as laboratory facilities, x - ray apparatus, pharmacy and pharmaceuticals , and costs." (p. 229).

Many studies have shown that hospitals tend to be concentrated in urban areas and serve only a small proportion of the population. In Ghana, for example, Accra has 23 per cent of the country's hospital beds but only 9 per cent of its population. The rural areas around Islamabad, which accommodate more than two - thirds of the region's population, have only 200 hospital beds, while in the city itself there are 10 times as many.

Studies have also shown that people living nearby are the main utilisers of health facilities. For example, in Ghana, 80 per cent of the in - patients at the country's major hospitals live in the town in which the hospital is located. The effect of distance on the utilisation of health facilities has been explored in many studies. In Uganda, for example, one study showed that the further people lived from health service facilities the less frequently they used them (this point will be discussed further in a later chapter).

Hospitals should have a dual function: they should provide general service beds for the local area and referral or consultative beds for the whole country. The extent to which the beds are used in the latter varies from 5 to 15 per cent. This figure includes both direct admissions and referred patients (Fendall 1972).

However, politicians and decision - makers in third world countries have not yet changed their attitudes toward the distribution of health service facilities, although it is clear that the concentration of

these facilities in urban areas and the building of new and even more expensive hospitals will not be sufficient to improve health conditions and eradicate the spread of infectious diseases. This concentration on curative measures is due in part to pressure exerted by the medical profession (Reid 1986).

1.4.4 Characteristics of Health Systems

The structure of the medical care system in many developing countries is hierarchical, consisting of not less than three levels of health care facilities. At the top of this hierarchy come the hospitals, in second place the health centres, and then the dispensaries, which have different names in various countries (Gish 1975).

Hospitals vary in terms of building structure, bed capacity, number of personnel and equipment, from a building with as few as thirty beds, usually found in rural areas, to a large building equipped with advanced sophisticated technology, research centres and as many as 2,000 beds, commonly located in urban areas, particularly large cities (Gish 1975). Hospitals are often designated as district (or rural), provincial (or state) and national (or referral) hospitals. In some countries, provincial hospitals provide tertiary (highly specialised) care, while regional hospitals deliver secondary (specialised) care. In addition, there are other types of hospitals which provide certain types of long stay hospitalisation service, such as tuberculosis and psychiatric. Hospitals are often run by highly qualified trained consultants and specialists.

The health centres, which are usually less well equipped than the hospitals, constitute the second level in the hierarchy of the health system network. They are mostly found in suburban areas and small towns. In some countries, these health facilities provide in - patient services, where distance from a regional or provincial hospital is great (Werner 1983). However, the level of services and number of patients admitted are not as great as in the hospitals. In some countries, care in the health centres is provided by general practitioners, in others by a team of " primary care specialists" such as paediatricians, obstetricians \ gynaecologists, and internists. Also, there could be a social worker, sanitation officers and a number of nurses, technicians and other support personnel (Werner 1983) .

The last category in the health system is the dispensary, which is usually the least equipped in terms of facilities and personnel. Dispensaries are frequently located in rural and urban slum areas.

Most health systems in developing countries share the following common characteristics:

1 - The health services in most developing countries are administratively centralised; thus planning, organisation and funding are in the government's hands. Therefore, there is no real flexibility in implementing and delivering the health services to the people, and the decision - makers usually are far away from the actual needs of the people.

2 - Many of the developing countries' governments have adopted the industrialised countries' model of health care, which is hospital - based and curative in orientation. This strategy has failed, because the health conditions and problems in developed countries are different from those in developing countries. The tendency to create highly sophisticated health services staffed by highly qualified personnel absorbs the available scarce resources, without providing comprehensive health coverage for all the population.

3 - There is no relationship between the scale of health facilities and the population they are designed to serve. Hospitals are located in cities to deliver medical care for the urban minority, while the dispensaries are for the rural majority.

4 - In most developing countries, the choice of curative, high - technology and urban - based medicine is made at the expense of preventive, low - cost and more relevant medicine. This choice is reflected in the funding devoted to the former.

5 - The health services in most developing countries are fragmented, with curative medicine provided through hospitals, health centres, dispensaries and clinics, both public and private, and preventive medicine provided through other organisations. Ministries of Health provide immunisation campaigns against particular diseases, while environmental sanitation is the responsibility of municipalities or other organisations. The multiplicity of agencies involved in health care provision can lead to lack of coordination and cooperation, leading to waste in financial resources and efforts.

6 - Too little attention is paid to preventive medicine such as health education and protection against communicable diseases.

7 - In many developing countries, traditional medicine is still practised and is widely accepted by many categories of the community. However, officially it is not recognised in many developing countries, for example, in Arab countries, because the medical professions do not accept it and have not made any efforts to investigate it. However, in other countries, such as China and India, traditional medicine has been integrated and is treated with respect.

1.5 Conclusion

The combination of malnutrition and childhood infectious diseases such as whooping cough and measles leads to high infant and child mortality rates in developing countries. Lack of access to safe water, inadequate sanitation, poor housing conditions, and lack of access to quality health care contribute to the spreading of diseases, and the severity of their effects. The improvement in health determinants may therefore be expected to lead to improvement in health status.

In view of the differences between the developed and developing countries in term of the main causes of ill - health, kind of diseases, material resources, population size and structure and literacy levels, health planning in the two groups should be different. Modelling the health systems on those of developed countries, as has been seen, is insufficient to reduce the rates of mortality and morbidity. What has resulted from such patterns of health care systems in most developing countries, is continued poor health conditions. Mortality and morbidity rates are still high. Life expectancy at birth remains low. Children are still dying of preventable communicable diseases. Few people have access to potable water and proper sanitation systems, in both rural and urban areas.

It is apparent that in order to achieve any degree of improvement of health, particularly in terms of equitable distribution of services and prevention of dominant diseases, a radical change in delivery system is very necessary. Ministries of Health in developing countries should adopt a policy and strategy which will improve their population's health conditions, rather than pouring their scarce resources into a few prestigious projects with advanced technology, to which only a small proportion of the population have access. The discussion presented in this chapter provides a strong justification for adopting a primary health care approach, since this approach can do much to improve the health conditions, especially of mothers and children, at relatively low cost and with less highly qualified

personnel, such as health workers and auxiliaries. A primary health care (PHC) approach would appear to be the key to improving the health conditions of the developing countries and to bridging the health gap between the developed and developing worlds. Reported evidence showed that the main causes of ill - health in developing countries imply the need for preventive care and health education which are the cornerstones of the PHC approach which should greatly reduce many causes of diseases and mortality. Thus, the following chapter will discuss the primary health care approach in detail.

2.1 Introduction:

The previous chapter showed that health conditions are associated with and result from many other factors: economic, social, cultural, environmental and political. Therefore, improvement in health conditions cannot be achieved by addressing only a single factor. This chapter discusses the emergence and philosophy of the primary health care approach (PHC), which emerged as a world-wide movement more than fifteen years ago. PHC is widely perceived as being the only effective means to achieve the World Health Organisation's goal of "an acceptable level of health for all by the year 2000".

The concept of PHC is not new in itself. It was introduced for the first time in 1920, by Lord Dawson of England. At the time, Lord Dawson's concept was a combination of primary medical care and organised preventive services, delivered by general practitioners. A similar idea was put forward a few years later by Dr. Herman Bigges, the health commissioner of New York (Al - Osimy 1991). Lord Dawson's concept was implemented for the first time in the former USSR, as an integrated health care service providing both curative and preventive medicine through health centres. In the United Kingdom, some elements of the PHC concept are apparent in the medical system. For instance, most doctors work in groups of three or more, with nurses and public health nurses, under the title "primary care". Social workers are sometimes included in the team (Horder 1986). Thus, neither the concept of PHC nor its practice are new. What is new, is the global political support given by governments and non - governmental organisations, to the adoption and practice of this approach (Gish 1979). The concept, purposes and development of the PHC approach will be explored in the following section.

2.2 Primary Health Care Background:

In 1973, the Executive Board of the World Health Organisation (WHO), after careful consideration of the findings of a study of the world health situation, arrived at the conclusion that in many countries, and particularly in the less developed world, the health service delivery systems, which were supposed to help in improving health conditions, were not keeping pace with the changing needs of populations, either in quality or quantity, and that in some cases the situation was getting worse. This deficiency was evidenced by the lack of equity in distribution of health resources,

which resulted in limited or no access at all to health care service facilities for a large proportion of the world's population (Klecxkowski 1980). In some parts of the world there was no co - operation between health services and other related sectors which have a great role to play in health conditions, such as education, communication and social organisations. Little attention was paid to community involvement. The study suggested that at least one reason for this was the conventional approach to health service delivery, based mainly on high technology and concentrating on curative care, irrespective of the needs of the local population, or of social realities. The result was an imbalance in the types and distribution of services provided, with a lack of harmony between preventive, promotive, curative, rehabilitative and supportive functions. The study also pointed out the increasing cost of health care, which presented a major problem in both developed and developing countries. This cost was in part attributed to the misuse of technology (Klecxkowski 1980).

Similarly, in May 1975, the report on a study sponsored jointly by WHO and UNICEF, "*Alternative Approaches to Meeting Basic Health Needs in Developing Countries*", revealed that, despite the great efforts made by governments and international organisations, the basic health needs of the majority of people throughout the world had not yet been met. The study also criticised the existing patterns of health systems, which were often modelled on those in the industrialised world, and called for revolutionary changes in approaches to health services, which should be remodelled and linked to the prevailing cultures, norms and values of each individual society (Djukanovic and Mach 1975).

" In many countries less than 15 per cent of the rural population and other unprivileged groups have access to health services... the strategy adopted... by many developing countries has been modelled on that of the industrialised countries, but as a strategy it has been a failure... In sum, ... the conventional health services, organised along Western or other centralised lines, are unlikely to expand to meet the basic health needs of all the people... Clearly the time has come to take a fresh look at the world's priority health problems and at alternative approaches to their solution" (Djukanovic and Mach 1975, p. 7).

The study explored the strengths and weaknesses of several health systems in different parts of the world, selecting case studies of different countries with different political, economic, socio - cultural, environmental and ideological features. From the analysis of these approaches, the study concluded that despite economic and other formidable problems, it was possible, using the available

resources, to meet the basic health needs of the populations in developing countries, achieve better health care coverage and improve the levels of health conditions, by giving health high priority in general development programmes and using health workers chosen by the people from among themselves and suitably trained, as contrasted with reluctant, alienated, frustrated groups of bureaucrats "parachuted" into the community (Djukanovic and Mach 1975:104). The need, then, was not only for the reorientation of the existing health system and the training of "new" primary health workers, but also for community participation in decision - making.

Against this background, numerous studies have been carried out to explore the role of community participation. For instance, Newell (1975) argued that basic health needs should be delivered by non - professional people, and explored in more depth the aspect of community participation, referring to several examples to represent the different approaches to delivering community - organised primary health care. He identified the key similarities between these successful approaches as follows:

" Each country or area started with the formation, reinforcement, or recognition of a local community organisation. This appeared to have five relevant functions. It laid down the priorities; it organised community action for problems that could not be resolved by individuals (e.g., water supply or basic sanitation); it "controlled" the primary health care services by selection, appointing, or "legitimising" the primary health worker; it assisted in financing services; and it linked health actions with wider community goals (Newell 1975 p. 193).

Similar observations have been made by Benyoussef and Christian (1977).

Health by the people is both a philosophical and a pragmatic idea. Philosophically, community organisations, through practising their powers of self - determination, should be the starting point of health care services. Practically, because of very limited available resources, the community should be the starting point for any effective health system. This type of health care is an approach to medical care that is shaped around the population it serves.

These studies and others undoubtedly gave momentum to the promotion of the notion of primary health care, and to the call for high priority to be assigned to the identification of solutions to health problems and social injustice, particularly among rural and urban slum dwellers. Therefore

health became a social target for government. The World Health Assembly resolved (WHA 30.43), in its thirtieth session, in 1977, that

" The main social target for governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health which will permit them to lead a socially and economically productive life" (WHO 1979, p. 7).

This was the starting - point for the well - known goal of " Health for all by the year 2000" (HFA/2000). After 1975, a series of national, regional and international meetings, seminars, workshops and conferences had been held throughout the world by WHO and UNICEF (Bennett 1979), culminating in Alma - Ata Conference of 1978, which was attended by government delegations from 134 member states together with representatives of 67 United Nations' organisations, specialised agencies and non - governmental organisations in official relation with WHO and UNICEF (WHO / UNICEF 1978). This conference has been described as the largest and most authoritative international meeting on health affairs ever convened (Golladay 1980) and as the largest single - theme conference ever held (Bennett 1979).

There were six objectives for this conference:

- 1 - To promote primary health care in all countries.
- 2 - To define the principles of primary health care and the operational means to overcome the problems expected be encountered in its development.
- 3 - To exchange experience and information on the development of primary health care within the framework of comprehensive national health systems and services.
- 4 - To evaluate the health care situation throughout the world as it related to, and could be improved by primary health care.
- 5 - To identify the role of governments, national and international organisations in technical co-operation and support for the development of primary health care.
- 6 - To formulate recommendations for the development of primary health care (WHO / UNICEF 1978:11) .

The immediate outcome of the conference was a ten article declaration reaffirming health as a fundamental human right and world-wide social goal, and calling for a new approach to health and health care, to close the gap between the "haves" and "have - nots". Governments' roles and duties towards their populations' health, as well as towards social and economic development, were

emphasised, as was the importance of individual and collective participation in the planning, operating and provision of health care. The relationship between the primary health care approach and development in general was emphasised. Moreover, the technical and operational aspects, and the national and international strategies and plans of action to further the approach were highlighted. The declaration concluded with 22 specific recommendations (WHO / UNICEF 1978). Some aspects of the declaration are discussed below.

2.2.1 Definition and Components of Primary Health Care:

The Alma - Ata conference distinguished clearly between primary health care and the much narrower concept of primary medical care, which is still all too often mistakenly regarded as the same (Reid 1986).

Articles VI and VII are of particular practical importance to those concerned with the provision of PHC, as the first clearly defines PHC, while the second explains in detail the definition's components. Primary Health Care (PHC) was defined as:

" An essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spite of self - reliance and self- determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process"(WHO / UNICEF 1978).

The concept of PHC was further elaborated to describe in more detail the content of the definition and the support needed from the other levels of the national health system and co-ordination with other sectors, as follows:

Primary health care:

1 - Reflects and evolves from the economic conditions and socio - cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience.

2 - Addresses the main health problems in the community, providing promotive, curative and rehabilitative services accordingly.

3 - Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child health care including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

4 - Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors.

5 - Requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care; making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate.

6 - Should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need.

7 - Relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (Ibid.).

This definition described the ideal PHC package. However, it was stressed that there is no single model of PHC approach, to be implemented in every country. Each country must determine its own approach to PHC according to its political, socio-cultural and economic circumstances.

The need was pointed out to define the main national health problems in the community, and to provide the necessary measures, ranging from the promotion of health care through to rehabilitation care, with an appropriate balance between the primary health care elements.

The third component of the declaration listed eight basic essential medical and health aspects, implying wider political and practical measures, involving the commitment of other individuals, organisations, and governmental agencies than those usually responsible for health and medical care. Coordination between all these levels is a crucial challenge.

The definition of PHC given at Alma - Ata stressed individual and community participation in the planning, organisation, operation and control of PHC. Undoubtedly, most countries recognise the importance of community participation in relation to PHC. However, there is no clear cut definition of community participation. It may range from direct and universal involvement on the periphery levels, such as electing or nominating primary health workers, to a high level of participation in designing policy, planning, operating and organisation of the services. Community participation in PHC will be discussed in more detail later.

The definition also highlighted the relationship between PHC and the various others tiers of the health care systems, stressed the referral systems, and the end goal of providing comprehensive health care coverage, particularly to those most in need.

A further important issue covered by the declaration was the concept of the PHC team. Human medical resources, as mentioned in the previous chapter, are a crucial problem for developed as well as developing countries. The declaration of Alma - Ata recognised that for this reason, the provision of health care must rely on health workers, ranging from highly qualified personnel on the referral secondary level (hospital), to traditional workers who can be trained and supervised appropriately to work with the other providers as a health team. Also, it was stressed that members of the team can be promoted to upper levels. This will be discussed below.

Thus, PHC approach is not only concerned with the delivery of health care services, but also implies many other aspects. In the first place, it links health and development strategies. Rifkin and Walt (1986) pointed out that:

" Primary health care is not merely health service improvements. It is understanding and improving the range of social, political and economic factors which ultimately influence the improvement of health status." p. 561.

The close relationship and interdependence of health and social and economic development was stressed at the international conference on PHC. Furthermore, the conference considered PHC as an integral part of the socio - economic development process and therefore, it emphasised that all the activities of the health sector should be coordinated at all levels national , intermediate, and community, with those of other social and economic sectors. Moreover, health activities must be conducted in parallel with measures such as those for the improvement of nutrition, protection and improvement of the environment; alleviating the level of poverty; increase in production and employment; and equitable distribution of wealth (WHO / UNICEF 1978). Therefore, the PHC approach is believed to be an instrument for development as well as provision of health care and improving health conditions. Bennett (1979) argues that:

" primary health care has been firmly established as the avenue which most developing countries will explore in the next twenty years, in order to improve the quality of life and health of every individual in every community". p. 505

The expected role of PHC in meeting health needs, particularly in developing countries, encouraged the World Bank and other organisations to give support and momentum to the approach. For example, the World Bank agreed to begin direct lending for health projects, with the aim of strengthening the planning and budgeting capacities of Third World countries to improve their PHC system (MacPherson 1982).

However, although the approach was received enthusiastically by many commentators all over the world, a number of writers have criticised the concept and, more precisely, its feasibility in a particular political setting (Sidel and Sidel 1977; Doyal 1979; Gish 1979; Walsh and Warren 1979; Rifkin 1981). Sidel and Sidel (1977), argued that the PHC approach has been possible only in societies where a fundamental shift and redistribution of power and wealth took place within the political structure from those who had most to those who previously had least, and cited strong evidence that the PHC approach, like the medical system as a whole, is a reflection of the socio - political and economic structure of any society. Examples were presented from different parts of the

world. The former socialist countries tended to provide free public health services, either through polyclinics or health centres¹ which served a defined neighbourhood, as the first stage of contact, then secondary and tertiary services. In keeping with their ideology, the health services in the former USSR and other socialist states were socialised, centralised and professionalised (Sidel and Sidel 1977; Morley 1983). In the capitalist countries such as USA, PHC reflects an overall socio - political structure characterised by the private sector " free - market" economy. The only exception, the authors argued, is the UK' s National Health Service (NHS), which is " socialised" and comprehensive in scope in the sense of looking after the whole population; the same is true of Sweden to some extent (Klein 1989). In countries such as Saudi Arabia, where the political structure is neither capitalist nor socialist, this is reflected in the health sector, where both public and private services are offered (this will be discussed in a later chapter).

Gish (1979), argued that the context of health programmes in countries such as China, Cuba and Tanzania (usually quoted as major examples of changes in health policy), are taken for granted, and sufficient and careful examination of health programmes and their improvements in these countries has been lacking. Furthermore, he argued that the present reality is different. In any event, historical experience is not such as to encourage optimism. In the short run at least, the " alternative approaches to health by the people" may only contribute to the status quo and assist some governments and health ministries to get " off the hook"

Rifkin (1981), using the Chinese health care model, which is consistently upheld as the ideal model to follow for primary health care development, argued that although most of the ideas of the Alma Ata declaration on PHC were based on the Chinese health care experience, the model has been subject to many misinterpretations, and the lessons concerning the political will and community participation have not been understood. The political will is too often taken to mean simply the commitment of the national governments to allocate the necessary resources to the health sector. In China, political will is an instrument by which the entire society will be transformed to meet the goals of the nation. The delivery of health care does not create, but follows, the strategy of total development. She further argued that changes in the health sector reflect changes in the national

approach to development. It is not possible to create, support or maintain changes which are divorced from other social changes.

Similarly, community participation, which is seen as one of the fundamental components of the PHC approach, has been taken as a means to mobilise community resources, while to the Chinese community, participation is a way of educating a large proportion of the population to understand, accept and act upon government's policy concerning production and social activities. Rifkin saw the Chinese health model, not as a model for improvement in health care delivery system, but as a model for social change.

" Health improvement ... came as a result of a strategy of total development not as a result of change in the health services alone" (Rifkin 1981, P. 5).

MacPherson (1982), argued that genuine PHC will only be extensively developed if there are fundamental reforms of the more conventional health delivery systems.

Due to the variations of political, economic, social - cultural and ideological characteristics among countries, the policies, strategies, plans of action and implementation of PHC programmes will consequently differ from country to country as well as within countries. In the coming section, some general elements of the policies, strategies and plans of action established by WHO will be discussed.

2.3 Policies and Purposes:

PHC, in its wider sense, involves several functions other than mere provision of health and medical care, as indicated earlier. Therefore, other related sectors which directly or indirectly influence health conditions must be included in the process of policy formulation. The declaration of Alma - Ata clearly stated that PHC is the essential key to achieving HFA 2000 as part of overall development and in the spirit of social justice. Furthermore, it called on all governments to formulate policies, strategies and plans of action necessary to initiate PHC as a part of the overall health system and to ensure that a reasonable standard of such care is available to all. The International Conference on PHC urged:

" All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors ... it will be necessary to exercise political will, to mobilise the country's resources" (WHO / UNICEF 1978: 5).

In the light of the magnitude of the prevailing health problems and the insufficient and uneven distribution of health resources between and within countries, the declaration also stressed the urgent need for international and national action to narrow the variation between the "haves and have nots". Policy should pay particular attention to those who are at risk or underserved, in urban slums or rural areas, as well as children and women.

In January 1979, the World Health Assembly adopted resolution WHA 32.30. based on the resolution EB 63.R21, of the Executive Board of WHO. In that resolution the Health Assembly urged governments to act both individually and collectively on regional and global levels in pursuit of HFA 2000 (WHO 1981). It recommended using as a basis the guiding principles issued in the Executive Board's document entitled "Formulating Strategies for Health for All by the Year 2000", which outlined a flexible general framework for governments to formulate their policies, strategies and plans of action in accordance with their political, socio - cultural, economic and geographical circumstances as well as the aspirations and capabilities of their countries.

Countries will differ in setting national goals. Some may concentrate heavily on the provision of health services, while others may concentrate on the health status of the population. Countries may also differ in identifying the acceptable level of health. In addition, different approaches may be adopted to provision of health services. Some countries are able to provide a full range of health services, while the provision of services in other countries is limited; either selected groups of population may enjoy restricted types of health services, or a small range of health services is provided to all the population, for example immunisation, or programmes to eradicate a particular endemic disease.

When the strategies have been formulated, health will constitute an important contribution to social and economic development. For this reason, WHO (1979) stressed the importance that should be attached to health policies, as compared to urbanisation, rural development or industrialisation, to which developing countries tend to give priority (WHO 1979). Health policies ideally reflect the social and economic goals of the government and the people. Thus, the strategies for health, social and economic sectors will be mutually supportive, and together contribute to the ultimate goals of the society (WHO 1979).

Recommendations for changing health policy in Third World countries are usually focused on the need to develop a PHC approach which involves low - cost, preventive medicine rather than the curative physician - based medical services prevalent in the industrialised countries, and utilises low - technology care, which is affordable in the light of lacking of health resources. This approach depends on available and inexpensive means of delivering health care, such as community participation, and basic training of local healers and others in preventive health services, sanitation and nutrition. For countries with restricted health care resources, PHC is more appropriate than hospital - oriented systems (Bossert 1979), which are costly and likely to be inefficient and ineffective (Mburu 1981) and, since it is unlikely that the necessary personnel and facilities can be provided throughout the country, tend to exacerbate existing inequality of distribution, accessibility and utilisation of health care facilities.

The PHC approach has gained wide acceptance in the international health community, because of its goals and objectives. However, the same level of international agreement has not been achieved with regard to the formulation and implementation of policies. Some governments have shown some hesitation in adopting a health system based on the PHC approach. However, the process of formulating a health policy is a complex political process, and it will take more than medical evidence to gain government interest in adopting a new approach to health problems (Bossert 1979).

2.3.1 Health Policies in Poor and Rich Countries:

The health care problems in the rich nations are not the problems of need or lack of health resources; rather, the opposite. The hospital - based system, which exists in the industrialised countries, seems to suit the existing patterns of residence where more than 90 % of the population live in urban areas. Furthermore, the development of technology has led to or necessitated modernisation of hospitals and medical equipment. The demand for hospital diagnostic and curative medicine technology motivates the medical profession. Therefore, the public outcry in the UK, USA, and some other countries is not over lack of health care services, but rather demand for higher technology, increased hospital beds capacity and greater specialisation in medical fields.

In the less developed countries, as mentioned in the previous chapter, the problems are different. Generally, the demands of the population in the developing countries outstrip the volume of the

existing health care facilities. In addition, most of the population in developing countries are rural and can not afford to seek health treatment in urban centres. However, rich minorities have access to the same types of health care services as are available in the industrialised countries and demand more such services, regardless whether they are suited to the situation in their countries. This wealthy segment of the population is also more likely to have social and political influence, and so can easily exert pressure for meagre health resources to be distributed in favour of the urban dwellers, at the expense of the majority, the rural and urban slum dwellers, for whom the quality and quantity of health care is unacceptably low (Mburu 1980; Beryoussef and Christian 1977; WHO / UNICEF 1978).

In some developing countries, development of the health care system has meant simply expansion of the existing health system. This strategy is incompatible with the spirit of the Alma - Ata declaration, and will not lead to achieving the social, economic and political goals set by the PHC International Conference. Moreover, a large number of developing countries depend on assistance from rich countries and international organisations. Mburu (1980), questions for how long those countries will continue to rely on the rich countries and points out that as long as they so do, they try to model their health care systems on those in the rich countries.

2.4 PHC in Rural and Urban Context:

The health problems and mortality and morbidity rates in rural areas are very different from those in urban areas. Therefore, the policy and strategy for delivering health services through PHC programmes to rural and urban populations will be different. Differences between rural and urban populations of a country in level of mortality and morbidity reflect not only variations in natural environmental conditions, in the quality and distribution of health services and facilities per head, and furthermore, in the extent to which use is made of these facilities and services, but also the differences between the two populations of these communities in cultural and socio - economic characteristics. Urban and rural populations differ in respect of level of literacy, education status and income. With regard to the distribution of health facilities and services, rural populations have less choice than their urban counterparts, who have access to a wide range of public and private services, both general and specialist. Approaches and techniques of health education in rural and urban areas should concentrate

on issues related to the health problems and needs in every society. For example, most rural areas in the third world lack a clean water supply system and hygienic sewage disposal. The health problems of the urban people, particularly the poor can be associated with or result from poverty, environmental, and psycho - social problems, infectious diseases, industrial hazards, and social diseases (Harpham, et al. 1988). Urban populations need health education on issues related to environmental hazards, and on issues concerned with the air, water and noise pollution. Populations of both societies are vulnerable to infectious and communicable diseases. Therefore, they are in need of preventive measures and health education related to these issues.

Ityavyar (1988), discussing the difference between rural - urban distribution of health facilities, claimed that in some cases, even where dispensaries and maternity clinics are located in rural areas, services are unreliable as a result of shortage of drugs and health personnel to run them regularly. In many cases, rural populations face problems with access to health service facilities, because usually these facilities are in distant places and with few or poor roads, and little or no public transportation. Thus, rural people find it hard to gain access to these facilities. Using CHWs will help the health service to reach out to those areas.

Mburu (1979) stressed that to provide adequate health services for a fast growing rural population, three conditions of health development should be fulfilled: availability, accessibility and acceptability of health services. The availability of health services is a necessary precondition, though not sufficient for adequacy. Service facilities should be established and maintained among people who need them. If health services are to be appropriately utilised, they should be accessible to those who need them. Many studies have found that distance to the health facilities resulted in less utilisation of these facilities. Additional factors are availability and cost of transportation, the time consumed in travelling to the health services and time spent waiting to be served at the clinic. The third condition is the acceptability of the services to the prospective clients. The perceived quality, personnel behaviour and existing norms governing the interaction between the providers of the services and recipients are very important determinants of acceptability. They affect the pattern and adequacy of utilisation of the services.

Any health strategy to be implemented in rural or urban areas should take into consideration these factors, to be effective and efficient.

2.5 The Implementation of Primary Health Care:

As we have seen, no single model of the PHC programme was suggested at the Alma - Ata conference, but each country was left to choose whatever model is affordable and compatible with its political, socio - cultural and economic conditions. Several trends have emerged, the most prominent being " Selective Primary Health Care" (SPHC), " Comprehensive Primary Health Care" (CPHC) and " Basic Primary Health Care" (BPHC). These three popular approaches have been debated for a long time. The latter two have a wide scope of services and activities. However, BPHC does not include within its activities any environmental services such as supply of safe drinking water or sanitation.

The " Selective Primary Health Care" concept was first put forward after the International Conference at Alma - Ata, in an article by J. A. Walsh and K. S. Warren (1979) in *New England Journal of Medicine*. They attacked the PHC approach as defined at Alma - Ata, as being idealistic, and suggested that the concept needed to be narrowed in order to be practical and cost - effective. Thus, they suggested a switch to SPHC, based on identifying and prioritising the major diseases that cause the most deaths and morbidity in a given society. Walsh and Warren suggested that priority for prevention and treatment should be given to diseases which had:

- a - highest prevalence in the country or the community;
- b - highest morbidity or severe disability;
- c - highest risk of mortality;
- d - the greatest possibility of control in terms of the effectiveness and cost of intervention (Walsh and Warren 1979).

This approach gained support from some scholars (Evans, et. al 1981). However, opponents of this approach have criticised the suggested methodology and implementation. Gish (1982) accused Walsh and Warren of ignoring the reality that a health care infrastructure already exists in most developing countries, and of failing to realise the nature of the wider development process. He claimed their approach was " old wine in new bottles".

Berman (1982), criticised Walsh and Warren for their analysis and inappropriate use of cost - effectiveness evaluation methods, and pointed out the danger of applying simple technical costing techniques to very complicated public health problems. He also argued that SPHC is not a relevant or desirable alternative for most countries, though it demonstrates that improved effectiveness, equity and efficiency of primary health care need an approach that balances the efficacy of medical technology with individual needs and social context, all at a cost countries can afford (Berman 1982).

Banerji (1984), argued that the SPHC approach:

- 1 - neglected the concept of community participation with programmes from the "bottom - up";
- 2 - gave allocations to people with only priority diseases, leaving the rest to suffer;
- 3 - reinforced authoritarian attitudes;
- 4 - had a fragile scientific basis;
- 5 - had a questionable moral and ethical value, in which foreign and elite interests overruled those of the majority of the people.

Unger and Killingsworth (1986), argued that SPHC was to a large extent similar to vertical or disease - specific programmes which contributed to the elimination of yellow fever, smallpox and typhus in Europe and North America in the beginning of the 20th century. However, the failure of malaria eradication campaigns in some African and Asian countries, they argued, cast doubt on the ability of vertical intervention programmes to achieve significant reduction of suffering and mortality in the long - run. Moreover, they questioned the validity of the empirical support for SPHC claimed by Walsh and Warren.

Finally, Rifkin and Walt (1986) reviewed the debates concerning SPHC as opposed to comprehensive primary health care. They traced the origins of the PHC concept and suggested that PHC is not an alternative for health care delivery but a strategy for health development. As such, and in contradistinction to SPHC it emphasises process and change rather than programmes designed for repetition and replication. From this perspective, health service delivery is seen as part of overall social and economic development, rather than simply improving the health conditions of the people. The 1970s WHO strategy supports this perspective as it defines health as not only the absence of diseases

or infirmity, but rather, a state of complete physical, mental and social well - being (WHO / UNICEF 1978). The SPHC view, in contrast, sees health simply as an absence of diseases.

Reviewing the definitions and strategy of the both PHC and SPHC approaches, numerous differences can be pointed out:

1 - SPHC is concerned with medical intervention by the most cost - effective techniques, to improve the health conditions of the majority of the people in developing countries (Walsh and Warren 1979). PHC, in contrast, is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full involvement and at a cost that the community and the country can afford. It forms an integral part of both the country's health system, of which it is the nucleus, and of the overall social and economic development of the community (WHO / UNICEF 1978).

2 - It appears that both approaches seek to improve the health conditions, but from different standpoints. PHC considers health as a process of development and part of overall development, while SPHC, on the other hand, sees health as depending on the intervention of professionals to reduce mortality by attacking and controlling particular diseases. SPHC has confined health to a narrow meaning and has kept that meaning in the control of those trained to deal with disease, whereas, PHC has a broader perspective and has moved health from the responsibility of the medical professionals and highlighted the importance of other factors such as environmental and social context (Rifkin and Walt 1986).

3 - PHC emphasises the importance of community involvement in planning, designing and implementation of the health services. SPHC does not see any necessity to involve the people in such measures; it is sufficient for the people to understand and accept the medical interventions. In other words, SPHC is rooted in the "trickle down" concept that the medical professionals are the only segment of the population who have the right to choose and use the medical intervention measures, and that community participation is not cost - effective (Rifkin and Walt 1986).

4 - One strategy of the PHC approach is to distribute the health resources and facilities equitably within countries, so that all communities, and all people will have equal access to the available health services. SPHC target criteria make no mention of the needy or the poor. Rifkin and Walt (1986)

comment that evidence suggests that, particularly among the very poor, the provision of health care intervention is not enough to improve health conditions dramatically. Unless sufficient time, effort and money is made available to defeating social and economic problems, people do not utilise the services provided. SPHC fails to address equity. Furthermore, SPHC programmes, by identifying prevalent diseases and monitoring vulnerable groups, deprive the rest of the population of access to health services, so they have to turn to the private sector or folk healers.

The literature on assessment of primary health care is still somewhat rudimentary, the majority being concerned with the current practice of the approach in individual countries. The books, Primary Health Care 2000, by John Fry and John Hasler, and Practising Health For All, by David Morley and others report a number of primary health experiences in different countries. The coming section will explore some of these experiences. However, first, some essential features of primary health care need to be highlighted.

1 - Availability: PHC is theoretically supposed to provide curative, preventive, promotive and rehabilitative health services, the range of which will certainly vary from one country to another. However, in reality, where the health units exist, PHC is curative in nature. Many developing countries provide only curative services, with a minimum level of preventive aspects (Sebai 1988). The availability of curative care is crucial to both providers and recipients. Although the majority of the health problems facing the third world health can be tackled by adopting appropriate preventive measures, many people will remain unconvinced and have difficulty in accepting preventive care because they want good curative care, or because the effectiveness of primary health care is poorly regarded by patients (Stephen 1991).

2 - Accessibility: Several factors affect physical accessibility and therefore utilisation of the available health care facilities. One is the location of the health care centre. The farther patients are from any health source, the less likely they are to utilise it. This factor can be eased by availability and reliability of public or private transportation to and from the health units. Without this, segments of the population most frequently vulnerable to diseases, namely children, mothers, the elderly and the handicapped, will face great problems in obtaining access to these facilities.

3 - Acceptability: This aspect was stressed in the declaration of Alma - Ata. However, what is acceptable in one society may be very odd in another. This depends on several factors, including religious belief systems, cultural and social norms and values. Thus health planners and organisers should bear in mind these factors when planning the provision of the health services. One example of unacceptable practices in the provision of the health care is the use of male doctors in maternity and family planning clinics, when by tradition and for religious and cultural reasons, many people are only prepared to consult a female doctor. The presence of the male doctor may lead to under - utilisation of such clinics (Beryoussef and Christian 1977; Gallagher and Searle 1985; Stephen 1991). In many developing countries, PHC centres are accommodated in very poor buildings, inappropriate for health facilities. Equally important is that in some communities, expatriate staff are employed, who do not speak the local language and have inadequate awareness and understanding of the community's culture (Sebai 1983; Banoub 1984; Stephen 1991).

4 - Continuity: PHC involves individuals' first entry to the entire health care system. Thus typically the first contact takes place in the PHC centre, where the initial assessment and treatment for particular health problems also takes place. In order to provide effective health care, it is important that the health workers are in continuous contact with the served community. Such contact is highly valued by patients and is one of the reasons that traditional healers or primary health care workers may be more readily accepted and able to deal with many local problems better than any government personnel who just come and go (Newell 1975; Stephen 1991).

5 - Appropriateness: On certain levels, PHC can be provided by a health worker who need not necessarily be a doctor, but a person selected by the community to work in the health field. This will help greatly to save scarce financial and manpower resources in developing countries. It is necessary for those health workers to have sufficient training to diagnose and treat simple ailments and deal with some injuries and accidents. Health workers are acceptable in some villages and rural communities. However, in other areas they are not acceptable and it is inappropriate to deliver health care through them; for example in many developing countries, the nurse's role is seen as simply to take the patient's temperature and blood pressure.

6 - Referral: The PHC approach is based on a referral system, but without adequate support and co - operation from the secondary and tertiary levels of the health care system, the referral system will not be effective. Sebai (1988) argues that a PHC programme, delivered properly, can meet almost 80 % per cent of the health needs of the people and only 20 % per cent of health problems should be referred to secondary and tertiary health services.

7 - Essential Elements: At the present time there is a tendency to concentrate on the health problems of the rural populations in developing countries, but it is also necessary to remember the plight of the overcrowded shanty towns and slums of the major cities in the Third World which have grown so dramatically over the past twenty - five years (Tabibzadeh 1989).

2.5.1 Examples of PHC Implementation:

Following are two experiences of implementation of PHC from the Arab world, one from Bahrain, the second from People's Democratic Republic of Yemen. From these, it will appear that there are not only differences in the way PHC is implemented from country to country, but also discrepancies between PHC as envisaged in the Alma - Ata conference and as implemented in practice. A range of programmes and projects are termed as PHC. Several countries still carry on with some of the existing health system schemes as PHC. Others introduce small scale projects and called them PHC, while others adopted some ingredient elements of PHC, such as the extensive use of community health workers to main the same. Community participation, which is a fundamental function of the concept, has been rudimentary in countries where it is practised, with a limited scope and depth of involvement.

2.5.1.1 Implementation of PHC in State of Bahrain:

Bahrain enjoys a fair health status, similar to a great extent to the health conditions in many of the industrialised countries. In 1989, the infant mortality rate was 15 per 1,000 live births. In 1986, under 5 years mortality rate was 19 and maternal mortality rate 8 per 100,000 births (Ministry of Health 1986). Bahrain has enjoyed a rise in living standards in the last two decades, due to the rise in the oil prices and to its position as a communication centre in the Gulf region creating wide work opportunities.

In 1925, the Bahrain government took the first step towards organising a comprehensive health care system. In 1968, with the co - operation of WHO, the Bahraini government planned a

comprehensive development plan for the health service, the main objectives of which were to strengthen the existing health facilities by introducing a system of medical profiles, increasing the number of health centres to provide a basis for PHC, providing training for all health personnel categories and incorporating preventive medicine within the Ministry of Health. Immediately after the Alma - Ata conference, the Bahraini government adopted the PHC approach and a new department within the Ministry of Health was formed to deliver and supervise PHC. The Bahraini health policy allows all the population to enjoy virtually free PHC and hospital services, and most medication is free (Stephen 1991).

For delivery of PHC, the state of Bahrain is divided into four regions, each having its own officer for medical and nursing affairs. PHC facilities are distributed within the country in accordance with the population density of each catchment area. A network of health centres has been organised to deliver PHC to almost 98 per cent of the population. The health centres are categorised into three groups: A, B, and C. Group A centres serve populations of 20 - 30,000, and provide maternity and child (MCH), curative and dental health care. Each centre has a pharmacy, radiological and laboratory facilities. Most of the A type health centres have operational x - ray departments. Group B centres deliver health services to populations of 10 - 20,000. The health services available in this group are similar to those in group A, except that there are no radiological facilities in group B. Group C centres serve populations of 5 - 10,000. A basic curative consultation service is provided through this group but there are no MCH departments or laboratory, radiological or x - ray facilities. MCH services are delivered through a visiting midwife and doctor.

The health centres are open daily for two sessions from 7.00 am - 1.00 pm and from 3.00 - 6.00 pm. Any emergency cases after 6.00 pm go directly to hospital emergency departments. Services in these health centres are provided by doctors, community health nurses and midwives. Bahrain, like all Gulf States, including Saudi Arabia, compensates for the acute shortage of indigenous medical manpower by heavy reliance on expatriate physicians and qualified nurses from the Indian subcontinent, Arab, Western and some Far Eastern countries. The aim of the Ministry of Health is to assign patients and their families to one physician, who will be responsible for their long - term care.

Whilst curative health services are delivered through the PHC centres, little attention is given to preventive care, and no attempt has been made to integrate curative and preventive medicine. Preventive medicine is delivered through a separate division in the Ministry of Health (Stephen 1991). This in reality leads to the duplication of effort, as well as waste of resources.

Another ingredient of PHC is health education. Health education in Bahrain is by a vertical programme through health centre nurses or through TV, and concentrates on immunisation, ante-natal care and anti-smoking propaganda. Community participation does not exist.

It should be noted that Bahrain is a very small state, with a small population (the estimate for 1986 was 435,065), making it relatively easy to organise and supervise the health services. However, Bahrain receives financial support from other rich Gulf states, raising the question, whether the Bahraini government with its limited resources can maintain the same level of health care and continue to deliver health care free to all the populations.

2.5.1.2 Implementation in The People's Democratic Republic of Yemen.²

Yemeni experience with implementing PHC programme follows a different pattern, based on usage of community nurses, and midwives and health guides. According to the World Bank, the country is one of the poorest and least developed, with income per capita around US\$ 420. Health indicators show high infant, under 5 years and maternity mortality rates, of 118 and 197 per thousand, and 100 per 100,000 respectively.

At independence in 1976, medical care services did not exist in rural areas, but were confined to urban centres. A socialist approach to development was adopted and immediately, the government gave attention and priority to developing the rural areas. The government policy was to expand the health services, to concentrate on mother and child health care, and to train health personnel at the local level. In spite of the government efforts, basic health facilities and personnel are still insufficient in quantity and quality (Segall and Williams 1983).

Health services in urban areas are delivered by the following facilities:

1 - Mother and child health (MCH) centres: These centres provide health services to population of up to 70,000 and are usually staffed by six or more nurses, one of whom is a midwife and at least three community nurses. The MCH centres work from 8.00 am - 2.00 p.m..

2 - People's clinics: These clinics provide curative services for adult populations of 50,000 - 70,000. They are usually staffed by up to six physicians, and two medical assistants, one dental assistant, nine nurses, one laboratory technician, one assistant laboratory technician, and one pharmacist with two assistants. These clinics deliver their services from 8.00 am to 8.00 pm.

3 - Workers' Clinics: These clinics are mainly established to provide curative health care for industrial workers. They are very similar to People's clinics in their staff and facilities, but are open from 7.00 am to 2.00 pm.

4 - Polyclinics are organised to deliver comprehensive primary care - curative, preventive and follow - up of some diseases. They also provide specialist out - patient clinics. Each patient has a medical card on which vital medical and social information is recorded.

In rural areas, health care is provided through the following facilities:

1 - A health guide and midwife nurse deliver health care in small villages with populations of 200 - 500. The health activities include the provision of simple first aid, advice and education on sanitation and maintenance of clean water. Mothers are encouraged through health education to attend for basic ante - natal care and to bring their children for immunisation. The health guide and midwife visit people at home, and refer any emergency to the nearest health unit.

2 - In large villages with population ranging from 3,000 - 8,000, the delivery of health care is through health units. These vary in size and in number and type of staff, according to the size of the served population. They provide curative health care and some MCH services, as well as the diagnosis and initial treatment of endemic diseases such as malaria, bilharzia, tuberculosis and trachoma (Stephen 1991). Usually, these health units are staffed by one medical assistant who acts as a substitute for a physician; one practical nurse or community nurse midwife and a number of health guides according to the size of the served population.

The Ministry of Justice has made child immunisation mandatory. To enforce this, a certificate of birth can not be issued until the child has received the necessary vaccines before the age of one year. This, in turn, means the child can not be enrolled in school. However, in areas where immunisation is still not available, these measures do not apply.

Lack of reliable transportation and shortage of fuel still constitute major obstacles to delivery of health care to populations in remote areas, semi - desert and mountainous regions. The level of immunisation remains very low, because of inadequate and unreliable sources of vaccines, inefficient storage of vaccine and poorly trained and motivated staff. Moreover, numerous surveys have revealed the low acceptance of immunisation and high drop - out rates, because parents lack health education. Despite government efforts to remove all the obstacles to the delivery of health care services to all the regions, health indicators of infant, child under 5 years and maternity mortality rates are still among the highest in the world.

However, the political system in Yemen supports the community involvement in health activities. This is to some extent practised through the village health guides (VHG) who are chosen by the local community through organisations such as the local defence committee and local women's union. The criteria for selection are that the candidate is a volunteer, is able to read and write, is a permanent member of the community and finally is fully aware and supportive of the PHC programme. The majority of the VHGs are male, frequently teachers and farmers. However, since 1984, efforts have been made to recruit girls who will concentrate on MCH affairs, leaving the environmental and public health issues to the male health guides. Lack of financial resources is a major factor influencing the performance and effectiveness of PHC in Yemen.

2.5.1.3 Comparison Between the Two Experiences:

Primary health care in Bahrain was adopted as a mere extension of the existing health care system. Community participation or involvement does not exist. This could be attributed to the political organisation and system. From the way primary health care is implemented it appears that strong emphasis is being placed on curative care. Thus, the health workers are expected to be university qualified doctors such as physicians or GPs.

The South Yemeni example shows a different approach to PHC; many elements of the Alma -Ata definition are incorporated. There is much reliance on health assistants in the form of community nurses, midwives and health guides. Furthermore, the political system supports community involvement in health activities. These two examples may be considered representative of

health systems in the Arab world, most of which, with slight differences, fall into one or other of the above patterns.

2.6 Gender and Health:

Is there a gender role in health care ? The short answer to this question is yes. Gender still plays a pivotal role in health care in both developed and developing countries (Graham 1984; Mosse 1993). Women generally play a very crucial role in promoting health care, particularly in the light of their central position in the family, either as professional or as non - formal providers, and as recipients of health care.

It is important to consider women's role as recipients of the services. Men and women each have their own special health problems. It is widely recognised that women have special health needs related to their reproductive role: pregnancy, birth, breast - feeding. The principles of PHC and total coverage provide a framework for reaching women in greatest need. Of particular significance is maternal and child care. Countries are increasingly recognising the need for more active measures to make such care available. Maternity and child health care services are essential parts of the overall health service programmes, accorded special priority because mothers and children in every society constitute a major portion of the total population. Women of child - bearing age need particular care. Thus, the PHC approach concentrates on issues such as maternal and child health care; nutrition advice and information and education on common health problems.

The extension of maternity and obstetric care is of particular importance, in view of the evidence of the lack of such care which still prevails in many areas, and the morbidity and mortality which result. For example, Ostergaard (1992) argued that high maternal mortality occurs every year, primarily in poor countries, among poor women, though in remote villages most of the cases may go unreported, so that accurate statistics are rarely available. However, data collected from various developing countries - Egypt, India, Indonesia, Malaysia and Turkey - have shown that a large percentage of maternal mortality took place either at the home or on the way to the hospital. The percentage ranged from 24 % of the deaths in Turkey to 82 % in rural India. The causes of these high rates of morbidity and mortality are many, and include lack of prenatal and post natal care, poor obstetric care, poor nutrition even in childhood, which impacts on the women's later health, the

adverse consequences of illegal abortions, and overwork. Furthermore, most deliveries in developing countries take place at home, in unhygienic circumstances.

Every year there are some 500,000 maternal deaths and millions of women are seriously ill after giving birth (Royston and Armstrong 1989; Ostergaard 1992). Yet a very high proportion of births are not attended by trained health personnel. In Africa, only 34 % of mothers have trained attendants, while in South Asia the figure is 31 % and in Latin America, 64 %. Even fewer women receive prenatal care (WHO 1985; Royston and Armstrong 1989).

Another issue related to women's reproductive role is that of family planning. On the one hand, there are the risks to female health posed by excessive number or lack of spacing of pregnancies, where birth control is, for whatever reason, not practised. On the other, there are serious health issues associated with the implementation of birth control. The birth - control methods which are used by women in developing countries are often inferior to those available in the industrialised countries. In other cases, drugs which are out of date or no longer used by women in developed world because of dangerous side - effects are quite often dumped on developing countries' markets. Alternatively, a new medical product may be tested on poor women. For example, the contraceptive, *Depo - Provera*, associated with a wide range of problems including depression, and risk of cancer, let alone menstrual disorders, has been prohibited in most of the industrialised world, but is widely available and used in countries such as Thailand and El Salvador (Brydon and Chant 1989).

The issue of family planning is very important because it involves religious and ethical as well as technical aspects. Although it concerns women, unfortunately, women, especially in developing countries, have no say in deciding on their own fertility. Family planning has in some developing countries become a governmental policy, and in some cases is imposed by outside donor agencies. In such cases, women become objects to whose fertility is controlled, without regard to their choice or human rights. Ostergaard (1992) stated that in many countries, contraceptives are distributed without any prescription, or precautionary measures. Governments justify such action on the ground that with such high birth rates, they cannot afford to wait for improved contraceptives. Family planning needs to be integrated into general health care and women must be informed about all the risks of taking any type of contraceptive before they decide which method to use.

It is not only in their reproductive role that women require special consideration as recipients of health services, however. An important factor to be considered in respect of the health needs of women, is the low status accorded to women in many societies, which has a number of health implications.

Some feminists, noting that women do not live as long as men, attribute the causes to women's physiology, others to the nature of women's lives or work and discrimination (Khan 1991). However, Harrison (1993) has argued that nature appears to have blessed women with a head start over men. Perhaps to make up for the fact that more males are conceived and born than females, the female organism is potentially more durable than the male, right from the moment of conception. The extent of this advantage can be assessed from developed countries, where the sexes may be assumed to receive roughly equal nutrition and health care. Here, women in the late 1970s could expect to live on average to seventy - six years, eight years (or 12 per cent) longer than men; the infant mortality of female children under one year was about 25 % lower than for male. In contrast, in developing countries, much of this natural potential is not realised. Average female infant mortality is only 10 per cent lower than male, and women's average life-span of fifty - six years is only two years (4 per cent) longer than man's.

A large proportion of the failure to achieve a good health standard of women's health can be attributed in many, but not all, developing countries, to excessive burden of work, procreation and gender discrimination in the distribution of family food supplies and health care. WHO (1985), reported the intrafamilial gender bias in the distribution of food and health care for children under 5; the calorific consumption was on average 16 % higher for boys than for girls. Studies have shown that male children are often given the lion's share of rich nutrients like milk, butter and eggs. The philosophy behind this is that it is important for boys, who will support their families later on, to grow up big and strong; they are therefore given much more than their sisters. Royston and Armstrong (1989), however, pointed out that if girls do not get enough supplies of protein, calcium and vitamin D while they are developing, their bones do not grow up as long and strong as they should, and as a consequence, these children become vulnerable to difficulties in labour. There is also evidence that boys are more likely than girls to be taken to hospital for similar complaints. There are studies

showing that treatment, when sought, was delayed for more than 24 hours for 44 % of female children as compared with 23 % of the male (WHO 1985).

Excess female mortality rates observed in some developing countries in early childhood reflect, on the one hand, the traditional predominant culture of societies which place low value on female children, and prefer males and on the other hand, the lack of maternity and child health care services. Both these situations show the low status of women in some societies in developing countries. Nearly half of all women of child - bearing age and 60 % of pregnant women in the developing countries suffer from nutritional anaemia. At its most extreme, this gender discrimination in feeding and care has resulted in increased rates of female mortality in childhood, and in some countries this has been sharp enough to lower the life expectancy of women, despite their biological potential to outlive men.

Researchers have found that women anxious for sons would aim to become pregnant again as soon as possible if the first child was a baby girl, and that they would stop breast - feeding the baby girl as soon as they became pregnant. If, on the other hand, the first child was a boy, they would try to delay another pregnancy as long as possible, and would breast - feed for an extended period, probably more than two years, to give the baby a sound start in life (Sebai 1983; Royston and Armstrong 1989).

Gender bias in distribution of food within families continues to affect girls as they grow up. It is the custom in many developing countries for adult women, together with young children, to eat after the men have had their fill, with the result that they tend to get less of the more nutritious foods (Sebai 1983; Royston and Armstrong 1989).

Any attempt to assess the role of women as recipients of health care must also take account of the health implications of cultural practices affecting girls and women, such as Female Genital Mutilation (FGM), often called female circumcision, though this term is somewhat misleading, as it is very different in scope, intent and effect from the male circumcision practised by Judaism, Islam, and certain Orthodox and African Christian sects. FGM is often mistakenly regarded as an Islamic practice, but it predates Islam by many centuries. The ancient Egyptian practice, for example, is reflected in the term, " Pharaonic" circumcision (Brydon and Chant 1989).

FGM takes three forms. The mildest form which, however, is rarely performed, involves the cutting of the prepuce or clitoral hood and as such need not physically impair a women's sex life (Brydon and Chant 1989). The second form is total excision - clitoridectomy. The extreme form, infibulation, involves cutting off both clitoris and labia minora, and stitching or pinning the vulva. Apart from the risks of the actual operation - haemorrhage, tetanus, septicaemia, damaged urinary tract, severe pain, shock and even death - the health effects last a lifetime, in gynaecological problems and complications of pregnancy and childbirth (Royston and Armstrong 1989; WHO 1985).

Although women have specific health needs, and female morbidity and mortality are often higher than male, women often have problems in actually using health services. Khan (1991) argues that Bangladeshi women have less access to health care services, because limited consideration is given to women's health needs apart from those related to their reproductive role, and the available mother and child care centres are concerned mostly with provision of birth control. She adds that health workers tend to be male, and due to Bangladesh's Muslim culture, this generally limits women's access to general health services.

The absence of female staff at health centres, and its impact in deterring women from making use of health services, has also been commented on by Benyoussef and Christian (1974) and Ostergaard (1993) and Elahi (1993). The latter reported that, in rural Bangladesh, since the majority of local doctors are male, it is unusual for them to be called in to a birth unless there is some complication. This factor has its roots in cultural and religious teaching. Therefore, health planners and administrators should consider this dimension. In Saudi Arabia, in an attempt to overcome such problems, there has been a call to establish an entire hospital to be operated and utilised by women only (Al - Da awah 1992). All specialisations and aspects of women's health needs will be available in the hospital. The call has been made because many women feel less embarrassed or become more free if they deal with women , taking into consideration the segregation between the two genders in Saudi Arabian society. Women need encouragement to make use of the health services, even if the services are delivered free for them, along with children, as Ostergaard (1992) suggested. However, there are many other obstacles which prevent women from making use of health services, among which are difficulty in access to health care facilities, long distance and poor or costly transportation.

We turn now to women's role as providers of health care, both formal and non - formal. In the health professions, women often constitute the majority of health care providers. In any country, the labour force in the formal health care system tends to be predominantly female, though women tend to fill the lower paid, less prestigious jobs, rather than those with status and decision - making power. If any country's statistics are quoted, females might constitute 73 % of the paramedical workers, but probably 25 % or less of medical doctors. In short, although the majority of medical doctors have traditionally been men, as many as 75 % of health workers are women. This, added to the informal care provided by women, means that health care is predominantly a woman's field (WHO, 1985). In Belgium, for example, out of every 100 health workers, 63 are women, in Costa Rica 64 % of health workers are women, In Jordan 24 % (Pizaruki et al. 1987), in Saudi Arabia 44.5 % (Al - Da awah 1992). On a global level, Pizaruki et al. (1987) pointed out that in the early 1970s, women constituted approximately 95% of the world's nurses, 39 % of its physicians, 33 % of its pharmacists and 15 % of its dentists.

What is often overlooked, however, is the vital role women play as non - formal providers of health care and education, to their families and communities. Women are important non - formal providers of health care, because it is usually mothers, wives, sisters and daughters who look after the family patient, nursing him or her, or giving medication. For example, a study conducted in four rural communities in Nepal, showed that only 20 % of the population who had experienced illnesses had consulted the doctor. In these communities, women are both " gatekeepers to" and " caretakers of " health (Brydon and Chant 1989). It is the women who are expected to be health educators; to teach sound health practices to future generations; to create a home environment that is conducive to health (from clean water to nutritious food); to ensure that children are immunised and cared for during the crucial years and to take them to formal health care services when necessary; and to care for the elderly. Women often serve without monetary compensation as traditional birth attendants in many countries, particularly in rural areas, where they still deliver most of the babies, and constitute the majority of volunteers in hospitals, self - clinics, and other community organisations (see traditional medicine chapter). In relation to PHC care they are already providing the large share of primary health care activities.

Women's organisations in any country can play a very important role by encouraging discussion of issues such as nutrition, child care, sanitation, health education, women's health care, women's health needs, personal hygiene, and education and preparation of the expectant female, psychologically and otherwise, for motherhood. Furthermore, through these women's organisations and the like, women can mobilise other women to participate in health activities and in implementation as well as in decision - making process in PHC.

Women's organisations have special characteristics that make them a key factor in community involvement and an ideal entry - point and partner in PHC activities (WHO 1985). They are traditionally able to understand and carry out intersectoral activities basic to PHC and they have a positive attitude towards voluntary activities. Their work in PHC is a positive action and can be seen as acceptable to both the family and the community.

Mosse (1993) quoted three examples of women's organisations' programmes in Bolivia, India and Brazil, which use many techniques to address issues concerning women's health and education, which she considered far better than the PHC approach. In fact, some of the services rendered by these programmes can be offered through health education services in which women can participate, in the PHC centre, while other aspects can be developed by women's organisations.

In Bolivia, " Women's Information and Development Centre" , is a programme that is concerned with the urban poor women. Its main aim is to integrate all the health aspects concerning individual and environmental health and the women's role in their family's health. The programme is delivered through a healthy woman clinic, a small pharmacy, and a legal aid programme, and produces a range of educational material, both for the women themselves and to provide gender education for professionals dealing with rape cases (Mosse 1993).

The second example was a project from North India, which aimed to increase women's health awareness by means of series of workshops dealing with issues related to women's health. The workshops use a range of techniques to explore issues of health , bodies and sexuality. Storytelling, drawing, and role play are all employed to deliver health messages and increase women's knowledge and participation (for more details see Mosse 1993).

The Passage Houses in Recife, Brazil, was the third example. This programme was set up for girls and young women, who survive on the street, abused, abandoned by society, living off their sexuality and casual work, and surviving on drugs to take edge off their pain. The main goal of this project is the health of girls and women: it provides the street girls with comfort and a social atmosphere, rehabilitates them and either returns them to their family or sends them to community homes. In the second stage of the programme, when the girls have become independent and able to take on responsibilities, they are offered opportunities to learn more about issues related to health, violence and civil rights. Moreover, much work is done on preventive measures (Mosse 1993).

In Saudi Arabia, Women's Charity Organisations are very active bodies in matters concerning women in general, and particularly poor women. These bodies try to improve the health conditions of women by providing general health education, covering a wide range of activities. Practitioners, male or female, are invited to lecture on a particular issue. If the lecturer is female, the lecture is given face to face, but if the lecturer is male, the lecture is transmitted through closed circuit television.

Many issues related to increasing women's health education and awareness can be tackled through women's organisations, or through cooperation between the PHC centres and women's organisations.

The cornerstone of the PHC approach in respect to health care is preventive measures. To achieve and extend health education in any community, the main target and the foremost client is the woman. If she is prepared with the necessary education, she will be able to deliver the message to her family. Penny (1991) stressed this point, and argued that health education should be designed to change attitudes towards women and women's health. Through such education and training, more women should be involved in the health profession. Most WHO publications on PHC show a great deal of concern for maternity and child health care. In fact, the second component of the seventh article of Alma - Ata declaration emphasised that primary health care includes at least maternal and child health care, including family planning (WHO / UNICEF 1978).

It is increasingly realised that women's health and involvement in health care are essential keys to health for all (WHO 1985), because women not only have their own especial health problems which relate to pregnancy and childbirth, but customarily do most of the caring for their families. So,

if they are ignorant, malnourished and overworked, their health and that of their families will suffer. This is very true for many millions of women who confront illiteracy, poverty and poor sanitation, especially where health facilities are poor or economically and physically inaccessible.

From the above it can be seen that women play a crucial role in both formal and informal aspects of health care, contributing to the welfare of the family and the community. Because of women's paramount role in health care they must be involved directly with the planning and decision - making process and implementation of PHC approach.

2.7 Community Participation:

Community involvement in several development activities is an instrumental strategy which has been used by many development approaches. The concept of "community participation" or "people involvement" is not new (Muhondwa 1986; Oakley 1989; Rifkin 1990). The development literature has advocated involvement of people in the development process, and for some time, the debate concerned which is better, "development with, by or for the people". In less developed countries, particularly in rural areas, projects such as "community development programmes" involve rural people in development activities, and popular participation is now part and parcel of most forms of developmental activities (Oakley 1989).

The concept of "community participation" in health activities is not new (Rifkin 1985). It was a key factor in the nineteenth century public health movement that swept Europe, Great Britain and North America. However, the idea gained great attention, from the 1960s and the 1970s onwards, and the Alma - Ata declaration gave momentum to the concept, though its application to health activities is not without problems, and its operationalisation is not straightforward (Muhondwa 1986). WHO has played an important role in the promotion of community participation. Since the late seventies it has actively supported a range of activities. Studies have been conducted in over twenty countries and work is still continuing in thirteen others. Community participation is central to WHO's strategy for "health for all", and needs to be considered by all health professionals, administrators and social scientists in devising programmes for health promotion (Oakley 1989). At Alma Ata, the concept was defined as:

"... the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop

the capacity to contribute to their community's development. (WHO/UNICEF 1978, p. 50).

Community participation is a wide concept involving many applications, ranging from consultation to decision - making. Participation could be by local elites, leaders or elders of the community or could be extended to include the general public. Rifkin (1985) shows how different approaches to health care define community participation in relation to its relevance in health service programmes.

The medical approach sees community participation as a means to increase the acceptability and utilisation of health services among the local communities. The *health planning approach* perceives community participation as a process for tapping resources embedded in the community which can only be mobilised if the community is involved in some of the decision - making procedure. Finally, the *community development approach* considers community participation as a way to break down and replace social, economic and political imperatives considered not compatible with development. The Alma - Ata declaration states that through the process of community participation, community members

" ... become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realise that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable" (Rifkin 1985, p. 50).

According to this concept, communities should have the power to initiate, to plan and to implement decisions on matters that affect their lives. That power should not be vested in external authorities who exercise it on their behalf.

No operational definition of the concept has yet been provided. Thus, community participation has been interpreted in different ways. The most common form of participation involves mobilising community resources (money, materials, and personnel) so as to contribute to government - planned and controlled programmes. Such contributions from the people are desirable but represent only one aspect of community participation. The second approach, which is more sensitive, views participation as a process through which the people gain more control over the social, political, economic, and environmental factors determining their health, by acquiring necessary skills and knowledge (Morley 1983). The difference between the two approaches is the degree to which people make decisions

themselves. In the first approach, the decision is made on behalf of the community and the people, therefore, respond to the already - made decision, while in the second approach, they may have a say in the decision and the solution to their problems. However, there are several determining factors, such as the nature of the society concerned; level of literacy; cultural aspects, economic realities and the political system.

Oakley (1989) argues that community involvement can not be isolated from the broader aim of encouraging the active participation of local people in the development process as a whole. His view of participation is summarised here:

Participation means ... in its broadest sense, to sensitize people and thus to increase the receptivity and ability of rural people to respond to development programmes, as well as to encourage local initiatives.

With regard to development ... participation includes people's involvement in decision - making process, implementing programmes ... their sharing in the benefits to development programmes, and their involvement in efforts to evaluate such programmes.

Participation involves ... organised efforts to increase control over resources and regulative institutions in given social situations, on the part of groups and movements of those hitherto excluded from such control. (p. 9)

However, it is still unclear who should participate, and how, or whether community participation is a means or an end (Rifkin 1990).

In spite of the emphasis on the significance of community participation in health programmes by both international organisations and individual commentators, de Kadt (1983) identified several areas of expected weakness in community participation, ranging from its application at the international level, to failure of individual countries successfully to adopt it for one reason or another. The growing interest in community participation has led to an increasing literature attempting to bring some order into an increasingly confused field. Surveying the literature on the concept of community participation in rural development, Cohen and Uphoff (1980) noted that the concept has popularity without clarity, " and is subject to growing faddishness and a lot of lip service" (de Kadt 1983, p. 230).

A crucial issue for the concept of participation is who initiates the programme in which the community members are expected to take a role. This key factor certainly will influence the other

related issues of who participate, and how. Two obvious ways of initiating programmes have been practised and can be identified; initiative from outside (governmental or non - governmental), and initiative from the community itself. The important point here is that if the initiative comes from outside the community itself, the community members will be participating in a project whose aims, goals and objectives have already been determined outside the community, or imposed on the community. In this sense, the community members have little to say. This approach will definitely affect how people will participate in such a programme, directly or indirectly.

2.7.1 How do people participate?

As outlined above, there are different approaches through which people can participate in health programmes; but all these approaches can be categorised under two mainstream functions: in the implementation of the programmes and in the decision - making process.

Implementation takes many forms. There may be only passive involvement, as in the case of the community members responding to the programme by receiving and utilising services and education provided from the health centres (Rifkin 1990). Al - Mazrou (1986) sees this approach as appropriate. According to him, community participation means that members of the community accept and obey the health professionals' instructions, and pass health messages on to friends, relatives and parents. This interpretation is usually held by health professionals, and reflects a particular professional ideology.

Another form of participation is mobilisation of resources. Members of the community contribute land, money, labour and help in construction or carry out certain health care tasks, such as distributing contraceptives, providing health education or preventive health tasks. This approach is considered as active participation, but the community members in reality do not participate in decision - making. They only carry out tasks designated by health professionals or health planners. Such participation has existed for quite a long time in many countries and in different ways. Community health workers are used in many different parts of the world (their role will be discussed later). Mobilising the people to build clinics and dispensaries is also common (de Kadt 1983; Sebai 1988). Examples are abundant of community participation in implementing small scale health programmes. In Jamkhed health project, in India, for instance, the community participated in

implementing the project in terms of money, land and labour. Those running the project explained to the community leaders their aims and asked the community to participate actively in delivering preventive and promotional health activities (Arole & Arole 1975). Another example can be found in Indonesia, where a project was initiated by a few health professionals with the help and support of the community and later gained support from the government (Johnston 1983). Here, people were only participating by contributing resources for the continuation of the project. Arole & Arole (1975) argue that:

mobilising the community at the grass roots, activating them to see their own needs, and involving them in decision - making gives the project a solid base in each community. Rural communities may be poor and less educated, but they are intelligent. They want to know " why" before they accept a programme. p. 87.

Literature is full of examples of community involvement in the implementation of health programmes (Djukanovic and Mach 1975; Newell 1975; Muller 1983; Warner 1983; de Kadt 1983; Morley 1983; Tabibzadeh 1989).

The second approach, participation in the decision - making process, is relatively difficult when compared with participation in implementation. This is more or less a political or power - relation issue which involves many factors in addition to health related - matters, such as the community's socioeconomic conditions, culture, sociopolitical system and social structure. The influence of these factors on community participation in decision - making can be illustrated in several aspects. There may be clashes of interests and medical professionals may be reluctant to recognise that some health problems do not necessarily need to be carried out by professional health personnel. They may see peoples' involvement in monitoring and evaluating health practice as interference, and resent what they see as loss of their own authority and status (Pritchard 1986).

Clashes of interests within the community may also ruin promising initiatives. For example, in Indonesia, a group of villagers started a PHC programme and won some support from their fellow villagers, but the village leader saw the programme as a threat to his authority and status. At the beginning, he showed some interest and support, but later, he destroyed the initiative by placing one obstacle after another in its way, until it eventually lost both momentum and direction (Williams 1983). A study conducted in remote rural areas in Peru, in three communities with different

socioeconomic backgrounds, showed that they reacted to participation and acceptance of the programme in quite different ways. One rejected it completely; one cooperated actively and the third demanded the right to participate and made a very substantial contribution (Muller 1983). Muller also provides an example of the clash of interest between government bureaucracy and the people, in his study of Lima's Villa El Salvador, an urban community, in Peru.

In some exceptional political circumstances, governments have encouraged participation in decision - making. Cuba, for instance, provides a good example. Since the revolution, popular organisations such as the Committees for the Defence of the Revolution, have played a very important role in health promotion. Through these committees, people have been able to participate in the decision - making on health - related issues and activities on a local level (Werner 1983; de Kadt 1983). However, the real power of decision - making is to a large extent in the hands of the medical personnel, and to some extent the government bureaucracy. The community members' participation in decision - making may be confined to choosing the persons who will be trained as CHWs , or deciding on the place where they themselves will build a health facility. Although community members are often said to have a task in supervising (and hence deciding on) the work of the community health workers, in many places this is insignificant compared to the role played by the technical supervisors from the health care system (de Kadt 1983).

Often, participation in decision - making can be achieved through consultation. Community needs and concerns can be identified. Members of the community can suggest the methods and means they feel are acceptable to them and which they can afford to apply in solving their health problems. For example, in Kuwait, people who utilise health centres have been asked for their opinions and comments on the introduction of particular health services. It is hoped that this type of feedback can be spread to all health centres and hospitals (Stephen 1992)

However, the essential problem still remains the relationship of state interest and community interest. By whom and how would the community be enlightened on various alternatives to solving their problems ? Certainly, it is what the state feels it can afford rather than what the community regards as relevant, and can afford.

The range and dimension of significant active participation in decision making by members of the community is difficult to establish. Participation can enable ordinary people to be more capable of coping with health problems without constant and immediate recourse to health workers, particularly professionals. In this regard participation means learning and broadening of skill and understanding (de Kadt 1983).

2.7.2 Who will participate ?

Although the issue of who participates is very important, it has not yet received much attention from writers and critics. Most of the existing literature on primary health care, and more precisely on community participation, discusses issues such as the mechanism of selecting CHW and mobilising communities to be involved in the programme implementation. Even the WHO publications on community participation concern only the selection, training and remuneration of CHWs (to be discussed below) (WHO 1989). Oakley (1989), Rifkin (1990), and Walt (1990) all discussed the issue of selection of CHWs when they come to the issue of who participate. However, as mentioned previously, the nature and pattern of health care delivery systems are often decided and dominated by the elites (politicians and professional alike) in every society. Thus, the issue of who participates in planning and delivering the services will also tend to be decided by these elites.

In rural areas, the involvement of some members of the community in decision - making may be achieved by forming committees which include the chief, leaders and teachers.

More often than not, local elites dominate health committees, which they consider as a way to consolidate their status in the community. If consultative participation is practised, the local elites are the first to be consulted, so their vested interest, rather than that of the community as a whole, will be considered. This problem applies to both governmental and non - governmental sponsored programmes (Skeet 1984).

So, there are no clear cut criteria to decide who participates in the decision - making. However, several factors should be taken into consideration. Level of education, particularly among women, cultural aspects, beliefs and behaviour patterns, which are interwoven with deep - rooted religious beliefs and practices, must be considered. This will require, above all, learning about and from traditional cultural values (de Kadt 1983). Such factors have often not been considered in the

formulation and implementation of PHC. Problems arise simply because PHC has already established people's needs and strategies for meeting them, so nothing is left for the people to participate in. This is compounded by the fact that often people are decidedly oriented towards the curative system, in which they have no role to play. Rifkin, (1985) found that people tend to see PHC programmes as an extension of the existing medical system and thus expect responsibility to be in the hands of the medical professionals.

To conclude, community participation as a function of implementing primary health care is a complex and difficult issue to analyse, because of differences in the social, economic and political characteristics of different societies. These imperatives determine the relative success or failure of the concept in various countries. Community participation could be successful under the sponsorship of government in some countries, while in others it will fail. Similarly, it might be more successful in some societies under non - governmental sponsorship.

2.8 The Community Health Workers:

Community Health Workers (CHW) programmes have been seen as one of the strategies of the PHC approach. The declaration of Alma - Ata emphasised the rationale behind utilising CHWs, particularly in developing countries, where they can bring health services to places which the official health services do not reach. This emphasis was stressed in one of the WHO publications as follows:

" For many developing countries, the most realistic solution for attaining total population coverage with essential health care is to employ community health workers who can be trained in a short time to perform specific tasks. They may be required to carry out a wide range of health care activities, or, alternatively, their functions may be restricted to certain aspects of health care. ... In many societies, it is advantageous if these health workers come from the community in which they live and are chosen by it, so that they have its support" (WHO / UNICEF 1978 p 62).

The term " community health worker" (CHW) includes a very wide range of health personnel. Many countries and programmes termed such workers by different names. The " Barefoot Doctor" in China; " Village Health Team" (VHT) in some African countries, Mali for instance; Primary Health Workers (PHW); " Village Health Guides" (VHG) in South Yemen and India, are all subsumed under the name community health workers (CHWs). ³ These CHWs may be paid or voluntary; male or female; and work full or part - time. Their training varies considerably in length

from a short period of only 1 - 2 weeks to as much as two years. Their services may cover a small community of 50 persons or as many as 4,000 people. CHWs, in several parts of the world, form the foundation of PHC approach and as they are the first contact with the patients, they are also the referral instrument.

The WHO and UNICEF have attempted to promote the strategy of utilising CHWs within the health system, by conducting international workshops and meetings to overcome problems. WHO has held meetings with countries training CHWs, in order to exchange ideas, perspectives and information on the strengths and weakness of the existing CHW programmes (WHO 1989). The first such meeting was held in Jamaica in 1980. At this conference, it was apparent that the definition of CHWs was too broad, and great differences existed between the participating countries in understanding and defining the term. Thus the participants agreed to narrow the definition as follows:

" Local people who were not expected to move away from the communities which they served, preferably female because their targets were women and children, they should receive a very short training courses and unlikely to have the opportunity to be promoted to higher positions, or to be transferred to another part of the country sometimes they were paid, sometimes they were not" (Walt 1990).

Many countries introduced CHWs programmes within their health policy as a response to the declaration of Alma - Ata, though literature shows that CHWs were used in some countries even before the Alma - Ata conference (Bose 1983). Some examples were available from India, China (Sidel and Sidel 1975), Guatemala (Behrhorst 1975) and Iran (Assar and Jaksic 1975).

CHWs are capturing the attention of many health planners in developing countries, because a consensus seems to be developing that staffing shortages in rural areas are not being met by conventional means. In the past, rural health needs were largely ignored or dealt with unsuccessfully by attempting to train sufficient numbers of physicians and middle - level workers to serve rural populations. Critics of this conventional approach point to the high cost of training physicians and the inefficiency that can result when they are placed in extremely dispersed rural hamlets where they may be idle, or kept busy seeing repetitive common illnesses that could be treated by lesser skilled practitioners (Scholl 1985). Critics also point to the difficulty of keeping physicians in rural areas for longer than a year or two. The cities offer conveniences that even the most socially - conscious

physician may find hard to pass up. In addition, most physicians are from the middle or upper class of society, have lived all their lives in the city, and have difficulty in relating to, and communicating with, rural peasants. The CHW approach appears to resolve the major problems implicit in the conventional approach. In theory at least, CHWs who are backed up by physician referral and support mechanisms can provide rural populations with the basic elements of primary health care in the form of a person who is accepted by the community and who knows its problems intimately, and at a cost that the community and the nation can afford (Ibid.).

2.8.1 Common Characteristics of CHWs:

There is considerable variation in the type of health services provided by CHWs. However, there are some common fundamental characteristics of CHWs, which can be categorised as follows:

- 1 - They are usually selected by their community, to work within that community.
- 2 - They are the most accessible primary health care providers in the community.
- 3 - They should be members of the society where they work.
- 4 - They should be answerable to the local community for their activities.
- 5 - They should be supported by the health system but not necessarily a part of its organisation.
- 6 - They should have a shorter training than professional workers (WHO 1989).
- 7 - Because they come from communities where they live and will work, they are aware of the cultural and social aspects of the community they serve.
- 8 - They are the first point of contact between the people and the health service network.

The types of CHWs vary by country and community according to the availability and distribution of health services, community needs, the available resources and community acceptance and satisfaction. Thus, they may in some societies include people with low or limited levels of education who can be trained in a short time to carry out specific tasks (WHO / UNICEF 1978). Many countries consider the CHWs as extenders of health services to remote and rural areas and to urban slum dwellers. The early programmes of CHWs training were vertical in nature and to some extent specialising in one task of health care, such as family planning programmes, childhood diarrhoeal diseases and malaria eradication campaigns. These programmes were planned to meet

local needs with inexpensive and quickly trained health workers, to deliver health services to communities which official services could not reach, and in time of need only.

In some countries, CHWs are restricted to carrying out specific tasks, such as sanitation advice or administration of immunisation. In others, they carry out duties which involve preventive measures such as nutrition, immunisation, family planning, child care and sanitation and are expected to encourage people in need of regular care or treatment such as diabetics and hypertensives to keep up their appointments with the health centres and to follow up their health status through home visit. Additionally, CHWs are expected in some societies to help in collecting information and keep the staff in the health centres or district hospitals up - to - date with the health conditions in the community where they work, by bringing relevant matters to their attention.

Availability of and equitable distribution of the health services; the community acceptance and perception of CHWs, financial resources and the types of prevalent diseases are all crucial factors in designating the tasks of the CHWs. However, many working in the health field view training community members to provide some aspects of health care as part of a larger development process. Some small scale - projects train people from the community to provide health care, but such people are conceived as agents who will educate the community to understand the causes of diseases and help them to improve health conditions. CHWs are seen, particularly in rural areas, as more than community - based health services deliverers, but as agents of change in a development process (Walt 1990).

2.8.2 Weaknesses and Constraints of CHW Programmes:

The implementation of CHWs programmes in some countries has encountered many difficulties, leading to their collapse or standstill. Part of this failure can be attributed to political, economic and social constraints and to the built - in weakness of the implementation strategies. Some factors that contribute to the failure or success of such programmes are:

1 - Selection of the CHWs and the cultural and social realities of the community:

In certain programmes, the selection of the CHWs ignores the cultural and social realities of the community. For instance, selection should include both males and females according to the need and the services designated to each of them, bearing in mind the cultural and social context of the

community. However, the practice shows that male candidates are constantly favoured at the expense of females or vice versa, without any balance between the two and without any consideration of the type of the health services to be administered. This attitude has led in some communities to loss of the effectiveness of some functions. Examples from India and Jamaica show some that programmes, such as antenatal care programmes in India or family planning in Jamaica, recruited predominantly female CHWs, on the assumption that all of the audience would be females. No attention was given to educating male members of the community about these programmes, whereas men in the community should also be subjects of the new initiatives of family planning programmes and be aware of the needs of pregnant women. To achieve this, some male CHWs need to be assigned to the activity (Cumper and Vaughan 1985).

In contrast, other communities have appointed male CHWs to deliver health services, but women refused to talk to them about sensitive female health issues. For example, when the Egyptian health authority started a family planning programme, to educate people about the advantage of utilising contraceptive devices and explain to them how these devices are used, it was noticed that the numbers of the audience gradually declined from one session to another; the audience in the second session was mostly male. This attitude highlighted a very important cultural issue. When the health authority replaced the male with female health educators and doctors, women started questioning and asking for more details about some procedures.

Another cultural aspect to be taken into consideration is that in some societies, selection of CHWs is made by the health professionals. The CHWs are supposed to be links between the communities where they serve and the public health service facilities, so as to improve the utilisation of services and encourage preventive health practices. However, in some communities they tend to become increasingly remote from the community and to regard themselves as being based in health centres and to associate themselves with the health professional personnel (Cumper and Vaughan 1985).

2 - The lack of continuous supervision and support:

To ensure that the operational needs of PHC are met, other levels or branches of the health system are required to provide technical, supervisory, referral and logistic support, as well as

continuous education and supervision. There is a need for reliable, effective and efficient communication, and a health system that provides CHWs operating at the rural and remote areas with reliable back - up and continuing education, essential for their credibility in the community as members of the health care team (Skeet 1984). In the absence of such supervision and support from professional health workers, CHWs can not carry out their duties effectively. CHWs may well enlarge the outreach of professionals, but the latter have to remain ultimately responsible. They themselves must, therefore, have adequate logistic support for teaching, for supervision, for dispatching supplies, and for providing transportation.

3 - Professional Discontent:

Professional health personnel in some countries are reluctant to support the CHWs, or to allow them to carry out any health task apart from sanitation or similar small tasks. Where professional health personnel see some of their functions being undertaken by CHWs (and perhaps not being carried out as well as they should be), they often express their discontent and withhold vitally - needed support (Skeet 1984). The expected role of the health professionals is to give guidance. They should go to the community and seek out its health problems. They should make frequent contact with the members of community organisations and thus gain an insight into their characteristics and interests. Their supervision will result in improving the status of the CHWs and increase their knowledge about the health conditions in their communities.

4 - Training:

The success or failure of the CHW programmes to a great extent depends on support programmes such as training and education. With continuous review and improvement in the content of the training scheme, the programme can achieve the targeted aims. The CHWs need very special training, because they are expected to educate people in certain health aspects; they are both trainees and trainers. Some of the existing programmes have been criticised (Skeet 1984; Tennakoon 1987). Skeet (1984) argues that CHWs need to know how to teach or, better, how to help people to learn. Unfortunately many CHWs, having been taught by a " talk and chalk" method, come to despise their own traditional and folk methods of learning. Others lack the intelligence to adapt them for use in fields such as health education and mother and child care. In many countries, curricula are unrelated

to the job done, because this has not been determined beforehand. Much training is theoretical and not adequately supervised. Manuals and other learning aids are often available centrally but not where they are actually needed. Also, they are frequently irrelevant to the specific problems and sociocultural circumstances of individual communities.

Tennakoon (1987) stressed the importance of health education in this connection. It should not mean merely talking to people and sticking up posters but should also aim at community diagnosis and health development by improving people's knowledge, attitudes and practices and stimulating action. Daytit (1985) viewed the health programme in which health workers are trained, was one good way to initiate community organisation. It was hoped that eventually people would go beyond health problems and tackle other community issues.

In some communities, the educational level of the CHWs may be low. Therefore, those CHWs should be provided with a "community health worker's manual" which is a reference text with pictures and is colour-coded. For example, malaria is given the colour blue and is dealt with on the blue pages of the manual, where the user is directed to a treatment chart giving drug dosages for different age groups; the medicine, chloroquine, is kept in a container with a blue label. On completion of treatment, a tally mark is made on the blue page of the record book to indicate the month and the patient's age and sex.

5 - Political System and Social Structure:

The political system and social structure of some countries provides the ground for communities to participate in development. Organisations such as farmers, women's unions and patients' parents and friends have deep roots in the social reality of the society, so their participation in activities such as community development or illiteracy eradication is understandable and acceptable. For instance, Sri Lanka provides a valid example for community involvement in the rural development which lays down the basis for the population to participate in health care (Tennakoon 1987). The Chinese "barefoot doctors" experience would not have succeeded if there had been no political will and support behind the implementation of the scheme.

In other societies, CHWs become victims of political violence, or are accounted as government agents. In certain cases, CHWs have been used by the party of government as a means to spread its

policy and ideology, and to mobilise communities to vote for the party (Strak 1985). This has made them less acceptable in the community and led to underutilisation of their services.

6 - Financial Constraints:

The financial factor is a very crucial in the delivery of health care in general. The effect of finance on CHWs programmes can be seen in many aspects of the scheme, for instance, in recruitment, training, number of CHWs and remuneration. In some countries it has been a requirement for recruitment of new candidates that the candidate be resident in the community he or she is to serve, e. g. Jamaica (Cumper and Vaughan 1985) and Turkey (Fisek and Erdal 1985) . However, it was found that the best candidates often did not live in the areas where their services were most needed. Consequently, CHWs who wanted to move to other areas had to be considered. However, due to economic constraints, these CHWs needed to retain their employment and also needed a travel allowance to move from their original area to the new one. As this was costly, the residential requirement was dropped (Cumper and Vaughan 1985). Financial constraints make reappraisal of the CHWs programmes essential. Many health centres through which PHC is delivered are underutilised. Emphasis is given to maternal and child health clinics, and there is increasing pressure to provide more curative services. Therefore, there is a need to reassess the priorities of the primary health care programme. Both client demand and staff availability differ from one community to another. Every assessment should affect the role and the number of CHWs.

2.8.3 Selection or Recruitment:

Theoretically, CHWs are supposed to be selected by their communities, as this procedure denotes the community's involvement in its health affairs. However, in practice the selection of the CHWs in many communities is usually done by either the health professionals or health authorities, and in some communities, the leaders or chief play major roles in selecting the candidates. Sometimes the selected candidate may be one of the community's leaders, or the son of a prominent local figure.

Skeet (1984) discussed the abuse of the selection or recruiting process, emphasising that virtually no criteria have been laid down for selection. The tasks and functions of CHWs will depend on many factors, one of the most important being their ability and suitability for the job, both of which their

own people will know. Yet it is, perhaps, in this area of recruitment and selection of CHWs that the concept of community participation is most often ignored. There are several reasons for this. One is that a community can not express its views or act upon them if there are no proper channels through which to do so. Moreover women, who traditionally play the main role in promoting and taking responsibility for family health, may have little voice in village affairs. Poverty itself (and throughout history, most villages have been poor) discourages cooperation because the prior commitment is to family rather than community: suspicion is often aroused among fellow villagers by those who attempt to organise groups or committees. While none of these difficulties is insuperable, their existence means that the selection procedure for CHWs is often abused. Relatives or friends of political or other influential people are often "chosen", regardless of suitability or commitment. Sex, age, and degree of literacy may or may not be criteria, but commitment to service of the community is essential. Also needed is the intelligence, not only to undergo the required training programme, but also to recognise and keep within the acquired limits of competence (Skeet 1984).

If the CHWs are selected or appointed by the health professionals, attention must be paid to some factors that might influence the community acceptance of the CHWs. The first variable that seems to influence the degree of acceptance is the age factor. Some of the younger CHWs in some societies have had difficulty in being accepted by the community, even though they often had higher levels of education and were more skilled in clinical work. Increasing the recruitment age will also lead to stability, as older persons are less likely to migrate to urban areas. Furthermore, the older workers are generally better established, carry more authority, and are less likely to demand remuneration.

Where a CHW moves outside his or her own area or community, the new candidate should learn about the culture and traditions of the community which he or she will work. Villagers sometimes hold different perspectives, ideas and beliefs about illness. So, the cultural and sociological aspects of the communities should be taught during training. The community health workers should encourage what is good and discourage what is bad. The best way of learning about community culture is by experience, living and observation.

As indicated previously, place of residence is also an important issue in recruitment. Although it is preferable that the candidate is a member of the community and selected by it, in some cases an outsider will have the particular skills needed and some living allowance and accommodation must be provided. This will entail financial support from the government or the community, so that the CHW risks becoming a burden on the community.

2.8.4 Tasks and Functions:

Tasks and functions drawn up for the CHWs by ministries of health have been based, to a large extent, on the eight essential components of PHC outlined in the Declaration of Alma - Ata. This means that they are often expected to take responsibility for a wide range of functions, including home visits, environmental sanitation, provision of a safe water supply, first aid for injuries, treatment of simple and common ailments, health education, nutritional surveillance, maternal and child health, immunisation and family planning activities, communicable diseases control, community development activities, patient referrals, record - keeping, and the collection of data on vital events. In some countries, CHWs' tasks are primarily to carry out the activities at the health centres and to provide some help in simple tasks such as record keeping, weighing babies, plotting growth charts, and helping to manage the flow of persons at clinics (Cumper and Vaughan 1985). CHWs in some communities perform a wide variety of curative tasks in addition to disease prevention and health promotion tasks. Others may carry out health education only. Although it has been stated innumerable times that the functions of the CHWs should be determined jointly by the community and the health authorities, in practice they have often been determined by the country's Ministry of Health, with little or no involvement of the community (Skeet 1984).

2.8.5 Remuneration:

The problem of remuneration of the CHWs has received much attention. The basis of remuneration reflects whether the CHW is viewed primarily as one of the community, or as another worker in the health care system. There are three possible approaches. The workers may be sponsored by the official health system (government) or by the community or provide the work on a voluntary basis. All these three approaches are possible and receive support from some commentators. But, still there are problems.

If the CHW is paid by the government on a salary - basis, he or she will regard himself as part of the health system, thereby increasing the desire to acquire more training so as to be fully integrated into the structure of the health profession. This would lead to change of the basic function of the CHW. As they become professionalised and thus absorbed into the health service bureaucracy, will become isolated from the community. This approach has been criticised. Cumper and Patrick (1985), for instance, report that the remuneration system led to reformalisation of some aspects of CHW's jobs and duties. For example, the relationship between the CHWs and the health centres has changed. Instead of going to the centres at specific times to perform certain activities, the CHWs now consider themselves as being based in the health centres, and their working hours have had to be changed to those during which the health centres are open. In some countries, the CHWs associate themselves with the health organisation and claim to be nursing auxiliaries. Scholl (1985), noted that the recompense CHWs receive in some countries is free medication for themselves and their families, whenever they go to the clinics or hospitals.

Where the CHWs are supported and paid by the communities, the problem of continuity of support and sponsorship arises. The community's ability to pay salaries for the CHWs and perhaps also to cover the expenses of maintaining some of the health facilities, could be limited. Many communities, especially in rural areas in developing countries, are so poor that they are struggling to survive, let alone provide remuneration for CHWs.

The third approach is for CHWs to work on a voluntary or part time basis. According to the stipulations of the Alma - Ata Declaration, community - based CHWs are supposed to work on a voluntary basis, and not belong to the health organisation. However, in practice, they can not provide their services without remuneration. Therefore, this clause creates problems and has not escaped criticism. Muhondwa (1986) observed that this may undermine the ability of the CHWs to spearhead health promotion. Also, one limitation of voluntary work by the CHWs is that several experiences show that it is only the well - to - do members of the community who can afford to become CHWs. This is considered a drawback, because it means that the health concerns of the poorer section of the community may not be addressed. The CHWs will most likely limit their attention to the better - off, with whom they identify. The implication here is that some members of

the community are discriminated against, thus reducing participation in, and benefit from, PHC. Generally, the determining factor as to whether members of the community will work voluntarily or not is their economic status. Muhondwa (1986) stressed this:

" ... whether the PHWs should be paid or not, and who should pay them, are not inconsequential. The PHWs need a strong economic base if they are to do half of what is expected of them. It may be much easier for PHWs to turn up to the village health posts for a few hours every evening to give medicine, but much more of their time and devotion are necessary if they are to be seriously concerned with health promotion and community development". (p. 1255).

A solution is for support to be shared between the government and communities. The government provides salaries (if the CHWs are recruited rather than volunteers), medical equipment and essential drugs and the community provides the building for the health centres and the necessary maintenance.

2.9 Resources: Facilities

Gish (1971: 64) posed the question, " How then should a country with perhaps 10s per head to spend on the health care of its population (a not untypical figure) utilise its limited financial resources ? "

In rich countries, the focus of health care has been gradually shifting away from the family doctor / general practitioner to the hospital and hospital based specialist. This process has not been an easy one and its desirability has been called into question. Desirable or not , it must be recognised that the massive shift to hospital based medical care is only of fairly recent origin and is coincidental with other aspects of change consequent upon economic development. In most low income countries, the same sort of hospital based medical care systems are being established (or at least trying to be established). However, in the absence of substantial economic development, such hospital - based systems are making impossible the spread of essential health services to the mass of the population. It is not unusual for the capital costs of a large capital city / regional type teaching hospital in Africa to be as great as the entire annual health budget of the country. The cost per head in such circumstances may very well run upwards of £ 8,000, and that in countries with incomes as low as £ 30 per capita.

In principle, teaching hospitals in the capital city function not only as the teaching base for the medical school (as well as being a centre of research) but also as the peak of a medical care referral

systems. That is, patients from all parts of the country are sent upwards along a health care chain which starts with aid stations or dispensaries or health care centres, then moves up through rural and district hospitals, and finally ends with the capital city teaching hospital. Hospital based medical care and the hospital referral systems are, however, likely to work only to a very limited degree. Rural and district hospitals need not be as expensive as teaching hospitals. A bed in a teaching hospital in Africa will cost *at least* £ 5,000, and a bed in a district hospital perhaps £ 3,000: a rural hospital bed may cost only half to three - quarters of that figure, or sometimes even less.

The cost of equipping and running various types of hospitals follows closely upon their capital costs. Not only will the larger, more expensive type hospital have a higher running cost, due to its size, but the cost will be proportionately higher than for the smaller institution. One major reason for this is that a teaching hospital will have more specialists on its staff, more general duty doctors, more registered nurses etc., than will district hospitals, and district hospitals in turn will have more than rural hospitals. The more capital intensive a hospital is, the more skill intensive it is likely to be.

Poor countries (if not rich ones as well) concerned with reaching the whole of their population with a health delivery system must find an alternative to a system which depends upon hospital beds costing from £2,000 to £5,000 (or more) each. That alternative is a health delivery system which reaches the population at the lowest possible level. The health centre aims to provide the entire health requirements of a family except those which can only be provided in a hospital. A health centre in Africa can be built for somewhere around £20,000 - the cost of a few beds in a teaching hospital - and can provide most of the health care requirements for roughly 20,000 people. In a country like Zambia, 250 health centres, enough for the entire population, could be built at the cost of the new teaching hospital in Lusaka. The recurrent costs of such a health centre are not likely to be more than £10,000 per year, or 10s for each of the 20,000 people covered by the centre. Thus, a country with only 10s per capita to spend for health care could still provide basic health care services for its entire population.

Properly staffed, a health centre can supply at little cost much of the medical care required by the people of a developing country. This is because so many of the diseases from which they suffer are what might well be termed 'health centre diseases', that is conditions which health centres are

particularly well able to prevent or treat. They include the prevention through immunisation of measles (one of the most important killing diseases in many developing countries), tuberculosis, poliomyelitis, smallpox, and whooping cough, and through the health education of their mothers the amelioration of some part of the widely prevalent malnutrition in childhood. Most cases of many common diseases can also be readily treated in these centres; among them, patients with leprosy, tuberculosis, pneumonia, gonorrhoea, diarrhoea and dehydration (especially in childhood), malaria and hookworm infection. Health centres can provide family planning services, antenatal care, care of the normal delivery, child welfare facilities, school clinics, advice on environmental sanitation, and curative clinics for a wide range of important diseases. Health centres *do not* have operating theatres, X - ray plants, or more than minimal laboratory services, nor can they provide a doctor's opinion, so one case in a hundred has to be referred to a district hospital; common among these being abnormalities of labour and the consequences of trauma, particularly from accidents on the road. A district hospital in its turn has to refer about 1 per cent of its cases to a regional or national hospital for specialist opinion or special facilities.

This account of health centre services is, of course, oversimplified in that it assumes an evenly (and conveniently) spread population so that each health centre can cover its required number of people. Many countries, however, have very low population densities, with people either scattered in small villages or perhaps even nomadic. Such situations are usually best met with systems of aid stations and mobile clinics run from health centres.

2.10 Traditional Medicine:

Although modern medical services now constitute the dominant form of health care in developing countries, " traditional medicine" or " folk health care" or " local medicine" still plays an important role as a source of health care for many people, even though it has not yet been officially recognised by many governments (Nichter 1978; Kleinman 1980; Koumare' 1983 Lee 1983 and Yoshida 1990). Koumare' (1983) argues that although African traditional medicine covers 80 % or more of the African populations, its practice is barely tolerated by most health authorities. It is important to recognise the role played by traditional medicine, especially in rural areas, where such services enjoy high demand. In this chapter, some aspects of traditional medicine will be discussed,

and the important question is raised, as to how the traditional health care systems can survive in some developing countries where modern medicine is practised.

" Traditional medicine" is a broad term, loosely employed, and there is no clear - cut definition to distinguish between all the types of health care activities practised under such term. Thus, current literature classifies all the non - " modern", " scientific", " Western" medicine as traditional medicine. Therefore, all the alternative approaches to health and illness are officially unrecognised in many societies. It is a major problem to differentiate between a complex system of health care such as the Arab " Unani" or the Indian " Ayurvedic" on the one hand, and home remedy on the other. Primarily, it can be said that there are two types of practised traditional medicine, the professional and non - professional.

2.10.1 Professional or Scholarly Traditional Medicine:

Some attempts have been made to categorise professional traditional medicine. Gesler (1984), for example, used a geographic regional approach to classify some types of scholarly traditional medicine practised in different parts of developing world: Asia, the Arab World, Latin America and Africa. The systems practised in these regions include Chinese acupuncture, Ayurvedic, Unani and Galenic medicine.

All these types of traditional health care systems are practised by professional personnel, who have obtained qualifications form official institutes and enjoy official and international recognition. The Arab traditional medical system, called " Unani Tibb", was developed during the Islamic civilisation, and was the product of several regional civilisations and cultures: Greek, Persian, ancient Egyptian, Babylonian, Indian, African and Arab, though it was the latter who developed this particular approach. The Unani medical system was the principal system of medical care practised in the Arab World and some Muslim countries until the nineteenth century (Gesler 1984). The system is credited for its five main achievements: systematisation of medicine, construction of hospitals, developments in pharmacology and surgery, and ophthalmology (Burgel 1976). However, the people's attitudes towards Unani tibb, and its development and continuity, were adversely affected when many of the Arab countries came under foreign domination and new approaches in medicine were introduced. Initially, when the new medical approaches were first introduced, their influence

was limited, but under the growing influence of the Western life - style, traditional medicine receded from a central position to a peripheral one and the new modern medical system took over (Baasher 1983). It is not so important in the Arab world today as it is in the Indian subcontinent and among Muslims in Southeast Asia, where it arrived along with the spread of Islam, a long time ago (Dunn 1976).

The Unani practitioner holds a respected position in society, especially in rural communities. In urban centres, Tabibs (healers) are usually consulted for treatment of diseases and in matters relating to the protection of health. The healers adhere to traditional moral and social values while dealing with their patients, which results in an excellent healer - patient relationship (Said 1983).

2.10.2 Non - Professional Traditional Medicine:

The other type of traditional medicine includes " natural" or " herbal" medicine, and religious, spiritual or " magic" medicine. This division of traditional medicine can be defined as " the total body of knowledge and techniques for the preparation and use of substances, measures and practices in use, whether explicable or not, that are based on the sociocultural and religious bedrock of communities, are founded on personal experience and observations handed down from generation to generation, either verbally or in writing, and are used for the diagnosis, prevention or elimination of imbalances in physical, mental or social well - being" (Koumare' 1983). This definition can also be applied to professional traditional medicine. However, the influence and effect of cultural, social and religious aspects of the societies are particularly strong in this field of traditional medical systems. In the majority of cases, this type is practised by professional healers but in some cases, non professional healers practise such service, which distinguishes the former from the latter. Non - professional medical systems may share common characteristics world-wide, but their concepts and beliefs, which are associated with many cultural practices and aspects, limit their diffusion beyond their local areas, in contrast to the more professional traditional medical systems (Gesler 1984). There is also another type of folk medicine which is practised by ordinary people in their every - day life, without recourse to either professional or non - professional healers. This type can be termed " home remedy". There can be few, if any places in the world where traditional or folk medicine of one kind or another is not practised, suggesting that these various practices are not only culturally acceptable, but are also

perceived as dealing more or less to the local people already exists, and this form deals more - or - less satisfactorily with many health problems.

Herbal Medicine mainly uses herbs in treatment. Every culture is believed to have some literature about using herbs in medication. Traditional herbalists provide a wide range of activities. Among illnesses treated by herbalists are childhood diseases. Measles and diarrhoea are the major diseases, especially among children under 4 years old. Moloney (1984) reported that herbal practitioners quite often use some modern medicine in their practice. For example, wounds and ulcers are treated by creams bought at a pharmacy (in some cases toothpaste is used for this purpose) and Moloney was told by one herbalist that she used penicillin powder for infected wounds. Local and imported herbs are used to cure many kind of diseases.

There is a growing awareness of the importance of investigation and survey of the medicinal plants in many countries (Ashour 1985; El - Sheikh 1984; Moloney 1984; Baasher 1983). Moloney (1984) argued that in herbal medicine lie undiscovered but powerful medicaments which only a detailed scientific study using modern pharmacological research methods would reveal.

Cautery (*Al - Ki*) has been practised by Arabs for a long time. Many people regard cauterisation as a reliable source of curing particular diseases. Moloney (1984), in his investigation of local healers of Qasim, Saudi Arabia, mentioned that Umm Ahmed, a local healer practising cauterisation, received on average about five patients a day, at least two of whom would be cauterised, and there were several other local healers who practised cauterisation, receiving a similar number of patients. Also, El - Shafei (1985) reported that practice of cautery in Makkah is widespread. At the time of his study two famous local healers practised it there in addition to other traditional medical activities. Ibn Saleh and Ali El - Quorashi each received about 30 patients a day, for bonesetting and cauterisation. Some people go to cauterisers either because they have tried modern medicine without success, or because they have been told of its benefit.

Al - Khouly (1984) in his survey of traditional medicine in urban and rural areas, reported that cautery is practised only among the Egyptian Bedouin who live in the desert. Rural people used to practise cautery on a limited scale in areas where modern medical services were either very poor or

had not reached the people. He also claimed that cautery was practised popularly until the 1960s, but since then, its practice has been very limited in rural areas.

Cupping (Bleeding) is still practised in some countries, particularly the Middle East and some African countries (Moloney 1984; El - Shafei 1985; Maikudi 1988 and Greenwood 1992), but it is not so popular as cautery or bone - setting . The practitioners of the profession are not readily distinguished from other folk healers, probably because the practice is officially resisted by many health authorities and municipalities.

Bone - setting is a popular and successful practice within traditional medicine. To a great extent, bonesetters enjoy a good reputation. Some of them have succeeded in repairing a fracture set badly by a doctor, by refracturing and resetting. Most bonesetters use their hands to check the injured parts, but some in some cases have X - rays done. They practise from their homes but if necessary they go to the patients' homes to set the fracture. Popular bonesetters may be called to far cities, or patients may travel from many different cities, towns and villages to see them.

2.10.2.1 Religious and Spiritual Medicine:

Religious medicine is a form of practice based on sacred scripts. Practitioners of such medical systems exist in every religion - Islam, Christianity, Judaism, Hindu and Buddhism for example. The rabbi, priest, or imam could be the healer. Usually this type of medicine deals with mental and psychological disorder.

Islamic religious medicine, is strictly based on stipulations in the *Qur'an* and the prophet traditions (*Hadith*). There are various names designated to the Islamic religious practitioner. Popular names include *cherif* and *fqih* (Greenwood 1992), *mullah* in the Gulf States, Iran and Iraq, the *fekki* in Sudan (Baasher, 1983), *sheikh* and *mutawae*, which are common in most of the Arab world, and *mallam* in some African countries. All these names denote one status - a scholar in Islamic studies, particularly the *Qur'an* and *Hadith*. The variation in names arises because in Islam, no clerical system exists. However, this does not mean that every *sheikh*, *mutawae*, *mallam* or *fqih* is a religious healer. Islamic religious healers prevent and cure many problems. Generally, healers in this category advise patients to contact modern medicine practitioners if the illness is physiological, but if the case is considered to be of supernatural or satanic origin, then they will treat the patient.

Treatment is mainly based on recitation of some verses of the Qur'an; healers know which verses to use for particular sicknesses.

There are two types of people who visit the religious healers: patients and clients. The former are people who seek treatment for illness, and the latter are those who ask for solutions to various problems concerning family and business affairs such as making of a good marriage, marital difficulties, children's illness, financial problems and lost objects. Marriott (1955) argued that this religious medicine is regarded as notably more dignified than any other type of traditional, or even modern medicine.

2.10.2.2Magical Medicine:

Magicians play a salient role in folk medicine in many countries, and they practise witchcraft activities, either as healers or purely for magic's sake. Marriott (1955) said that magical medicine "Comprises a body of mechanical techniques which can be directed against invading spirits. Its techniques include the wearing of protective strings and amulets and the expulsion of invading spirits by rituals of exorcism". People who practise and utilise such medicine believe that within this context, the main causes of illness are the anger of gods or ancestors, the activities of witches, or the breaking of a customary rule (Gesler 1984). Treatment in this kind of folk medicine takes two approaches: protective and curative. The former takes the forms of spells or wearing amulets or charms; the latter is done by prayers, sacrifices and exorcism, as well as wearing spells, talismans and amulets.

Magicians are divided into two groups. The "good magician", provides his activities to cure people of their suffering. The other kind practise what is variously called "bad magic"; "evil magic" or "black magic". Such a practitioner may be labelled a "Satan man", "demon man", or "man who does not fear Allah". Al - Khouly (1984) found that most of the magicians in fifty - five villages in Egypt were age from 35 - 55 years old, with elementary education and their practice was the main source of their income. Al - Saaty (1983) found that the practice of magic was not the sole preserve of either gender; in her study, more than 50 % per cent of the practitioners were female. As regards age, she reported that 78.45 % fell in the age group from 40 - 50 or more years old. Few fell in younger age groups (Al - Saaty 1983).

Visitors to magicians vary. Some have strong belief in the magician's power of curing, and seek his or her help in problems, to a great extent, as some people do with religious healers. Others consult magicians, only after they have tried all other means without success. Usually, magicians are asked to help with some family problems, broken marriage, love affairs, to resolve conflict between husband and wife, to cure infertility, or to rid a person of an evil spirit. A businessman may visit a magician to ensure his trade to flourish, people may seek help to locate a lost object or child; a student may visit the magician for help in passing exams (Marriott 1955; Geertz 1960; Al - Saaty 1983; Al - Khouly 1984 and Gesler 1984). Literature is full of stories of people who consult magicians.

Regarding the socio - economic characteristics of the utilisers of this type of healing (discussed in more detail elsewhere in this chapter), it was found that most of the utilisers were female (66%); married people were 51.28 %, while unmarried were 28.27 % . 43 % reported that they benefited from consulting magical healers. The study reported that the utilisers of magical healing were from all social classes and had different levels of education and income.

Attempts to understand and study magical healing have often been confounded by a failure to distinguish between magical and religious healing. This is a weakness found in the studies of Al - Saaty (1983) and Al - Khouly (1984). For example, a study was carried out in Cairo Egypt in 1978, by Al - Saaty (1983) to identify the practitioners of magical healing and their frequent visitors; also, to identify the magicians' and the utilisers' backgrounds and the effect of socio - economic factors on utilising such type of healing. However, neither Al - Saaty nor A- Khouly had a clear perspective of the differences between the religious and magical healing. Al- Saaty (1983), reported that religious leaders and figures practised magical medicine and she mentioned mosque Imam, Islamic school teachers and priests; but when she described their practices, it became clear that they were practising not magic, but religious healing such as reciting verses of the Qur'an for Muslims, or the Bible for Christians.

2.10.2.3Midwifery:

Midwifery is practised by female traditional healers, whereas all other types of traditional medicine can be provided by both males and females. Midwifery is the oldest health service

practised by women and it is their main role in providing health care. Midwives are in many areas the only traditional healers who are recognised and can obtain permission to practise. Over two-thirds of births in the world are delivered by midwives who trained in the traditional system of birth and in some rural areas the midwife is the only source of assistance and care. She might deliver over 90 % of the births. Usually the midwife acquires her skills by working with and under the supervision of another birth attendant - often her mother - or by herself. In some societies, her services are sought only at the time of labour and delivery, while in other communities they include prenatal and postnatal care and treatment of maternal and childhood illnesses.

Most traditional midwives are middle - aged women, illiterate, and familiar with their clients and their families because they are members of the local community. Their status differs from one society to another. For instance, in India the *dai* occupies a low status, due to the belief that birth is unclean and polluting; only a person of low caste is allowed to deliver the baby, cut the cord, and dispose of the placenta. In contrast, the midwife enjoys a high status in African communities. In a few countries, midwifery services are carried out by men, for example in Mexico, Ghana, and Philippines (Cosminsky 1983).

In order to reduce infant and maternity mortality and morbidity rates and to expand PHC coverage to rural and nomadic communities, attempts have been made by WHO to incorporate traditional midwifery service into the health service system. Health planners use midwives' services as an important source of health care, and now the midwife may practise in both traditional and modern health systems.

2.10.3 Folk Healers and Practitioners:

There are some common characteristics shared by most folk healers in many developing countries. Folk healers are not appointed by anyone, but are recognised as healers by the local people. They are usually unlicensed individuals whose practice lies outside the realm of official modern medical care. In some countries, some healers can obtain official permission to practice. For example, midwives, bone - setters and sometimes religious healers may have a certificate of legitimacy to practise given by the local government or city council. Some folk healers cannot be directly approached; they have a representative or agent through whom any person seeking their help

must deal - especially if the healer practises some illegal activities, such as magic. Many have reputations and therefore practise as full - time practitioners and may charge fees. Others practise as a secondary occupation on a small - scale basis, occasionally helping the locals with some health problems. There are variations in methods of practice. Some prefer to practise at home, for example, Quranic scholars, bone - setters, and sometimes the spiritual healers and herbalists while others move about a great deal, usually visiting people at their homes and in some countries visiting the local markets periodically.

Both males and females can become traditional practitioners, but religious practices are dominated by males, while other kinds are practised by both genders. In Saudi Arabia, female practitioners practise all sorts of healing: bone - setting, cauterisation and herbal. In Jeddah there are many noted female practitioners, such as Umm Ali Barashed, well known for cauterisation, bone - setting and obstetrics. Folk healers are usually adults, middle - aged or older, between 36 and 70 years old. This does not, however, imply that younger practitioners do not exist.

Some folk healers specialise in a particular field of healing, such as midwifery, bone - setting, herbalism, cauterisation or religious healing, and practise only one function, but other healers practise more than one type of healing and deal with medical and non - medical problems. Yoshida (1990) in Indonesia, found folk healers involved in more than one practice in urban and rural areas and among every ethnic group. In Saudi Arabia Quranic scholars are known to cure many health problems, particularly those which are psycho - social and not physical in nature. The herbalist operates even more widely, claiming to treat all sorts of illness; physical and psycho - social. The bone - setter on the other hand, restricts his activities to treatments of fractures and sprains.

2.10.3.1 Acquiring the Healing Role:

Usually, folk practitioners acquire their knowledge and skill from another person, by occasional observation or by a lengthy apprenticeship. Some have learnt from spiritual inspiration or mystical experiences (Yoshida 1990; Bakker 1992). Several means can be identified by which folk practitioners qualify to practise:

Some healers acquire their skills and knowledge in a hereditary manner, that is, healing experience, skills and knowledge all transmitted within the family. Some healers gain their skills and

knowledge by a long association with other practitioners. Duration of apprenticeship varies for individual practitioners, and it depends on the ability and motivation of the newcomer. The average duration could range from one to three years.

Particularly in religious and magic practice, some healers claim to have acquired their skills and knowledge through revelation, calling, dreams or meditation. Others largely depend on spiritual forces. Al - Amri (1993), a famous religious healer in Saudi Arabia, asserted that he acquired his skill through a dream during a long experience of illness which caused him to lose his voice; he indicated that the illness was the result of an "eye envy", and while he was asleep, he heard someone telling him, "what you have is an eye and I will pull it out of you, but you have to recite these verses of the Qur'an". When he woke up he did as he had been instructed. Yoshida (1990) reported various cases of people gaining their skills through spiritual power, or hearing someone order them to help people. Bakker (1992) reported similar cases in Morocco.

In addition to gaining skills and knowledge of folk healing through family inheritance or apprenticeship, practitioners try to augment their healing skills and knowledge through individual empirical training, by making intensive use of books and journals. The writer counted more than 150 book titles inside one bookshop on religious healing, and a similar number on herbal medicine in Jeddah.

2.10.4 Utilisation of Traditional Medicine:

Several studies conducted in different parts of the world have shown that the practice of traditional methods for curing illness is widespread. Abel - Smith (1967), reported that a certain amount of traditional medicine was found in Costa Rica and to a greater extent, Peru. In Taiwan, Hong Kong, and Singapore, although a government service was available to most of the population, it was supplemented by the services of both herbalists and traditional practitioners. Herbalists were also used to a considerable extent in East Africa.

Jaspan (1969) reported that the traditional health care systems provided a real health service to a great number of the population in Southeast Asia. He also estimated that for more than three quarters of the people of Southeast Asia, the treatment of pain and disease is the field of traditional therapy and the theory of medicine that underlies such treatment. Several studies of traditional

medicine carried out in Southeast Asia indicated that the demand for traditional medicine is still high, despite the long - establishment of modern medicine (Yoshida 1990). Leiban (1976) stated that the traditional practitioners in Cebu City, a major modern centre in the Philippines, have a substantial following among the city's population and these practitioners, especially the most famous of them, attract many patients from other areas. The utilisation of traditional healers in Malaysia is a common phenomenon. Chen (1975) reported that diverse traditional medical systems such as Malay, *Orgng Asli*, *Iban*, *Kadazani* and Chinese, thrive in towns and in rural areas, and play an important part in satisfying health care needs in Malaysia. He estimated that there were 2000 full - time *bomohs* (Malay folk healers), about the same number of modern physicians in government service, and more than 20,000 part - time *bomohs* in peninsular Malaysia. Heggenhougen (1980) also found many traditional Malay healers (*bomohs*) with prospering practices in the bigger cities.

Maikudi (1988) indicated that traditional healers operate in both rural and urban areas in Bauchi state, in Nigeria, with a greater majority in rural areas. Healers provide a wide range of medical care services to a large number of the population. They provide medical care of somatic and psycho - social problems.

The choice of traditional practitioners depends upon the kind and nature of the disease, for example, people with psychological problems will tend to visit either religious or magical healers, and this to a great extent depends on the value and belief systems in the society. Reasons for choosing traditional healers rather than modern medicine vary from country to country and even within individual countries. Some writers argue that the shortage of health facilities, particularly in rural areas, motivates people to utilise traditional medicine. Others (Marriott 1955; Geertz 1960; Ashour 1985; Yoshida 1990) reported that modern health services were available in areas where they conducted their studies; therefore, it is not only the availability or absence of health service facilities which makes people opt for traditional medicine, but there are other reasons, such as doctor - patient relationship (Marriott 1955; Cosminsky 1983). Ashour (1985), argued that some people choose traditional medicine because modern medication is thought to have side - effects. He pointed out that every medicine bears instructions for use, often warning of side - effects. He considered this to be the negative side of modern medicine. Cultural aspects are also important. For instance, some

societies believe that modern medicine can not cure some kinds of illnesses, therefore people prefer to see folk healers, particularly in prolonged illnesses (Yoshida 1990). Traditional healers manage to view the patients holistically as an integrated human being, while modern medicine treats him only from one aspect, the illness side, with no regard to his or her psychological, social and economic circumstances.

2.10.4.1 Characteristics of Utilisers:

Utilisers' characteristics may provide insights into who uses such medical care services, and why. It is often thought that people with a low level of education are more likely to have recourse to traditional medicine, but various studies have shown that many people with different backgrounds, levels of education and even religion approach folk healers. Al - Amri (1990) found that 45 % of his sample of students of King Abdulaziz University in Jeddah visited indigenous healers and utilised traditional medicine. Yoshida (1990), in his study of traditional medicine in Indonesia, reported that highly educated persons too, consult folk healers, particularly in prolonged diseases. Furthermore, some health personnel sometimes do so. Regarding consulting or visiting magician and its relation with level of education, Al - Saaty (1983) showed that people of all levels of education go to see magicians; for example 57 % of her sample were illiterate, or could just read and write, while the remaining 43 % of the sample had levels of education ranging from elementary to university level; 17. 47 % of the sample had a high level of education. Al - Saaty's result is consistent with that of Owais (1970).

In terms of age, Al - Saaty (1983) reported that all age groups visited the folk healer (magician) but the majority (83 %) were between 20 and 50 years old . In these age groups, many life activities take place such as marriage and establishing a family life, and entering into work. This age group is also associated with achieving ambitions.

Al - Khouly (1984) emphasised that while seeking help from traditional healers is not related to level of education, social status, or age group, there is a gender connection; females are the most frequent visitors to magicians. Similarly, Al - Saaty (1983) reported that the most frequent visitors to magicians in Egypt were females. This was due to lack of security; she found that 62 % of the

sample were women who seeking to have a son , or wanting to cure infertility, having problems with their husbands due to lack of trust, or wanting to get rid of the husband's second wife.

Men who go to magicians do so for different reasons, such as to locate lost objects, succeed in business, to seek treatment for illness or to counteract the spell of another sorcerer.

2.10.5 Relationship Between Traditional and Modern Medicine:

The interest in traditional medicine appears on many levels, individual as well as international. On the international level, WHO expressed its interest when it called for the incorporation of traditional medicine practices in its programmes in 1976. Further emphasis was shown when, as part of the policy of achieving its popular goal, " health for all by the year 2000", it encouraged the member states to utilise all available useful methods and mobilise all possible resources. These methods include various types of folk practices and among the resources are numerous kinds of traditional practitioners and midwives or birth attendants (Mahler 1983). This attitude was endorsed in the declaration of the International Conference on Primary Health Care, Alma - Ata in 1978, which referred to the need for a variety of health workers, including traditional practitioners as needed, suitably trained socially and technically, to work as a health team and to respond to the expressed needs of the community (WHO / UNICEF 1978).

At another level, increasing interest in traditional medicine is reflected in the recommendation by many health administrators in developing countries that traditional healers be included in PHC because, according to them, healers know the sociocultural background of the people, and are highly respected and experienced in their work (Mahler 1983). However, although this factor has lent some support to the increasing concern with traditional medicine, the true situation is somewhat different. Writers who recommend the inclusion of the traditional healers in the PHC programmes because of their knowledge of the population backgrounds and socio - cultural aspects of the community, may be making an assumption which is not supported by fact. In practice, some of the traditional healers are practising in urban centres where a cosmopolitan culture exists. In such centres, the utilisers of folk healers came from different backgrounds and the healer is not necessarily aware of their family's background. However, if the community where the folk healer is practising is relatively isolated, tribal

or a small peasant village, traditional healers might well be advantageously incorporated into the health team of PHC (Foster 1983).

Other factors such as economic considerations, the shortage of health professionals, particularly in rural areas, and the strength of traditional belief systems, give weight to the increased concern with traditional medicine.

Some technocrats (doctors and health administrators), who think in terms of technology and organisation of the existing health care systems think of traditional medicine practitioners as no more than a possibly useful source of manpower to increase the coverage of modern medical services. This attitude is also noticeable in many of WHO's publications, which emphasise the use of the midwife to provide health services in rural areas after a short period of training (WHO / UNICEF 1978). The Alma - Ata declaration referred to the need for a variety of health workers, including traditional practitioners as needed, suitably trained socially and technically, to work as a health team and to respond to the expressed needs of the community.

In several countries, many traditional practitioners have suffered from official neglect. Many modern medicine practitioners and foreign - educated people belittle the traditional medicine.

It can be said that at present, there are four organisational relationships between official and traditional health care services. The first might be termed monopolistic, because it gives to allopathic practitioners, sole legal right to practice medicine. The second might be termed tolerant because, while not recognising traditional medicine, allopathic exclusivity is limited to specific medical and public health care activities while traditional and unofficial practitioners are free to work and be paid for services in all other fields, provided they do not claim to be registered medical doctors (MDs). The third relationship, which might be described as parallel, occurs when practitioners of allopathic and other systems of health care are officially recognised and render services to patients through equal but separate systems. Fourthly, there is the integrated system, in which modern and traditional medicine are merged in medical education and jointly practised within a single health service.

2.10.6 Traditional Medicine and PHC Approach:

Bannerman (1983) argues that in light of the inadequate resources in developing countries, the only hope of overcoming this acute shortage is by the exploitation of useful traditional health

practices, including wide use of locally - produced herbal medicines and the incorporation of traditional practitioners into the health team, particularly at the PHC level. A number of developing countries in Asia, Africa and Latin America are exploring the possibility of developing their well known and tested herbal medicine for use in PHC centres. Furthermore, he added that in many of the developing countries, primary health care devolves on the healers, herbalists, traditional midwife, and other traditional practitioners. These are the health workers who offer services to the disadvantaged groups that total up to 80 % of the world's population and have no easy access to any permanent form of medical care. Traditional medicine, therefore, has a major role in delivering primary health care in terms of the numbers of people served by that health care system throughout the world. Whatever their defects, traditional healers are the true community health workers in their society. They have the confidence of the people, and whatever their level of skills, it is essential that they understand the real health needs of their community.

The role of traditional medicine in providing health care to the community is now widely recognised and it is realised that there is a great potential in traditional medicine to contribute to the PHC, especially in developing countries. Such a potential is clearly due to a large extent to the wide acceptance of the traditional medicine in many communities and to its simple, inexpensive, non - toxic remedies for the alleviation of diseases and disability (Mutalik 1983; Ashour 1985). Furthermore, a great number of traditional medicine practitioners live and work in remote rural areas and are considered as the only available source of medical care. Thus, their association or integration into the PHC is particularly desirable. The incorporation of traditional health systems into the official health care system requires a major policy decision at very highest governmental level, however, as in China and India.

With the support and co-operation of the formal health care system, traditional healers can be incorporated into the health system. The Chinese experiment provides a good example of the co-operation of both systems. In China both systems work together in the same clinic; there is the modern practitioner and also the traditional practitioner. Also, in the pharmacy, both traditional pharmacist and modern pharmacist dispense both traditional and modern medicine according to the

prescriptions (WHO 1983). China is the most notable example where traditional medicine has been well integrated with modern medicine, and the CHW practises both (Oakley 1989).

In recent years, with support from the WHO and United Nations Development Programme, groups of nationals from different countries have visited countries such as India and China where traditional medicine is practised, and well organised as a part of the national health system, and as a result of such visits, subsequent World Health Assemblies have also emphasised the important role of the traditional medicine practitioners in meeting the health needs of the population and including and utilising them in PHC programmes (Mutalik 1983).

The relationship between traditional medicine and PHC approach has been emphasised in various publications of the WHO, particularly the declaration of Alma - Ata. Reference has been made to the use of midwifery in health centres after a short period of training. Traditional medical practitioners generally and birth attendants particularly exist in most developing countries. They are to a great extent part of the community, reflecting its culture and traditions. In some societies, they enjoy high status and exercise considerable influence on the local health practices.

The traditional midwives constitute a special category. In developing countries, as mentioned above, they form the main body of primary health care workers in maternal and child health care, and in some countries they are responsible for more than 90 % of births. Their role and functions are very crucial in encouraging people to improve their health awareness and to utilise the available health services. In some communities traditional practitioners and midwives are trained and selected to deliver some elements of health care as CHWs.

The attempt to integrate traditional practitioners into the PHC approach and benefit from their practices must take into account some considerations such as the identification of the areas of health care in which they could contribute and difficulties and problems relating to their further development. In some countries where traditional medicine systems are practised, national governments and health authorities do not give strong political support. With some exceptions of Ayurveda in India, Arabic (Unani) in Bangladesh and Pakistan and traditional healers in China, most of the practitioners of these systems are in the non - official sector.

2.11 Conclusion

Although in developing countries, more and more resources have been dedicated to curative, hospital - based health care, at the expense of preventive medicine, poor health has persisted. Recognition of this problem led to the emergence of the PHC approach. This calls for a complete change, not only in the health sector, but also in the whole socio - economic and political environment of developing countries.

PHC emerged as an operative strategy to deliver basic health needs to the unserved or underserved population in rural areas and urban slums, who are prevented from enjoying and practising their right to decent human life. The approach is not only concerned with health care, but is, in fact, a tool for furthering development and increasing people's understanding and awareness of their right to participate in and benefit from development. The implementation of the approach depends to a great extent on the political, social and economic environments of every country. Thus, no one universal approach can be implemented in every community. Gish (1979) described the new health care strategy which has emerged is based upon the provision of primary health care for all, although "provision" is perhaps not quite the right word, as the new approach calls for popular participation in the creation and implementation of health campaigns and services, or health " by the people" as opposed to health " for the people"(p. 208).

It is believed that the new health policy approach will make a dramatic, indeed radical, change to health care priorities in both developed and developing countries. However, the implementation of PHC faces many constraints, including lack of adequate financial and human resources, and lack of support and back - up from other health service levels. Although PHC has rightly become the focus of attention by the WHO, UNICEF, various aid organisations and individual governments over the past fifteen years, it must be stressed that without adequate support and back - up from the secondary level it will function below its full potential, and people will be discouraged from using PHC facilities.

The approach is based upon the philosophy of people's involvement in decision - making as well as the implementation of issues relating to and affecting their health. Such a perspective will give rise to democratisation of the health services, and will help alleviate the problem of manpower shortage.

People's involvement in decision - making and implementation of health care will help local communities to set up and organise their own development programmes. During this process, it will be possible for them to identify their health problems and needs. Only when these are known can tasks be identified, and only on the basis of these tasks can selection criteria, curricula, and training programmes for each category of CHW be derived. In addition, to activate PHC, attention must be given to referral facilities, and especially to the departments and establishments in the health network, which are close to the PHC centres and able to support their activities. The functions, staff and infrastructure of these organisations should be compatible with the activities carried out by PHC centres. Professional staff in these organisations should always be involved in education, planning and reviewing the CHWs training programmes.

The implementation of the PHC programmes should take into consideration the differences and the special needs of the particular community context, rural or urban.

Gender is an important aspect of delivering health care. Much attention and concentration should be given to women and their role in health care, both as recipients and as providers. Women's organisations can play an important role in health activities as an extension of their voluntary work.

CHWs with limited training, inadequate supervision, poor referral facilities and sporadic supplies, will not contribute to improving the health conditions. CHWs should be an asset to health care system and the people they serve. They will be so, only so long as they are properly selected, trained, supervised, and supported. Developed in isolation from the other essential components of the PHC approach, they may be not just ineffective but positively harmful.

Most of the existing literature on the PHC approach has concentrated on the provision of the health services to rural and peripheral areas; very little attention has been given to urban areas. Thus, one aim of this study is to contribute to filling the gap in the literature concerning the urban areas.

The delivery of integrated health care through the PHC approach in some countries raises the question of whether or how to incorporate some of the traditional medical systems which exist in many developing countries. Therefore, the next chapter will discuss and explore some elements of the traditional medicine and its relation with modern medicine and PHC.

Traditional medicine systems exist in one form or another in every society, and the practice of professional or non - professional medical care varies and involves differing culture and beliefs. In some societies, neither professional nor non - professional traditional medicine is recognised by official and modern medicine practitioners, while in others professional forms are recognised.

It is apparent that traditional medicine concerns itself mainly with curative aspects, but it also includes preventive measures involving immunisation, the wearing of protective objects to stave off illnesses, sacrifices and offerings, and the observance of prohibitions, taboos and a number of rituals including bodily hygiene. Moreover, traditional medicine includes a vast number of behavioural teachings regarding eating, and the nature of foods, including their cooling and heating quality. This is often related to a similar philosophy, thus *Unani Tibb* sees the body composed of matter and spirit, and seeks to maintain or restore equilibrium in both aspects, as the key to health.

The integration of traditional medicine with modern medicine is thought to offer potential for correcting the deficiencies of each and for promoting the development of medical science in the future. Non - professional medicine has some elements which need to be investigated by modern research technology. For example, the study of herbal medicine may add new treatments which can be utilised in formal medicine also, and may help to reduce the cost of treatment. Study of religious and magical healing may provide valuable insights into psychology and the role of interpersonal relationships in the therapeutic process.

Whatever its strengths and weaknesses, it is apparent that for many people in developing countries, traditional medicine is in practice the only form of care to which they have access. The WHO has recognised the value of harnessing this resource, and the attempt at integration will have implications for finance, training, and the planning of PHC in the future, which governments would do well to consider.

This and the previous chapters have discussed health conditions and problems in the third world and the key role of the PHC approach in improving the health conditions and providing health care with inexpensive means. Furthermore, also traditional medicine and its role, both actual and potential, within the health care system was highlighted. The next chapter will discuss factors which affect people's pattern of utilisation of the health services.

¹ Delivery of health care services through public polyclinics is practised in the former USSR; for more details, see Sidel and Sidel (1977), Op. Cit. Cuba and other socialist states provide health care through health centres; Morley, David et. al. (1983), Practising Health For All, Oxford University Press, Oxford.

² On May 22nd 1990 the People's Democratic Republic of Yemen and Yemen Arab Republic united to become the Republic of Yemen with the capital Sana'a. However, there was an agreement between the two governments for a transition period of not less than two and half years, that government departments should function under one roof and administration. Nevertheless, because there are different ideologies, one socialist and the second tribalist, the implementation of social and health services varies. Thus, the experience of the People's Democratic Republic of Yemen in implementing the primary health approach is chosen.

³ Community health workers are given various names in other countries: In Thailand they are called village health volunteers (VHV); village health coordinators (VHC); urban health volunteers (UHV); community health volunteers (CHV); in Botswana they are called family welfare educators; in Ethiopia community health agents.

3.1 Introduction:

The issue of utilisation of health service facilities is a vital aspect of medical care. In studying health service utilisation, researchers investigate and explore factors which have a great impact on individuals' behaviours, attitudes and beliefs towards medical care, and the medical care delivery system. Study of utilisation enables researchers to measure and evaluate people's satisfaction with the medical care services available to them.

The utilisation of health services is a complex phenomenon, influenced by many variables, including income, education, marital status, age and environment. Because of the interest of these variables to fields of expertise both inside and outside the medical system, it is not surprising that there is still no consensus among researchers about either the most significant variables, or the most appropriate approach to study this phenomenon. Investigators employ different variables and different terminologies according to their own perspective. For example, economists place great emphasis on financial factors such as costs and expenditures, whereas geographers usually place the stress on the geographical distribution of the health care facilities, and the distance of the health service to or from the utilisers' residences. Psychologists would highlight the importance of the individual's motivations, predisposition to seek health care and doctor - patient interaction.

Others interested in this phenomenon are administrators and planners, because utilisation behaviour provides them with indicators and insights about the distribution of health services within certain areas: whether these facilities have been distributed equally among the country's regions; which sections of the population have difficulty in obtaining access to health care services and which do not; which organisational factors impede individuals and which induce them to make the optimum use of the services. Thus administrators and planners, may, according to the results of research, reorganise the health care delivery system so as to provide accessibility for all the population.

There are still other factors which are not related to the health care delivery system but which have a great influence on individuals' behaviour and attitudes towards medical care in general. It is the interest of sociologists to investigate and explore what these factors are, how they affect individuals, and how to encourage persons who make little use of health services to increase their use of them.

Most of the literature concerned with the phenomenon of health service utilisation has emerged in the developed countries during the last three decades (Benyoussef and Wessen 1974). These countries have experienced radical changes in their health and medical care services in order to satisfy and meet their populations' medical needs, and they have much lower rates of morbidity, mortality and illiteracy than developing countries.

In contrast, Benyoussef and Wessen (1974) stressed the scarcity of research in developing countries, and argued that information on utilisation of the available health services in such countries is subject to substantially greater error than is the case with the data from developed countries. In the writer's view, although research from the Third World is rare and inaccurate, it still provides researchers in other countries with insights into utilisation of health services and what factors influence utilisation of the medical services in developing countries. Inaccuracy is not the sole preserve of research conducted in the third world. Error may come from the variables employed, or the limited scope of a study set up to achieve a specific purpose.

It is worth mentioning here that factors most important in affecting the individual's behaviour in the developed world do not necessarily have the same significance in developing countries, because of the great differences of environment, socio - cultural aspects, belief systems and social structure. Moreover, the tangible differences in levels of knowledge about illness, disease and availability of health service facilities; ratios of health personnel / population and health services facilities / population; and the application and acceptance of breakthroughs in modern advanced technology and discovery of new medicines, all differ between the developed and developing countries. Because of such differences caution must be exercised in generalising findings from one country to another. This should encourage researchers in developing countries to undertake studies in their societies. Such studies will provide decision - makers with some knowledge of the health care delivery system and population satisfaction, as well as the accessibility and thus utilisation of health service facilities.

Most commonly, researchers of utilisation of the health services obtain their data of utilisation from one of the following three main sources: i) physicians' records; ii) hospitals', clinics' and insurance companies' records, and iii) direct personal interviews or questionnaires in social surveys.

The physician's records, if kept in an appropriate manner, may provide chronological data on patients' visits, their purposes, diagnosis, and treatment recommended. However, it is not generally easy to obtain access to these types of records. Furthermore, physicians are not usually concerned with, and do not include, all other related social, economic, and demographic personal information. Thus, difficulties in gaining access to these files and extracting information from them, eliminate them as a fundamental source of data for utilisation, although they may provide useful information for special studies such as serious illness and consultation of physician, or what are the main ailments that make people seek a physician's help.

The second source of data concerning utilisation of the health services is the records of hospitals, clinics and insurance companies, if complete. These records will show the use made by patients who were either referred or who came through the emergency department. Information can also be obtained regarding treatment and operations. However, such information would be more useful to health planners and managers than to sociologists.

The final means is through social survey, by using personal interview or questionnaire. This source of collecting information, it is believed, will make a significant contribution, among other reasons because it interviews a cross - section of the population. Also, if the latter approach is combined with data collected through the other two approaches, the findings will contribute significantly to the field of health services utilisation.

The existing literature can be classified into two categories. First, literature which investigates the characteristics of the health service delivery system and their effect on access to and utilisation of the medical care; second, utilisers' characteristics and their impact on either encouraging or deterring the individual's utilisation of the available medical services.

This chapter attempts to review some of the existing literature. Although it is beyond the scope of this work to review all the literature, an attempt will be made to focus on some main approaches and to highlight some important findings.

3.2 Characteristics of the Health Delivery Systems:

The discussion will start by considering the characteristics of the delivery system. In this regard, researchers usually focus on two components: resources and organisation. Andersen and Newman

(1973) showed the importance of these two components and their subcomponents. They mean by resources, the total volume of resources relative to populations served: labour, capital, health personnel, equipment and materials used in providing health services, and the distribution of these sources within a given country. The other component is organisation, which involves two dimensions: access to and structure of health services.

Researchers who employ this approach to investigate variables pertaining to the system, utilise the medical care delivery system as their unit of analysis. Studies undertaken in this area explore the impact of variables such as bureaucratic elements, distance, travelling time, waiting time at the place of provision, office hours and regularity of health care (McKinlay 1972; Andersen and Newman 1973; Fiedler 1981; Hibbard and Pope 1986).

A growing body of knowledge of organisation structure and process, and development in the theory of organisations, have led to an awareness of the effect of the bureaucratic on the utilisation of the health services. Bureaucracy in the public sector may lead to negative consequences in treating patients, such as impersonality in treatment, the rushing of patients to meet doctors' schedules, long waiting time, long waiting lists, complex forms, and multiple registration procedures (Al - Baz 1992).

3.2.1 Distance:

The effect of distance on utilisation of health service facilities has received great attention from researchers studying the construction of the health system, and from geographers studying location and spatial distribution of the health units. Some studies suggest proximity can have a positive influence on people's rates of utilisation. Shannon (1969), Bice et. al., (1969) and Acton (1975) found distance between health providers and consumers' residence to be an important effective factor in explaining differences in use of health services. Studies undertaken in rural areas in Finland (Nyman and Kalimo 1973; Purola 1973) showed that the long distances to be travelled to services by rural dwellers reduced full access to the service, even after introduction of the National Sickness Programmes.

To understand the distance variable, researchers investigate distance - related variables (Fiedler 1981) such as travelling and waiting time; availability of transportation between the consumer's house and the provider's premises. Many studies have emphasised the significance of transportation in

increasing or decreasing the potentiality of use. They showed that people who used public transportation expressed annoyance at the amount of time taken up by travelling to the doctor's surgery; consequently, lack of availability of transportation becomes a deterrent.

For utilisers who rely on public transportation (Hibbard and Pope 1986) another interrelated factor is travelling time. Some studies have found a negative association between travelling time and utilisation (Kansas University 1960, cited in Fiedler 1981), while, on the other hand, Phelps (1975), and Luft (1976) discovered a positive relationship between travelling time and use of services. Hibbard and Pope (1986), in their study on " Age differences in the use of medical care", found travelling time for elderly groups had little importance, whereas for younger groups it had very significant implications, since time spent travelling to and waiting at the doctor's clinic, is time lost from work. Bice and White (1969) found patients living within a range of 15 minutes from the health service are more likely to seek help and make use of the services than individuals who either live at a distance of more than 30 minutes travel time or have no regular source of care.

The effect of distance seems to be different for different groups of people, for different type of services and various ailments or severity of disease. Joseph and Phillips (1984) questioned whether distance itself is the major factor influencing the utilisation of the service, or just an intervening obstacle to health care.

Collver et al. (1967) recommended (perhaps impractical in some areas) that

"... one way of overcoming this effect is to place branch clinics in scattered strategic locations". Moreover, they suggested that these "... branches should be placed not more than ten miles apart."

Their suggestion was based on their finding that most women who failed to keep appointments did so because of either distance or travelling time. Furthermore, they concluded that if it was not possible to have conveniently located branch clinics, alternatives would be either mobile clinics, or the provision of transportation to "... more centrally located facilities".

Waiting time at the provider's premises also influences utilisation of medical care services, though findings on this effect are inconsistent. Hibbard and Pope (1986) showed no serious effect of waiting time for elderly people, while, on the other hand, findings of other studies show a positive

relationship. For instance, Enterline et al. (1973a) pointed out that a long queue to see the doctor means a long waiting time. Other studies conducted in rural areas have supported the relationship between waiting time and use of the service (Nyman and Kalimo 1973; Purola, 1973; Enterline et al. 1973a; Enterline et al. 1973b; Benyoussef and Wessen 1974). Waiting time in rural areas could indicate that medical care and health personnel / population ratios are inadequate. Waiting time, therefore, is considerable. However, rural populations still have no other choice than to wait. The writers also drew attention to the long queues usually associated with public (government) hospitals. Those people who put up with waiting were either low - income, or using the emergency department.

3.2.2 Office Hours:

It is the providers of the service who set the working hours, and the problem arises here that the most convenient time for an individual to obtain care may not be during working hours, as he has other responsibilities towards family, jobs etc. Fiedler (1981) emphasised this point:

" ... Because service hours are determined by providers and not patients, the most convenient time for patients to obtain care may be very different from the time that is acceptable to providers" (p 133).

Moreover, the significance of clinic hours and their impact on rates of utilisation can be understood in cases of an elderly population. Hibbard and Pope (1986) assert the difficulties that face the elderly when barriers of office hours combine with lack of availability of public transportation at the time of need. It is very important to link these three variables - working hours, the individual's duties and the availability of transportation - within any framework in order to understand the effect of clinic / office hours as an incentive or impediment to seeking professional medical care.

3.2.3 Attitudes of providers or interaction with the Health Personnel

Many studies have stressed the importance of the patient - doctor relationship and its impact on the utilisation of the services (Al - Shuruq 1992). The attitude of the physicians, paramedical and other administrative personnel towards consumers is a very important covert factor which influences utilisation of health care services. In the public health service, the physician's attitude, e. g. whether he or she is willing to listen, to spend sufficient time with patients, or to give what is felt to be appropriate treatment is very important in encouraging consumers to make use of the services (Ben - Sira 1976;

Joseph and Phillips 1984). The administrative personnel or bureaucratic procedures may hinder people from using the available public health services. Another related factor is that most of the practitioners come from the "upper or middle class" and many of the consumers are "working class", or low - income. This gulf between the providers and the recipients of the services may adversely affect communication between them and may cause some difficulty in understanding patients' feelings, which will reduce the potential use of the health services. Some physicians, particularly in the public sector, also deal with the patient as a case rather than as a human being. All of these factors influence patient satisfaction. Consumers' satisfaction has been examined by many researchers in developed countries. For example, Fisher (1971) carried out a study to find out which factors had strong influence on patients' satisfaction with the medical services that they received in out - patient clinics. 150 patient were randomly selected at the time of their visit to one of three out - patient clinics. The results of this study showed that consumers were to a great extent happy and satisfied with time spent with the physician. The majority of interviewees indicated that their conditions had improved and about 80 % of the patients felt that their diseases had been adequately explained. On the other hand, many patients were dissatisfied with items such as not seeing the same physician on repeated visits, waiting time before seeing the doctor and uncomfortable seating. Also, the study revealed that a high percentage of the patients showed a more favourable attitude towards a particular physician than to others, and preferred to be seen by him. Similarly many other studies have shown that patients commonly evaluate the physician's performance and ability (Linn 1975). Francis et al. (1969) found that patients highly satisfied with their last visit to the doctor were more likely to follow doctors' orders and to re - visit their physician, than patients who were less satisfied.

3.2.4 Regular source of care:

Several researchers claim that individuals or families without regular sources of medical care are more likely to make less use of the health service facilities, though this claim has been disputed by others. Luft and his associates (1967) claimed that populations with no regular sources of care are likely to make less use of the medical care. Likewise Fiedler (1981) highlighted the importance of having a regular source of medical care

" ... Because an individual or family's regular source of care serves as a port of entry to the entire health delivery system. Once the decision has been made, the regular source largely determines the type, site, volume and continuity of care the patient receive."

Fiedler also argues the operational role of a regular medical source.

" A regular source of care will also minimise the delay between the time a patient feels he needs care, the time he initiates actions to secure that care and the time he actually receives it." p. 134.

Muller (1978) emphasised that people with a regular source of care are less likely psychologically to find it difficult to obtain access to medical care in general. Bice and White (1969) found, in their cross - national study, that persons with no regular source of care are less likely to seek care.

Several questions arise here, including who has a regular source ? Are there differences by socio-economic status ? Enterline et al. (1973), Nyman and Kalimo (1973), Purola (1973) and Aday (1978) suggested that the introduction of Medicare in Canada, the National Sickness Programme in Finland, Medicare and Medicaid in the United States and the National Health Service in Great Britain, facilitated access for the low income population and uninsured groups. All the studies carried out to evaluate the effects of these new policy measures, found that introducing these programmes resulted in a dramatic increase in utilisation by poor people (see, for example Andersen and Anderson 1967, Aday 1978, Enterline et al. 1973a; Bice 1969). However, these researchers considered the superficial aspect of this phenomenon - increase in the number of utilisers - with no attempt to investigate beyond this increase.

3.3 Utilisers' Characteristics :

Here we shall discuss the effects of individual characteristics. Before we consider this it is worth commenting that some studies use terms such as " overutilisation" or " underutilisation". McKinlay (1972; 1973) states:

" ... relatively little is known about utilisers, underutilizers, and specially overutilizers, except at a very superficial level."

He therefore recommends that research about over - and under - utilisation should be carried out. It would seem to the researcher that one can not research these levels of utilisation without some

criteria for definition first being set. It is preferable to examine the factors that prevent or encourage people to seek help in the present situation than to determine over - utilisation / under - utilisation, unless by under - utilisation is meant non - utilisation of the service.

3.3.1 Economic Factors :

The most salient factor to which researchers have drawn attention is the economic. McKinlay (1972) indicated that

" It is repeatedly suggested that a major determinant of the use made of medical services can be found in the financial costs of medical care. A vast literature exists in the United States which links families and individual income to the utilisation of, for example, maternal and child care services; dentists; physicians and hospital facilities."

Andersen and Newman (1973) broaden economic factors beyond the individual's or family's regular income using the term " enabling" factors. They classify these into two categories - "family" and "community". Family enabling factors include income, health insurance, type of regular source, and access to regular source, while community enabling factors include ratios of health personnel and facilities to population, price of health services, region of country and urban - rural characteristics. Enabling factors thus includes both societal and individual determinants. Most studies have examined individual or family determinants separately from societal determinants.

Theodore (1968) outlined stages in the formulation of a seeking for health advice or treatment. These are successive in nature, as follows: i) existence of physiological or psychological conditions; ii) perception of the existence of such conditions; iii) willingness to manage or control such conditions through health care services; iv) ability to transform need into demand for health care. It is suggested that individuals in the fourth stage (the transformation of need into demand) are directed by " economic" factors such as income, health insurance cover, the cost of health services and the availability of free medical care (McKinlay 1972).

Although many studies have been conducted to investigate the influence of economic factors, findings about their effect are controversial. Some studies have shown a positive correlation between income and rates of use. Andersen and Anderson (1967) found that people with high income used physicians' services more than people with low income. Similar findings have been found in other

studies, for example, Bice and White (1972), Bice et al. (1973) and Anderson (1973). Findings on cross - national studies demonstrate likewise the positive association between an individual's income and his tendency to utilise health service facilities. Bice et al. (1973) confirmed that rate of utilisation of physicians' services is high among high income people and utilisation decreases as income decreases.

In some countries such as the United States, Great Britain, Canada and Finland, governments have introduced programmes to remove the economic barriers, so all the population could have access to medical care services, irrespective of income, race and education. Researchers concerned with the effect of removing economic obstacles which impeded people from using health services, have undertaken research to examine the effect and the role of these new programmes. As indicated above, Bice et al. (1973), Bice (1973), and Aday (1975) found that as a result of the government sponsored programmes - e. g. Medicare and Medicaid - the number of visits made by the low income group were increased and they all attributed this increment to removal of the economic barriers. Similar results were found in Canada, when the government introduced the Medicare programme of free services. Enterline et al. (1973a; 1973b) stressed that free service resulted in a high rate of utilisation among low income groups in the Quebec region. Similar findings were obtained by Purola (1973) and Nyman and Kalimo (1974) in their research in rural areas in Finland, to explore the effect of the " National Sickness programme".

The general use of the health services will, to a great extent, vary in accordance with the influence of economic factors, even in some countries such as UK (NHS), Saudi Arabia, ex - USSR, and China, where all health services are socialised in the sense that health services are provided free to all the population; economic barriers to utilisation should in principle be limited only to the cost of transportation to services. However, in Britain as well as in Saudi Arabia, a growing private medical sector, which many can not afford, and perhaps increasing waiting lists for public health care, may be creating some economic barriers even within the NHS (Joseph and Phillips 1984), and the Saudi Health network. McKinlay (1970, 1972) argued that there is no firm evidence

that free health services have been able to eradicate the effect of economic factors on use of the health service in relation to social class.

All of the above studies proved the significance of economic factors and their positive association with use of services. Poor populations and low income groups, with their limited sources of income, can not purchase the services they desperately need. Recent research, however, has shown evidence that the rate of utilisation by the poor or low - income persons is higher than that made by the better - off. This led Bice et al. (1972) to conclude that

" the relationship between incomes and use has diminished considerably over the past four decades".

Aday (1975) offered a different interpretation of recent research findings on the increased number of visits made by the low - income population. She showed from the National Centre for Health Statistics data that in 1966 - 1967 and 1963 - 1964, the trend was in favour of the affluent as they made the optimum use of the physicians' services or health services in general. On the other hand, new research shows the poor averaged a higher number of visits to physicians than the non - poor. Aday attributed the new trend among the poor to their poor health status:

" People with low incomes have traditionally had greater morbidity than those with high incomes" (Aday 1975 p 448).

Moreover, she argued that if the trend in utilisation among the poor is considered in relation to the greater need of care, then it may appear that the poor population's use of services is still less than that of the non - poor.

Bice et al. (1972) claimed with support from survey, conducted in the 1960s, that the change in rate of use between the poor and high - income groups could be attributed to the decreased utilisation by the high income groups and that this may be partly due to their shift from utilising public services with all their concomitant inconveniences, to private physicians.

An indirect effect of income on individual utilisation of the health services, occurs in cases where the government is very poor and has limited financial resources, thus spending on health care is very low. This results in very inferior health services facilities which are unable to cope with the demand of the people served. This in itself may cause a lower level of utilisation.

It appears that the economic factor is one of the most important variables that influence individuals or families to seek health care, but there are also other considerations to be borne in mind in explaining utilisation behaviour.

3.4 Sociodemographic Factors :

The second distinct analytical approach concerned with individuals' characteristics and use of health service is the sociodemographic approach. Several studies have been undertaken to explore the effect of sociodemographic variables on the utilisation of medical care facilities.

3.4.1 Age:

The old wisdom always associates age and illness, as age increases vulnerability to disease. Thus the elderly are apt to make the highest rates of use of medical services. Many studies have shown this tendency. For instance, Hibbard and Pope (1986) found the medical "need" is the strongest indicator of medical use made by the elderly. Other researchers found other incentives led the elderly to utilise the services. Haug (1980) found that older persons were more likely than younger to contact the physician for routine check-ups in the absence of symptoms and to show high rates of utilisation for "non - serious" symptoms. Similarly, Andersen and Anderson (1967) found that utilisation of health services was higher for old groups and declined for children. Furthermore, Rosenthal (1964) cited in Anderson (1973) asserted that age is the third most important predictor of the rate of use of health service, after income and a component of sex and marital status. Beryoussef (1974) in his Tunisian study, found a positive association between age and use of service in both rural and urban areas.

Due to improvements in living standards and the increase in life expectancy in both the developed and some parts of the developing world the proportion of the elderly population has increased, and as they make more use of the health services, it is very important to take their needs into consideration in planning for health services. However, findings about the relationship between age and rates of utilisation are only valid if other variables, in particular sex, education, socio - cultural factors and income, are controlled.

3.4.2 Sex :

The second variable in the sociodemographic model is sex. Available data about the correlation between gender and utilisation of medical care is inconsistent. In general, researchers show that females tend to make more use of the facilities than males. For example, McKinlay (1972) stated

" ... utilisation is generally lower for males than for females".

Fiedler (1981) attributes the differences in use between sex to biological and epidemiological aspects. He argued that high rates of utilisation among women are due to higher morbidity rates than among males. Furthermore, he emphasised that evidence in the United States showed this difference in all categories of socioeconomic status, rural and urban areas, and even by employment status. Similar findings were found by Benyoussef and his colleagues in their study conducted in Tunisia in 1974.

The high rate of female utilisation was also confirmed by Andersen and Anderson (1967) who found a high rate of use by females in almost all age groups, and particularly in the age range 18 - 34.

" ... Young women 18-34, on the contrary are much more likely to have examinations in response to symptoms and as a measure of prevention on their own volition" (Andersen and Anderson 1967, p 22).

Some researchers attribute females' high rate of utilisation to the fact that women of child bearing age make much use of prenatal and natal care. Although this justification could be accepted to a certain extent, nevertheless, researchers have asserted that not all women have prenatal or postnatal care, for example McKinlay (1972, 1973), Graham (1984), Calnan (1987). Moreover, Graham (1984) and Calnan (1987) emphasised that working class women with children and holding a job will sustain the burden of illness rather than go to see a physician immediately, because of their family commitments. Lack of child care, worry about housework, and the fear of losing their jobs, all impede such women from seeking care. Graham (1984) raises an interesting point:

" While a mother is quick to identify and respond to symptoms of illness and disability in others, she appears less assiduous in monitoring her own health."
p 159.

In relation to this, Hibbard and Pope (1983) found a correlation between women's role obligations and rate of reporting symptoms: first, females report higher rates of symptoms than males do;

secondly, they found that women with low role responsibilities report more symptoms than those with greater role responsibilities.

Benyoussef and Wessen (1974) found urban females make higher use of medical services than males, particularly in the age group 15 to 65, whereas rural females make less use than their counterparts in urban areas and less than rural males. This appears to be the effect of socio - cultural factors. Women in rural areas usually tend to be conservative and more reluctant than city women to see a physician, especially if the physician is male. This would account for their lower use of the services in Tunisia.

Joseph and Phillips (1984) argued that women are more prone to psychiatric disorders than males. They supported their argument stating that it had been shown in Britain, that 11 % of males and 17 % of females were estimated to experience a psychiatric disorder at some time during their lives, and in the USA that women in 1966 - 1968 comprised at least 60 % of the adult population in psychiatric facilities and two - thirds of diagnosed schizophrenics. They concluded that females have consistently been found to have higher rates of depression and stress than males.

3.4.3 Marital Status :

Another sociodemographic variable thought to have an influence on rate of utilisation is marital status. Several researchers have shown a positive relationship between marital status and use of medical care. Abel Smith and Timmuss (1956) showed there were higher rates of use by both men and women among single, widowed and divorced categories, than among married people. Similar results have been cited by Morgan (1980), using the 1971 census of Great Britain, except for the age category 25 - 29 years. He explains that this exception may be attributed to obstetrics use made by married females.

Available evidence also shows more in - patient and long - stay hospitalisation by unmarried people than those who are married, while the latter showed higher registration in out - patient departments. This could be interpreted in two ways. First, the lower use among the married category may be because they have someone at home to look after and care for them and thus have less need of hospitalisation. Second, the stability of life for the married may reduce much of the everyday stress and psychological pressure that may contribute to physiological illness.

3.4.4 Education:

This subcomponent of sociodemographic factors is thought to have strong impact on the individual's utilisation behaviour. The general impression is that the highly educated will have a higher rate of use, because they are expected to have greater awareness of illness, diseases and symptoms. Thus, most research places emphasis on the significance of education for the use of services. For example, Rosenthal (1964) found the relationship between education and both admission to and length of stay in hospitals to be positive. He explains his findings

" ... as indicative of increased awareness among the more highly educated members of the population of the value and importance of seeking prompt medical treatment." p 107.

Luft et al. (1976), have gone so far as to claim that education is the primary determinant of the likelihood of seeing a physician.

Bice et al. (1973) and Andersen and Aday (1978) asserted the importance of education on the utilisers' behaviour in two respects, direct and indirect. The direct effect appears in the greater number of visits made by persons with higher levels of education, whereas the indirect effect is that higher education leads to more awareness of sickness and less illness, hence, less need for utilisation of physicians. Similar conclusions have been reached by other researchers (Phelps and Newhouse 1974). An individual with higher education will be aware of health facilities available to him and have a greater knowledge about how to benefit from these services. Grossman (1972a, 1972b) supporting the positive effect of education on health use, stated that the better educated have more knowledge about health problems, more information about good health and thus can use the information more effectively so as to achieve a good health status.

Other investigators view the relationship between the use of medical care and level of education as negative, for instance the indirect effect found by Andersen and Aday (1978) which led to less use of service by better educated people. In a study conducted in order to find out who was more likely use self - medication, Saeed (1988) found people with a high level of education tended to make less use of health services and use self - medication as long as they viewed the symptoms as minor, or in order to save time and money. People with less education made less use of self - medication.

Another study undertaken in Tunisia showed that the relationship between education and use of medical care is positive in both rural and urban areas. Moreover, it showed that those with a good command of a foreign language made greater use of the services than others who had no command of other languages and had less participation in public events, in both rural and urban areas. Furthermore it found a link between lower level of education and reliance on folk medicine. People with a higher level of education were less likely to use folk medicine.

In general, then, we can conclude that the relationship between education and appropriate use of medical care is positive, as proved by evidence collected from different societies. What has been viewed as a negative effect by some researchers is a result of greater awareness of health issues, which has led to less need of medical care.

3.4.5 Race or Ethnicity:

The race or ethnic background of individuals has been suggested as a cause of differential utilisation of the health services. Many of these studies focus on the relationship between white and non - white and the use of medical care. Most, if not all, theories and findings in this respect show utilisation is greater among whites. Andersen and Newman (1973) found that admission to hospitals, visits to the physician and to the dentist were higher for whites than for non - whites. Andersen and Anderson (1967) and Bice et al. (1972) obtained similar findings. This trend could be due to the fact that, non - white in America generally means blacks, most of whom are members of the working class, have low - incomes, and tend to have lower levels of education. On the other hand, Salber et al. (1976) reported that

" increased education levels, which presumably would alter health attitudes and change perception of health status, did not increase the use of service by the blacks, although it did for whites. This and other assorted circumstantial evidence indicates that the black - white utilisation differential is a result of discrimination and / or institutional racism" (Salber, et al. 1978, p 163).

Berki (1973) reported that immigrants, mostly from Latin America, tended to make less use of medical care, particularly because of the language barrier. This factor can be noticed in any society with groups of people who do not speak the same language. Other studies of ethnicity and use of service have obtained similar findings, though not including the language factor, for example

Rosenthal (1964), Andersen and Anderson (1967), Bice et al. (1972), Grossman (1975) and Andersen and Aday (1978).

Joseph and Phillips (1984) argued that in the United States, preventive medicine is very much a white, middle - class preserve which racial / ethnic minorities use less. Furthermore, these minorities frequently may make use of paramedical healers, e. g. pharmacists, turning to a professional physician only quite late in their illness. In countries where health services are not free, underutilisation may be linked to poverty, e.g. many members of ethnic minorities are more likely to be among the poor groups. Among the ethnic poor the elderly or those with large families may be least able to use the health services effectively or commensurate with their actual needs. Also, in some societies it is possible that some health care facilities may be denied to ethnic minorities or non - natives, purely because of their race or nationality, so explicit " racial barriers" to utilisation may exist.

3.4.6 Occupation :

Several studies have found a positive correlation between occupation and use of services. For instance, Bice et al.,(1969) found in their international comparative study conducted in three different societies, that the relationship between occupation and service utilisation differs from one society to another. In some places, individuals engaged in middle ranking occupations were more likely to use services than those in lower and higher groups, while in other societies, agricultural workers made higher use of services than all other adults in the same society. Fiedler (1981) supports the suggestion that individuals doing physical labour are likely to make more use of medical facilities than individuals holding intellectual professions. In the writer's view, this is because those who perform manual or physical jobs are more likely to be exposed to dangerous events than those in non - manual professions. However, such use indicates imposed cases rather than volitional attitudes, as contact is of the emergency and casualty type. In this respect, occupation is not a reliable indicator, as it is a biased variable. To assess the occupational factor, one could identify a number of diseases and symptoms then measure the responses towards them by occupational status, excluding work injuries. Then the effect of occupational status on utilisation of medical care services could be measured.

3.4.7 Religion :

A very important factor which, unfortunately, has not yet been adequately researched is the effect of religion on utilisation of medical and health care facilities. Few studies have considered it, and then not as the central variable. Some research has been carried out to measure the effect of belief on utilisers' behaviour, but in this sense, belief does not mean religion. It means trust and reliance of the individual on the health system and its various personnel, and people's attitudes towards modern and traditional medicine; in another words, culture rather than religion itself. However, the effect of religion on rate of utilisation was recognised by Andersen and Newman (1973) who counted it as a predisposing component in their behaviour model. Collver et. al. (1967) found that Catholic women showed lower attendance at prenatal, postnatal and family planning clinics, though those who attended church infrequently were more likely to visit all types of clinics, even more than Protestants.

Some findings have demonstrated a contrast between Catholics, Protestants and Jews. Studies have shown differential use between these three believers in terms of medical type. For instance, Horwitz et. al. (1985) found that Catholic and Jewish children were more likely than Protestants to make use of paediatric medical care. Another study conducted in Nigeria (Nnadi and Kabat 1984) found Muslims made more use of both modern and traditional medicine than those practising other religions in Nigeria. Furthermore, Iyun and Oke (1993), found in Nigeria, that there were differential differences between utilisation of contraception and religion, 44 % of Christians indicated that they have used family planning clinic as compared with only 23 % of Muslims. However, other studies have claimed that religion has no serious effect on use of medical care services. For example, Schaefer and Hughes (1976) found that religion had no effect on use of maternity and child health care.

In Saudi Arabia religion has an effect through the treatment of women. In most Middle Eastern countries, segregation between the sexes to some extent is applicable in both Muslim and non - Muslim societies. However, in Saudi Arabia, the practice is clearer than in any other society. For this reason, health care for women is provided by female physicians, as most Saudi Arabian women are reluctant to be diagnosed by male practitioners. Thus, utilisation is low if there is no female provider.

The contradictions between the studies cited here could be attributed to several reasons. In most of them, religion was not the core matter. It was treated as any other sociodemographic variable, such as age, sex, and socioeconomic status, that is as a dependent variable rather than an independent one. Secondly, researchers did not reveal whether the interviewees were practising believers, or only nominal adherents to a religion. Further, it is not clear whether the researchers considered the religion's teachings and their effects on followers' use of certain types of health care, such as family planning. Also, as with race, present or past discrimination in some areas may mean that religion is associated with income and socio-economic status.

3.5 Health Belief Approach:

The health belief model is concerned with people's perception of illness, diseases and health, on the one hand, and on the other, their trust or distrust of modern or traditional health care, and belief or disbelief in its ability to heal. The approach tries to explore establish the relationships between attitudes and beliefs towards medical care and utilisation of the health service. For example, some studies employing this approach have suggested that low levels of utilisation were found among certain ethnic groups because those groups tended to be more sceptical of the benefits of modern medical care (Brenner et al. 1980). Young (1980) assessed the health belief model, of which he alters a refined version. His approach is based on four central considerations: 1) Gravity or seriousness of the disease; 2) Knowledge of a home remedy: if an effective home remedy is available for the illness at hand, the individual is more likely to choose that treatment rather than to go to the professional system, whereas if no effective home remedy is available and known to the individual, s/he is more likely to seek medical treatment from a professional source; 3) Faith: this element reflects the individual's belief in the efficacy of traditional medicine as opposed to modern medicine, in treating particular diseases; 4) Accessibility: this reflects the costs and availability of various type of health services (Wofinsky 1980).

However, the health belief approach may not be applicable in all countries. For example, in many developing countries, people have no more than one choice of health care. Even in the

industrialised world, this approach may not be practical, if health alternatives are very limited or do not exist.

3.6 Conclusion:

We have considered a range of indicators which have been employed by researchers to explore the utilisation of the health service facilities. These can provide decision - makers with tangible evidence for reorganisation of the medical care delivery system and enable them to rethink policy in order to provide health care for every citizen.

Geographic, economic, socio - demographic and health belief approaches have all been considered. None of the approaches reviewed seems adequate, if used alone, to explain why, when, how and where people utilise health services. For example, although some differences in utilisation have been found in relation to income and socio - economic status, it has also been found that removal of cost, by the introduction of free health services, has not removed all differentials in utilisation; obviously, the income factor, though important, is not sufficient to explain differences in utilisation. Similarly, socio-demographic factors can only be of limited use in explaining health behaviour. For example, the findings on differences in utilisation between the sexes are conflicting. Another point worth making is that conflicting findings may have arisen because researchers have attempted to generalise to all health services, the findings from studies conducted in a specific context. It is necessary to define clearly the type of service investigated.

Despite these differences, the various approaches reviewed in this chapter provide valuable insight into the range of factors which may encourage or impede utilisation of health services in various settings. In the present study, the researcher has drawn on this theoretical background, in selecting variables for investigation in relation to utilisation of health centres in Saudi Arabia.

First, however, it is necessary to have some understanding of health service policy and provision in Saudi Arabia in general, and the study site, Jeddah, in particular. Some consideration must also be given to the nature and role of traditional medicine, which continues to be used alongside modern

medicine in many developing countries and may be regarded as an important element in the pattern of health behaviour in Saudi Arabia. These issues will be explored in the next three chapters.

CHAPTER 4 Health Policy and Services in Saudi Arabia:

In order to understand the health services and policy in Saudi Arabia, it is helpful to know something of the geographic, historical and economic background of the country. This chapter, therefore, provides general background information about the Kingdom.

4.1 Geography and Demography of Saudi Arabia:

The " Kingdom of Saudi Arabia" occupies eighty percent of the Arabian peninsula. It is bounded by eight Arab states, and three bodies of water. These boundaries embrace a large country whose area is officially estimated at 865,000 square miles. In 1963, the country was divided into five geographical and administrative provinces: the Central province (Najd), the Western Province (Hijaz), the Eastern Province (Al - Hassa), the Southern Province (Asir), and the Northern Frontiers.

The Hijaz region contains four of Saudi Arabia's major cities. Jeddah, Makkah, Madinah and Taif. Najd, in the centre of the country, holds Riyadh, the capital of Saudi Arabia.

The size of the population of Saudi Arabia has long been a matter of dispute, because there are no precise official figures, despite government efforts to make an accurate assessment. Review of the various available estimations reveals contradictions and suggests that most of the available assessments make use of subjective judgements and were put forward to serve particular purposes or interests. No accurate enumeration has been carried out to survey the entire population of Saudi.

Despite the confusion and discrepancies, population enumeration is not an untried instrument in the country.⁴ Some observers attribute the confusion to the shortage or absence of an effective system of birth and death records (Al - Shammasi 1985). Records do exist and have been used for a long time, but are inefficient because of the large area of the country, and the fact that some of the population are not permanently settled. For instance, Bedouins travel from one place to another searching for water and grass for their herds. In such cases, life events such as birth or death are not registered until the need arises to apply for national identification or to claim any aid from the government agencies, when claimants have to give the actual number of their dependants. However, the record system is successfully applied in all cities, towns and villages. In addition, the Ministry of Interior's passport and nationality department emphasise the importance of registration within one month of birth or the parents will be fined. In case of death, the body can not be buried without a

permit from the hospital, court and the police department. Thus, the argument of the shortcomings of registration in Saudi is exaggerated. Others assert that accurate population figures are unavailable for security reasons, though again, there is no evidence to support this argument.

The first census was conducted in 1930, two years before the unification and declaration of the Kingdom of Saudi Arabia, in Hijaz, now the western province of Saudi Arabia. Unfortunately, the results of that census are not available. In 1933 an estimate put it at 5,110,000 (Hamza 1933). In 1956, an official estimate put the population at 6,036,400. In 1962/ 1963 the government carried out a general census which put it at 3,300,000. However, the result was repudiated by both the government and the United Nations because the survey did not cover all the population (Ministry of Finance and National Economy 1963; Nyrop 1977). The various estimates between then and 1974 all suffer varying degrees of uncertainty. When the Saudi Arabian government in 1974 conducted the first national census, it put the population at 7,012,642 (Nyrop 1977). This census did not escape criticism, though its estimation sounded reasonable. First, it was conducted by 10,000 counters, most of them teachers and it is unlikely that this number of counters was able to cover the whole population of such a huge area in one night. Secondly, at the time it was not easy to obtain some information from the family heads in the absence of any advance campaign informing people about the importance of the census and the confidentiality of information. Thirdly, there were remote places which were very difficult to reach at the time, as no paved roads existed. Fourthly, the population were scattered all over the country, and the Bedouins were wandering from one area to another. Finally, there were illegal residents from whom it was difficult to obtain any information because they feared to disclose their status. However, despite these criticisms, it is believed that the 1974 census covered a sufficient proportion of the population to produce reasonably reliable figures.

Since 1974, all population - related characteristics such as volume, sex, fertility rates and other related indicators have been estimated, because no official information is available. However, the UN 1982 assessment of world population prospects estimated that in mid - 1984 the population of Saudi Arabia would be 11,093,000, rising to 12,483,000 by the mid - 1987. The Saudi Government estimates put the number for mid - 1987 at 13,612,000, increasing to more than 14 million by the mid - 1988. The official estimate for mid - 1989 was 14,435,000. In 1980 it was estimated that 67%

of the population lived in urban areas, the remaining 33% comprising settled farmers, clustered around oases and the bedouin (nomadic desert dwellers), living in rural areas.

The government conducted a national population census in 1992 to enumerate the population and housing, but the full details of the results will not be known for some time. However, Al Eqtisadiyah (1992) daily newspaper printed out the first results of this census, putting the total population of Saudi Arabia at 16,929,294, of whom 4 million are expatriates. 50.4 % of Saudis are male and 49.6 % female, whereas for expatriates 70.4 % are male and only 29.6 % are female. No more information from this census is available as yet.

Undoubtedly, sixteen years from the previous census, several changes will have occurred in all aspects of life. Old cities have expanded, people's standards of living have improved, and the population structure in terms of gender, age distribution, percentage of urban to rural and nomadic have changed. Thus, the census will bridge the information gap.

General observations from Saudi Arabia today show that urbanisation is very rapid. The younger generation prefer public sector civil or industrial employment rather than agriculture. Several social and economic studies conducted by Ministry of Planning showed internal migration from the Northern province, south toward the major cities such as Jeddah, Riyadh and other large cities and industrial estates, because the job opportunities are greater and other facilities available. A study conducted in 1980 showed the age pyramid structure of Saudi Arabia population (Al - Bniyan and Shita 1980).

Table 4 - 1 Age Distribution of the Population.

Age category.	Population.	Percent %
Less than 14	3,138,038	45
14 - 45	3,033,086	43
More than 45	841,517	12
Total	7,012,641	100 %

Sources: Central Department of Statistics, census of (1974), and Al - Bniyan and Shita (1980).

However, since as mentioned above, the available population figures are estimates, the only official figures being the 1974 census, these are unacceptable as a basis for analysing the present population structure.

4.2 The Political Economy and Social Development of Saudi Arabia.

Prior to the unification of Saudi Arabia in 1932, there was no comprehensive national economy. Economic activities outside Hijaz region were limited to livestock rearing by nomads, primitive agriculture and some traditional handicrafts made by local people in small towns around water sources. In Hijaz, commerce and services formed the basis of the economy. There were four main economic activities in Saudi Arabia, before and after unification. Animal husbandry was practised by the Bedouins in the interior areas, where sheep, goats and camels were reared. Agricultural activities were practised in Asir region, Tihamah plain, al - Hassa region on the Gulf coastal and in the hinterland, in those places where water sources existed. The main crops were vegetables, grain, fruits and dates, the staple foods for the population of the Arabian Peninsula. Commercial and handicraft activities were practised in the towns on the coast of the Red Sea such as Jeddah, Makkah and Madina and on the Persian (Arabian) Gulf on the Eastern coast. Fishing and pearl - diving were practised in the two coastal regions.

The discovery of oil in the area brought with it wealth and new job opportunities, not only for the residents of the Eastern coast, but for the whole country. Oil was discovered in the Eastern region of Saudi Arabia in 1933, but not in sufficient quantities for commercial use. New fields were discovered 1938, making commercial production viable, but the outbreak of World War II interrupted the production process and brought shipping restrictions. Output decreased and exploration, extraction and shipping were stopped till the end of the war. By 1940 it became clear that Saudi Arabia had vast oil reserves. The post - war period witnessed a rapid expansion in oil production, which rose from 20,000 barrels per day in 1943 to 500,000 barrels per day in 1949 (Lackner 1978). Oil has become the cornerstone of the Saudi Arabian economy. Almost all economic activities are based on oil products or financed by oil revenues. Thus, oil and its revenues have played a major role in the modernisation, development and wealth accumulation of Saudi Arabia.

4.2.1 An Analysis of Development Plans:

Saudi Arabia started to consider development in the 1950s. The government feared that its development proposals might be rejected by the conservative sector of the population, who might see

such changes as being contrary to Saudi traditions and Islamic teachings. However, with the continually increasing oil revenues in the following years, and the formation of the Saudi Monetary Agency (SAMA) to stabilise the Saudi Riyal, the pressure for development plans was stronger than ever. The first step towards forming an integrated economic strategy was made in 1954, when the first budget was announced under the advice of the International Monetary Fund (IMF) and the International Bank of Reconstruction and Development (the World Bank). In the late 1950s some financial and political instability took place which delayed the implementation of economic and social development plans. Nevertheless the government continued to explore the possibility of introducing a plan, and was assisted in this by the World Bank in co-operation with SAMA and the Saudi Economic Development Committee. In 1961, the World Bank Mission presented to the Saudi Arabian government the outlines for a two-year programme.

The World Bank programme was a cornerstone for constitution of the Supreme Planning Board (SPB) in 1961. The SPB functioned to provide the outlines of Saudi Arabia development programmes and to co-ordinate projects with the other government ministries and agencies. The political situation was growing increasingly unstable, particularly the relationship between King Saud and Crown Prince Faisal. In 1964, King Saud was deposed. After this period of instability, development planning was resumed. The development plans are summarised below:

4.2.1.1 First Development Plan (1970 - 1975)

The first development plan was introduced in August 1970. Its main economic and social objectives were:

- 1 - Maintaining religious and moral values.
- 2 - Raising the living standards and welfare of the population.
- 3 - Assuring defence and internal security.
- 4 - Maintaining economic growth and social stability.
- 5 - Reducing dependence on the export of crude oil

Those objectives were to be achieved through the following mechanisms.

- 1 - Increasing the rate of growth of gross domestic product.
- 2 - Developing human resources so that the several elements of society would be able to contribute more effectively to production and participate fully in the process of development.

3 - Diversifying sources of national income and reducing dependence on oil by increasing the share of other productive sectors in gross domestic product (Central Planning Organisation 1970 and 1975).

Table 4 - 2 Financial Allocations for the First Development Plan (SR. Million)

Development sector	Amount SR	%
Economic Resources Development	6,033.3	10.7
Human Resources Development	10,198.7	18.1
Social Resources Development	2,443.0	4.4
Physical Resources	14,086.8	25.1
Administration	10,466.5	18.6
Defence	12,994.7	23.1
Total	56,233.0	100

Sources: Kingdom of Saudi Arabia, Ministry of Planning (1976), and Ministry of Information, Outline of the Second Development Plan.

This plan was the first attempt by the government at a comprehensive approach to rationalising and modernising economic development. Defence received 23 % of the total allocations and infrastructure consumed 25 % per cent. Infrastructure projects such as roads, seaports, airports, hospitals, housing, health centres and other public services were essential before any development could take place in such a country as Saudi Arabia. Allocation for health and education was 22.5 % per cent of the total budget, not an impressive figure in a country where the literacy rate was estimated at between 10 and 15 per cent in 1971 - 1972 (Lackner, 1978).

The first development plan was modest in scale and expenditure, because it was introduced at a time of relative financial constraint. Yet, within the life time of the plan the Arab - Israeli war took place; and the oil production increased from 3.8 million barrels a day in 1970 to 7.1 million barrels a day and the price jumped from \$ 1.8 per barrel to \$ 12.40. The plan overall aimed to increase GDP by 10 per cent a year, and this was fulfilled easily. This however does not give a real indication of the development of the economy, as the increase in GDP was almost entirely due to the vast increase in oil revenues after 1973, rather than to increased output in industry or agriculture (Lackner 1978). However, the plan marked the start of a programme for rational development.

4.2.1.2 Second Development Plan (1975 - 1980):

The second development plan was introduced at a time when the government found itself in a very strong financial position, and was determined to embark on a massive programme of industrialisation and modernisation. The allocation of expenditure under this plan, no less than SR. 498,230 million, shows how ambitious it was. Many foreign commentators were pessimistic regarding the chances of success of the plan.

Table 4 - 3 Financial Allocations for the Second Development Plan. (SR. million).

Development sector	Amount SR.	%
Economic Resources	92,135.0	18.5
Human Resources	80,123.9	16.1
Social Development	32,212.8	6.7
Physical Infrastructure	112,944.6	22.7
Administration	38,179.2	7.7
Defence	78,156.5	15.7
External Aid, Food subsidies	63,478.2	12.7
Total	498,230.2	100

Source: Ministry of Planning, Second Development Plan (1975), P. 529.

The objectives were very similar to those of the first plan. However, the second development plan was introduced at a time when oil revenues had risen from \$ 1.2 billion in 1970 to \$ 22.6 billion in 1974. This was a double - edged weapon. It provided the government with the necessary financial resources for infrastructure, industrialisation and modernisation of the country, but on the other hand, it rushed the development of the country too fast, with poor infrastructure, leading to waits of up to six months to unload cargo at the seaports. There was an acute shortage of housing in major cities, made even worse by rent controls (Johany, 1982). Also, with the influx of foreign labour, supplies of electricity and water supply were no longer sufficient (Al - Ghamri 1988).

Under the plan, the physical infrastructure received the lion's share of the total expenditure, 22%. The economic development allocation in this plan was higher than in the first, taking second place with 18.5 % , compared to 10.7 % per cent in the first plan, because the government offered more financial support to the private agricultural and industrial projects, with interest - free loans and subsidies. However, the country during this period suffered high inflation which the government was unable to control.

Despite these problems, plans were made to increase industrial output and benefit from the oil by creating two new industrial cities, one at Al - Jubail on the Gulf coast and the other one at Yanbu, 200 miles north of Jeddah on the Red Sea coast. Many outside observers were pessimistic about the achievement of this project, but the government succeeded in its goal with great determination. The last three goals of the plan show the ongoing intention to provide the basic material and human infrastructure considered necessary for the modernisation in a country which only 20 years ago was entirely materially undeveloped. The plan aimed to

" develop human resources by education, training and raising standards of health (MOP 1975, P. 28).

It also aimed to

" increase the well - being of all groups within the society and foster social stability under the circumstances of rapid social change (Ibid. p. 28 - 29).

4.2.1.3 Third Development Plan (1980 - 1985)

The plan was introduced in 1980 after approval of the Council of Ministers. It was to a large extent a continuation of the previous two plans, with which it shared parallel aims. Allocations under this plan were very different from those under the aforementioned plans, due to the rise in oil revenues.

The major objectives of the Third Development Plan were:

- 1 - To promote structural change in the economy through emphasis on resource development and growth in producing sectors.
- 2 - To increase economic and administrative efficiency.
- 3 - To increase participation in the development process, thereby raising the overall level of social welfare (MOP, 1980).

Table 4 - 4 Financial Allocations for the Third Development Plan (SR. millions).

Development sector	Amount SR.	%
Economic Resources	120.4	18.3
Human Resources	124.3	18.8
Health & Social development	69.6	10.5
Municipalities & housing	108.9	16.5
Transport & communications	139.1	21.1
Special Credit Institutions	97.3	14.8
Total expenditure	659.6	100

Source: Ministry of Planning, Fourth Development Plan 1405 - 1410 (1985 - 1990) P. 26.

The emphasis in this plan was shifted from infrastructure projects to the productive sectors, with more stress on the agricultural sector, as the aim was to achieve food self - sufficiency. Also, this plan highlighted the need for native trained manpower, reflected in the allocation of 18.8 % per cent of the budget for human resources development. The plan aimed to reduce reliance on expatriate manpower. Therefore, the number of foreign labourers was reduced as a matter of government policy. The government adopted a new strategy of Saudisation of most of the public and private sectors, particularly banks.

Social development services in health and welfare and culture were expanded under this plan. Preventive medicine, health education and primary health care received more emphasis, as the allocation for health and social services rose to 10.5 %, while in the second plan it was 6.7 % per cent of the budget. A large proportion of this quota was absorbed by the setting up of new hospitals.

This plan encouraged the private sector to participate in the development process and undertake the expansion of the productive sectors such as agriculture, industry and mining. The Saudi Arabian Agricultural Bank (SAAB) and Saudi Industrial Development Fund (SIDF) provided long term loans free of interest, to the private sector.

The plan allocated 21.1 % of the budget for transportation and communications, as well as municipalities and housing, the latter being responsible for providing services such as streets cleaning, and lighting.

Diversification of the country's' economy required development of the agricultural, industrial and mining sectors. However, the manpower shortage compelled the government to opt for mechanisation

4.2.1.4 Fourth Development Plan (1985 - 1990)

This plan was introduced on 22 May 1985 at a crucial period for the region in general, due to the Iraq - Iran war of 1980 - 1988. Moreover, oil prices during this period started to fall. The decline in oil revenues slowed down economic growth, and led to a decrease in government expenditure, thereby reducing demand for goods and services more quickly than anticipated.

Table 4 - 5 Financial Allocations for the Fourth Development Plan (SR. million).

Development sector	Amount SR	%
Economic Resources	71.4	20.9
Human Resources	114.2	33.4
Health & Social Services	59.3	17.4
Transport & Communications	50.6	14.8
Municipalities & Housing	46	13.5
Total	341.5	100

Source: MOP (1990), Fifth Development Plan. p. 25. Excludes government - owned specialised credit institutions.

The plan's objectives were along the same line as previous plans: continuing structural change in the economy to diversify the economic base and reduce dependence on crude oil as the main source of national income; completing infrastructure projects to achieve long term economic and social development goals; development of human resources through education, health and raising living standards. The plan's figures were exclusive of defence spending and foreign aid. Priority was given to human resources (35.3 %), economic development (19.9 %), health and social services (18.2%) and finally the transportation and communications sector, with 15.6 %.

4.2.1.5 Fifth Development Plan (1990 - 1995)

On 2nd August 1989 a decree was issued to introduce the fifth development plan for 1990 - 1995. However, at the time of this plan, most of the country's infrastructure was being completed. The Fifth Plan will reinforce and extend the basic objectives of the earlier plans, but places even higher priority on the role of the private sector and on the policy and institutional innovations essential to economic diversification (MOP 1990).

Table 4 - 6 Financial Allocations for the Fifth Development Plan (SR. million)

Development Sector	Amount SR	%
Economic Resources	73	18.5
Human Resources	139.9	35.4
Health & Social Services	66.1	16.8
Transport & Communications	52.6	13.3
Municipalities & Housing	63.2	16
Total	394.8	100

Source: Ministry of Planning (1989), Fifth Development Plan p. 100.

Human Resources:

The plan shows that facilities for primary and secondary education will be increased in all regions in response to population growth. Funding for these facilities will consequently be increased and targeted spending in this plan will exceed that of the previous one by 20 per cent.

Health Services:

In this regard the plan will give priority to growth in the basic primary health care network in smaller cities and rural areas. The plan recognises some problematic issues in this field, and anticipates that new health and psychiatric problems will emerge, particularly as a result of increased urbanisation. Therefore, family primary health care will require further attention and support to combat epidemic and endemic diseases (MOP 1989, p. 71).

Transportation and Communications:

The transportation infrastructure to a large extent has been completed, so the need for new projects in this section will be limited. The priority will be to improve the postal services and the telephone system, thus, there will be a large increase in investment in communications facilities. Similarly, further investment will be necessary to extend television coverage to the entire country through the use of satellite technology.

Municipalities and Housing: Undoubtedly, as the demand for services grows, investment in municipalities will also increase to improve services in general and in smaller cities and towns in particular. In the housing sector, the plan envisages no new projects being needed in this plan's period; therefore, investment in this sector will be reduced.

4.3 Health Organisation in Saudi Arabia:

Public health services in Saudi Arabia, as in most developing countries, are of recent origin and are still in the organisational stages. The early philosophy of introduced medicine was strongly influenced by the ideas prevalent in the United States in the 1960s, that medicine should be specialist - dominated and hospital - based (Dodd 1986). To understand the mechanism of the health care delivery system in Saudi Arabia, several areas needed to be discussed. The most prominent ones are the following.

- 1 - The dominant characteristics of the health delivery system.

2 - The organisation of health care and the role of the Ministry of Health (MOH).

3 - Economic influence and health expenditure.

4 - The network of health care services.

4.3.1 The Main Characteristics of the Health Care Delivery System and its Development.

The health system in Saudi Arabia, as mentioned above, is in its early stages, and is still experiencing modification, expansion and improvement. It has features of both developed and developing countries. Health services are provided through two sectors, public (government) and private. The main characteristics of the public sector may be summarised as follows:

i - There is a concentration on curative rather than preventive medicine, as in many Third World countries. This aspect of health care is costly to provide and its sophisticated technologies consume a large proportion of the total allocations for the health budget.

ii - In comparison with curative medicine, much less attention has been paid to preventive medicine to deal with common prevalent diseases such as malaria, bilharzia and diarrhoea. This is partly because progress has been limited in the field of health and safety education and preventive care. For example, the infant and child mortality rate remains high. Moreover, deaths and injuries from road accidents constitute a major health care problem, because of inadequate road safety education (Hamour 1984).

iii - Planning, organisation and provision are controlled by the government, to ensure free access to health care facilities for all the population. The private sector is supervised, encouraged and subsidised by the government and it now delivers an estimated 15 per cent of the total health services to those who can afford to pay. In these respects, the Saudi health system resembles that of the UK. However, it differs in that health care is delivered through 14 government agencies and departments, apart from the Ministry of Health, each with its own policies, priorities and restricted clientele (Al - Ammari and El - Torky 1984).

iv - Centralisation: The planning, organisation, financing and decision - making of the health system is centralised, in the headquarters of the Ministry of Health in Riyadh. In line with the administrative division of the country the health system is divided into 14

Directorates, each headed by a director. However, the financial and administrative authorities of the directors are extremely limited. The major decision - making is in the hands of the King, as the Prime Minister, and the princes as governors of the regions.

v - There is a concentration of health services in urban areas, a feature the Saudi health system shares with other developing countries. However, similarities with health development in other Third World Countries are only superficial, particularly as far as expenditure is concerned. Health expenditure in Saudi, at 5 per cent of GNP, is parallel to the level in other developing countries, but health expenditure per capita is at a much higher level in Saudi than in many developed countries because of the oil revenues of the Kingdom. As a result there is a far better level of delivery of health care in rural and urban areas than in most developing countries and access to it is better.

vi - The Saudi health system shares various characteristics with the other oil - producing Gulf countries. They rely heavily on foreign manpower at all levels (Sebai, et al. 1984) due to the shortage of qualified and skilled natives. However, the variable quality of this manpower leads to uneven health care reliability. Moreover, although part of the health delivery system is very advanced and technology - based, traditional medicine still plays a strong role in the provision of services (Moloney 1984), although it has not been legally recognised by the health authorities. The system is, therefore, not integrated and it is useful to consider how it developed to its present situation.

4.3.1.1 The Development of Health Policy in Saudi Arabia.

Since the early days of the foundation of Saudi Arabia in 1926, the government has assumed the responsibility for providing the population with free health services, as represented by the late King Abdulaziz's decree that all government hospitals and health centres must provide the population with free health care. This policy was emphasised by the Ministry of Planning's announcement in 1980 that the Saudi Arabia government

" ... has always attempted to provide the finest health care services free to all inhabitants of the Kingdom" (MOP 1980, p. 344) .

This care is extended to pilgrims who come from all over the world to visit the Islamic holy places in the Western province of Saudi Arabia. Lipsky in 1959 mentioned that:

" The Saudi government assumed the responsibility of caring for sick pilgrims; facilities for pilgrims in Mecca [Makkah] have been expanded; a hospital has been established; and improved standards of hygiene have been enforced. In Jeddah the government, with the assistance from WHO, has built a quarantine station which has a hospital and isolation area" (Lipsky 1959, P. 272).

This was at a time when the country was very poor, with few resources and experiencing great hardship, relying on pilgrimage and external aid for its income.

At first, development of the Saudi health system was very slow, and not directed by any particular development plan or strategy. In 1926, there were only two small hospitals in the whole country. These in Makkah and Jeddah, had been established during the Ottoman Empire, mainly to deliver curative medicine services to pilgrims, as the risk of disease was high during Hajj, because of poor sanitation and lack of vaccines. In 1927, these two hospitals formed the basis of the Directorate of Health and Ambulatory Services. However, even after expansion, the service remained regional to Hijaz, attached to the Office of the Agent - Director in Hijaz. After a few years it came under the administration of the Ministry of Interior, and its functions spread to other parts of the country, until it was developed into the Ministry of Health in 1950.

The Ministry of Health consists mainly of technical and advisory members concerned with projects and planning, and administrative employees. The early activities of the Ministry of Health were handled by five regional health sectors (Lipsky 1959). All medical activities concentrated on curative rather than preventive care. In emergencies, these regional offices carried out immunisation campaigns against epidemics of diseases such as cholera and malaria. Most of the health facilities were in urban areas and the rural people used to travel long distances to the major cities in order to seek health care, or used the traditional medicine which was available in the area. Though the health facilities were situated in urban areas, services and supplies were poor, leaving scope for the private sector to play a major role in providing medical care, which was again mainly curative, at the expense of preventive care.

In the 1960s, the Ministry of Health and the Central Planning Organisation (which later became the Ministry of Planning in 1975) synthesised a plan in order to provide a comprehensive health service to all the inhabitants of Saudi Arabia, with the technical help of the World Health Organisation (WHO). When the government started to embrace a planned strategy for economic and

social development, the health care sector became one of the key components in the development plans.

The first five year development plan regarding health care was divided into two phases, each phase with its own goals. The first was focused on the improvement of the health services and programmes of the Ministry of Health, and the main objectives were:

- 1 - Making more effective use of the technical manpower employed in providing health services.
- 2 - Improving standards of sanitation, diet, services, maintenance and supplies in existing facilities.
- 3 - Undertaking studies of policies relating to the following:
 - a. Full or part - time employment of doctors;
 - b. Registration of patients or collection of nominal fees for medical services.
 - c. Encouraging the development and improvement of health services provided by the private sector.
- 4 - Preparing and implementing a preventive health service programme.

For the second phase, further organisational and technical goals were set. The severe manpower shortage became the first priority. Other objectives were to

- 1 - increase the number of doctors and technicians and expand training programmes;
- 2 - expand preventive health care services;
- 3 - commence the construction of new facilities and the reconstruction of old ones in accordance with the requirements of a general health network for the country that would provide health care throughout the Kingdom (First Development Plan 1970).

Although the first development plan (1970 - 1975) achieved some success in improving health care and social services, its programmes were impeded by the shortage of manpower at all levels; organisational and management difficulties; insufficient information and research on the characteristics of the country and the appropriate form and size of an effective health system; lack of integration of the preventive, curative and educational components of the health system; and low output from the Kingdom's medical training schools. For example, in the period 1970 - 1974, only 152 female nurses and 357 technical assistants graduated from the Kingdom's nursing school and health institutes (MOP 1976).

When the second plan was introduced, several measures were taken to remedy the shortages revealed in the first plan. These measures were designed to improve management and administrative patterns in the health services; expand skilled manpower; increase the number of hospital beds and enlarge the network of dispensaries, health centres and health points; and finally improve health education. For the first time, emphasis was on the integration of curative and preventive medical services. As the plan indicated:

" A primary objective of the development of the health sector in the period 1975 - 1980 is to provide the Kingdom's population in all regions with a comprehensive range of preventive and curative health services so that the people may, through higher levels of health, both contribute to and benefit from the socio - economic progress of the Kingdom" (MOP 1976, P. 376).

While the second development plan made some progress in the integration of preventive and curative care at the health centres level, and in the hospitals, most of the emphasis remained on the curative rather than preventive facilities and primary care. This was largely a matter of necessity at that time, when the aim was to provide prompt medication and treatment for people suffering from disease. As a result, by the end of the second plan, health care remained one of the country's critical problems. Al - Bakar (1983) found that infant mortality and communicable diseases remained high, because there were wide discrepancies in accessibility of health services and facilities, health manpower was being used inefficiently and was in short supply, and there was insufficient allocation of resources for preventive care .

The third and fourth development plans (1980 - 1990) gave priority to social development, with a major emphasis on health care. A broad range of health aims were decided, which may be summarised thus:

- 1 - To improve the health conditions of the population, in particular by ridding the country of endemic diseases.
- 2 - To provide the population in every region with a fully integrated and comprehensive system of free medical services.
- 3 - To strengthen primary health care as the basis of a comprehensive health service network, and to place greater emphasis on preventive medicine and environmental health programmes, including health education, maternal, and child health care, public immunisation and occupational health programmes.

- 4 - To develop further emergency medical services with special attention to the requirement of the influx of pilgrims in the Hajj season.
- 5 - To encourage the private sector to provide medical services for citizens and foreign residents in the Kingdom.
- 6 - To establish a National Health Council to determine the Kingdom's health policies, to guide the development and improvement of all health services in the Kingdom, to delineate the responsibilities of individual government health care agencies and the private sector, and to co - ordinate their activities.
- 7 - To increase the number and improve the quality of medical manpower and, in particular, to encourage more Saudis to take up medical careers (MOP 1980, p. 347 - 8 and 1985, p. 329).

As each plan was completed, the following plan tried to recognise and deal with the major needs still existing. As a result, issues which emerged during the term of the third plan - a time of rapid expansion - attracted special attention in the period of the fourth plan. These were:

Firstly, the need to provide more medical manpower of high quality to operate the new health facilities and to support existing ones. A major objective for health care developments was, therefore, to attract more medical manpower from other countries and to increase the number of Saudis working in the health fields. It was estimated that MOH facilities alone would require an additional 45,497 employees between 1985 and 1990 to run 45 new hospitals with 9,264 beds, 98 diagnostic / maternity centres and an additional 1,103 primary health care centres. Manpower increases of this scale were difficult to accomplish, however, because medical manpower internationally was in short supply, especially in certain specialisations, and takes a long time to train. Existing health service facilities in Saudi Arabia, specifically those of the Ministry of Health, were already understaffed. The Saudi percentage of the health service employees remained below the target level, so an extensive effort was required to increase the outgrowth of medical schools, allied health programmes and Ministry of Health institutes. For this reason, additional training and scholarship programmes were needed throughout the health service (MOP 1985).

Secondly, as it is an objective of development to ensure that all the population should benefit from and contribute to the development of the country and to provide an integrated health care system, the fourth development plan emphasised primary health care centres as the fundamental

health service unit. Greater effort was called for to improve and expand primary health care centres, including programmes to increase the network of primary health centres and improve their services at the household level. A proper family health record keeping system and hospital referral system was introduced in this expanding network of health care centres linked to the hospital system. It was also recognised that special attention must be given to the increasing demand for infant and child health services, where more co - ordination between the Ministry of Health and other agencies of the government was needed (MOP 1985).

The fifth development plan (1990 - 1995) emphasises that the fundamental objective of the health sector is to improve the health condition of all the population through the provision of comprehensive preventive and curative medical care services throughout the country, with particular stress on equitable and efficient primary care. This goal is to be achieved through:

- 1 - The completion of all preventive and primary health care facilities, and full implementation of the referral system for the optimal approach of preventive and curative health services.
- 2 - Development of the health information system necessary for efficient and effective health care provision.
- 3 - Further development of national manpower, through programmes that raise productivity and improve performance and that provide the specialisations needed to maintain a high level of health services (MOP 1989).

The fifth plan begins with a review of achievements under the previous plan, showing the extent to which its objectives had been accomplished, namely:

- i - The number of hospital beds per thousand population increased from 2.66 to 3.35.
- ii - The number of physicians increased, so that the population per physician declined from 726 to 548 persons.
- iii - The number of nurses also increased, so the population per nurse fell from 363 to 264.

The following tables provide comparative data on the hospitals at the start of the fourth plan and the end of it.

Regarding primary health care centres, the government aims to meet the WHO target of health for all by the year 2000. The policy of Saudi Health authorities and Ministry of Planning is to increase the number of health centres all over the country and make the service available to every

individual. Thus, the achievement of the fourth development plan shows an increase in the number of the primary health centres within the MOH and others as follows:

Table 4 - 7 Comparison between the Number of PHC Centres at the Beginning and End of the Fourth Plan.

PHC Centres.	1985 No.	1989 No.	%
MOH	1,119	1,477	32
Other Agencies.	287	298	3.8
Private Sector.	224 *	313 *	39.7
Total.	1,630	2,088	28.1

Source : Ministry of Planning (1989) Development Plan for (1990 - 1995) P. 305. * includes dispensaries and clinics.

Notwithstanding the accomplishments in the health sector during the implementation of the fourth development plan, a number of important and challenging issues have appeared which must be dealt with during the period of the fifth plan. Some of these issues can be addressed in the short term, while others are more structural in nature and thus require intensive evaluation and review before appropriate solutions can be undertaken. One theme underlying many of these issues is the need to achieve an efficient and effective allocation of financial, material and human resources.

On the other hand, epidemiological and clinical studies of the fourth development plan period reveal that a growing number of chronic health conditions, accidental injuries, industrial and urban - related health problems have been added to the constant burden of illness posed by endemic and infectious diseases. The rise of these more complex health problems will increase the strain upon the health service capacity (MOP 1989).

4.3.2 Other Government Health Organisations:

The Ministry of Health plays a major role in providing health care in Saudi Arabia and assumes the chief responsibility for meeting and improving the health situation of the population. However, as mentioned above, there are several other government departments and agencies, apart from the Ministry of Health, which provide medical and health services. Some make specialised provision to which the whole population can easily obtain access, while others provide health services only to their employees and their dependants, so that access to these facilities is restricted. Some of these agencies,

such as the military, offer the full range of medical care to their employees, and open some aspects of their medical provision to the rest of the population; however, access to these facilities is not easily obtainable. None of these agencies provides as wide a range of health services, at as many locations, as the MOH.

Four of these government agencies provide fairly comprehensive health care at selected places:

1 - The National Guard (Al - Haras Al - Watani), the Ministry of Defence and Aviation, and the Ministry of Interior provide a full range of health care at all levels to their employees and their dependants. Moreover, some of their facilities are open to lay persons at a limited number of points around the country. The Ministry of Defence and Aviation has the largest proportion, providing health care through twenty - one hospitals all over the country, at least one in each region. These hospitals vary in size and capacity from 200 - 848 beds. The National Guard has two hospitals, one in Riyadh with 328 beds, and another in Jeddah, with 310 beds. Admission to these hospitals can be obtained through health units in each city on a referral - based system. Finally, the Ministry of Interior has one hospital in Riyadh with a capacity of 120 beds and other health centres are widespread, particularly in large cities such as Jeddah, Makkah and Taif, but provision of health care is limited to the staff and their dependants only.

2 - The King Faisal Specialist Hospital and Research Centre in Riyadh is financed separately from the MOH to deliver the highest standard on care of selected conditions, to anyone, on a referral basis. This hospital has 460 beds and has direct links with international medical research institutes in North America and Europe. It enjoys a very good reputation, and its advanced medical technology and research unit make it one of the most sophisticated hospitals in the Middle East.

3 - The University teaching hospitals and university health units offer health services for all university students, staff and their families. They also provide some health care services to the public, including both primary and specialist services, but the provision is confined to areas where the universities are situated (MOH 1987).

4 - Finally, the other government agencies or departments which provide a restricted health care services are as follows:

i - The Ministry of Education and the General Presidency for Girls Education: These two institutions provide education to boys and girls, and primary health services for students, teachers and the organisations' civil servants, through school health units. They also operate a referral system to the Ministry of Health hospitals in each location. The health units are usually equipped with GPs and other specialists to provide almost a full range of services. Ironically, although the health units of the General Presidency for Girls Education are mainly for girls, they have no gynaecologists. During the academic year, medical personnel visit schools to conduct eye tests on students and sometimes to carry out immunisation against outbreaks of disease.

ii - The Saudi Red Crescent Society offers emergency services all over the country, including roadside clinics and ambulatory health services. It has 140 First Aid centres and 498 ambulatory units (Ministry of Finance and National Economy 1989) distributed all over the country. This society plays a crucial role in providing medical care particularly for road accidents, during disasters and during the pilgrimage (Hajj) season.

iii - The Royal Commission for Jubail and Yanbu offers general health care for employees in its own hospitals and health centres at the two industrial cities. Each of hospitals is equipped with 205 beds (MOH 1987).

iv - The Ministry of Labour and Social Affairs provides primary health services in some rural areas through Community Development Centres, and supervises a number of centres, two of which provide care for paralysed children under twelve years of age (Ministry of Finance and National Economy 1987).

v - The General Presidency of Youth Welfare deliver specialised treatment for sports injuries in sport centres in Riyadh and Jeddah only.

vi - The Ministry of Municipalities and Rural Affairs and the Meteorology and Environmental Agency have general responsibility for environmental health. This service does not include treating individual patients. The department of preventive health in the ministry carries out routine check - ups on all workers in the food and services industries, and quarterly inspection of premises where food is served, such as take - aways, restaurants and hotels.

vii - The flying hospital services or flying doctor service operated by the Ministry of Defence and Aviation has six planes fully equipped with advanced medical technology to carry out surgical operations on board, as well as six helicopters which function as flying ambulances to carry public or military patients to specialist hospitals from remote areas.

vii - King Khalid Eye Specialist hospital in Riyadh with a capacity of 248 beds, provides specialist ophthalmic care only. Admission is either by referral from an other hospital, or on a private, fee - paying basis.

With the exception of the rural community projects of the Ministry of Labour and Social Affairs and the Saudi Red Crescent, most of the facilities of this wide range of agencies are located in the main urban areas, especially in Riyadh, the capital, and Jeddah, on the western coast, so that only the MOH can fairly be expected to deliver the health care services to the small towns, villages and remote areas. It is estimated that overall, the MOH provides services to approximately 60 per cent of the total population of Saudi Arabia, yet it receives only 49 per cent of the total health budget. The remainder goes to the various other agencies. This imbalance is further compounded by the inadequate co - ordination between the different agencies, leading to inefficiencies in the system as a whole.

4.3.3 The Development of the Ministry of Health: An Overview.

Over recent years, Saudi Arabia has developed a fairly elaborate national health care system, with a huge expansion of facilities, better definition of health policies, as outlined above, and an increasingly complex organisational structure made up of several agencies. However, the MOH is responsible for most health care provision. As pointed out above, the MOH was established in 1951 to assume the national responsibility for providing health care to the public. At first, its headquarters were in Makkah, the religious capital, where its activities originated. Its programme of health care was expanded, and special disease control programmes were developed in co-operation with the World Health Organisation and the Arabian American Oil Company (ARAMCO), but for several years the facilities of the health service were limited. Throughout the 1950s, most of the medical facilities in Saudi Arabia were still situated either in the pilgrimage areas of the western province, where the health clinics were first set up, or in the eastern region, where ARAMCO headquarters were located,

to serve the oil industry's employees. Most of the rest of the country still had little health care provision and had to rely on traditional medicine provided by local healers.

When the MOH headquarters removed to Riyadh in 1953, the transfer signalled, as Alshammasi (1986), mentioned:

" ... a change in both the focus and scope of the Ministry's services from services to pilgrims in the main areas of the pilgrimage to health services to the public in all parts of the country." p. 256

The rapid rate of growth which followed led to major reorganisations in 1956, 1969 and 1983. For example, the regional health provinces have been reorganised several times. The country was divided into six health regions during the 1950s, and eight in the 1970s, but in the next decade expanded to 14 regions, largely based on the country's 14 administrative regions.

The Ministry of Health structure is centralised, and reflects the overall political structure of the country, in that there is very strong bureaucratic and centralised control. Policy formulation and decision - making are literally controlled by the government in Riyadh. This creates inefficiencies, because most decisions affecting individual regions can only be taken at or near the top of the organisation (Alshammasi 1986). The problems resulting from the centralisation of the political structure in such a cumbersome organisation have been acknowledged, but it is not easy to detect any consistency in the various programmes to reorganise the Ministry. In 1980, there was an attempt to decentralise and delegate more authority to each directorate. The reorganisation of health administration in 1983 aimed to decentralise management. Eleven health regions were set up to replace the eight which had previously existed, and three more were added in 1985.

In spite of this recent progress towards decentralisation, the regional health directors still have limited power over the health affairs in their region. They follow the policies and instructions of the central administration in the Ministry in Riyadh, hundreds of kilometres away, where the planning is still done. The regional administration is concerned with the daily operational problems of the system.

As a consequence of the centralisation of decision - making, little can be done without communication with the headquarters in Riyadh. Moreover, the mechanism depends on personal contact and the relationship of the regional directors with the top members of the Ministry in Riyadh to get major decisions made; thus inconsistencies in decisions, and therefore in health provision, can

result. On the other hand, because the Ministry of Health is financed by the government, and as the government financial system also is centralised and complex, the Ministry of Health is not in a position to guarantee finance for any new projects except after full consultation with and approval by the Ministry of Planning, Ministry of Finance and National Economy, which provides the necessary capital.

4.3.4 Private Sector:

The second category of health care provision is that rendered by the private sector. This provides almost every type of curative medicine, but no preventive medical services and the utilisers of this sector have to pay for the services they receive. It is estimated that this sector delivers almost 15 % per cent of the total medical services.

The private sector is to a great extent in line with and complementary to the public sector, in terms of facilities and services. Some private hospitals have the latest advanced medical technology and in some instances can provide medical services not available in most of the public sector. Furthermore, their accommodation is of a high standard, equivalent to a five star hotel, furnished with modern furniture, TV sets receiving several channels, domestic and foreign, free newspapers delivered daily to the patients' rooms, private telephones next to patients' beds, and single or twin rooms. Obviously, these services are reflected in the bill.

The medical services in the private sector are varied and can be grouped into seven categories:

1 - Specialised Hospitals:

This group provides specialised medical care services, such as ophthalmology, nose, ear and throat treatments. Other areas of service provided by this group are gynaecological and obstetric treatments, child care and paediatrics services, and finally, neurology. There are 64 hospitals with a capacity of 6,479 beds (Ministry of Finance and National Economy 1990).

2 - General Hospitals:

This group provides a wide range of medical services, including out and in - patient treatments, and 24 hours emergency services, 7 days a week. Advanced and highly sophisticated medical technology is utilised, and there are facilities for radiotherapy, physiotherapy and psychotherapy. Most of the providers of the medical services in this group are either specialists or consultants. The

majority are non - Saudis, yet, nowadays Saudi consultants are permitted to practice as a part - time consultants in the private hospitals if they want to. Most of the private medical hospitals are situated in the major cities of the country, such as Jeddah, Riyadh, Makkah.

3 - Health Centres or Dispensaries:

The medical services provided by the health centres differ from one health centre to another, according to capacity and the availability of medical facilities and staff. For instance, some health centres tender a wide range of medical services and carry out minor operations. Though a 24 - hours emergency service is delivered by these health centres, most do not provide in - patient treatment because they lack the necessary facilities. Therefore, when in - patient treatment is needed, the patient will be referred to a general hospital, either private or public. In 1990, there were 392 health centres (Ministry of Finance and National Economy 1990, p. 162). People prefer to go to these units because they are easily accessible, at a reasonably low cost, in contrast with other facilities such as hospitals. Another dimension is the personal interaction in these units; patients do not feel the huge establishment organisation and its bureaucracy. These factors have helped in the growth of this type of medical service.

4 - Collective or Polyclinics:

Medical services in the collective clinics are to a great extent similar to those in the health centres, but medical treatment in the former is supplied by specialists or consultants. This group also does not provide in - patient care, and no emergency services are available in polyclinics. However, both the polyclinics and health centres have diagnostic facilities such as laboratories, X - ray, ultra sound etc. The medical services in these two groups include dentistry, intestinal medicine, gynaecological and obstetric care, paediatrics and ear, nose and throat treatment.

5 - Specialised Clinics.

The provision of the service in this group depends on the specialisation of the provider. In this group each clinic is run by one specialist with two other personnel: one is a nurse, either female or male, to assist the doctor in checking the patients' temperature, measuring the blood pressure and preparing patients, particularly children, for the specialist; the second assistant acts as secretary / receptionist and collects the fees from the patients.

6 - General Practice Clinics:

In these clinics the practitioners are broadly similar to GPs in Great Britain. They provide a wide range of medical advice and treatments. Usually, the clinics in this group are run by one GP with one male or female nurse, and one receptionist who keeps the patient's records. The total number of these and the specialised clinics is about 627 units all over the country, However, most of the practitioners prefer to stay in major cities because of the easy access to other facilities and the lifestyle which is more flexible than in small towns and villages. MOH has issued a fees charter to control the fees charged for each type of treatment, according to the qualifications and facilities required.

7 - Pharmacies.

The pharmacy, or as it called in the UK, chemist, provides medication according to prescription, usually issued by a physician. In Saudi Arabia, Ministry of Health regulations forbid any medicine to be dispensed without prescription. However, the pharmacists who run these pharmacies do give medication without any prescription, except if the medicine is listed on the narcotic chart. These are considered illegal drugs unless prescribed by a physician, and if they are provided without prescription, the pharmacist will face legal action and might be prevented from practising. These pharmacists, in addition to dispensing medication, often provide medical advice. The pharmacist will, when asked for such advice, prescribe a medication, and the customer will be charged for the medicine only. In 1990 there were 2066 pharmacies and 255 drug stores all over the country (Ministry of Finance and National Economy 1990, p. 161).

The growth of the private health sector reflects the strong demand for its services and the flourishing medical market in Saudi Arabia. It is not uncommon for all eleven daily newspapers to carry advertisements of new medical facilities, or to announce the arrival of visiting specialists or consultants from various countries all over the world, to practice for one or two months. Others use different techniques, such as persuading clients to give testimonials. Another approach used to attract new customers is to place an ordinary advertisement in the papers, quoting prices for particular operations and giving estimates for hospitalisation. However, when a client goes to the hospital, he finds that the prices quoted cover only the cost of the operation and he has to pay extra for the necessary medication and other related services.

Another factor accelerating the emergence and growth of the private medical sector in Saudi Arabia, is the acute shortage of manpower that Saudi Arabia faces. With the economic boom of the 1970s and 1980s, the government has implemented ambitious development programmes symbolised in the five year development plans. The execution of such plans necessitates huge numbers of foreign workers. In the mid seventies, many Korean, Japanese, European and American companies signed contracts with the Saudi government or with Saudi businessmen who had already grabbed some contracts with the government to accomplish public projects, such as constructing roads, housing, or new seaport berths, installing new communication systems etc. When those foreign contractors brought their labourers to Saudi, the influx of manpower needed medical care, and the available medical and health facilities were not able to provide coverage for the native Saudis, let alone the newcomers. Simultaneously, the Ministry of Labour and Social Affairs enacted regulations which stipulated that every firm, enterprise, or organisation dealing in trade or industry and employing more than twenty persons, should provide them with medical care, either within the company's private clinic, or by contracting with the private medical sector. This gave further momentum to the growth of the private medical sector, as did internal migration from small towns and rural areas to the cities in search of job opportunities. Like Saudis, the migrants were entitled to use the public health and medical sector; thus, the demand in some areas began to exceed capacity, leading to long delays in provision of services. As a result of the congestion, those who could afford it began to turn to the private medical sector with its advanced medical technology, speed in handling services, the opportunity to choose the time of admission to hospital, flexible visiting hours, and generally better service.

Further encouragement was provided by the government which met 50 % per cent of the total expenditure for constructing medical facilities and exempted all medical apparatus from customs duty, while 15 % per cent of bed facilities would be utilised annually by the MOH. All these factors encouraged and motivated Saudi doctors who used to work in small surgeries to set up private medical enterprises. Most, if not all, the private medical sector in Saudi Arabia is owned by Saudi Arabian physicians, either in joint venture partnerships with Saudi businessmen or as sole owner. Usually, when a Saudi doctor, GP or specialist becomes the proprietor of a medical organisation, he

ceases to practise, and instead takes on a managerial and administrative role. This indubitably means a waste of the country's skilled human resources which will lead to additional dependency on expatriate manpower.

The provision of medical care through the private sector is not a modern phenomenon in Saudi Arabia, but goes back to the early days of the practice of modern medicine in Saudi Arabia, particularly in Hijaz region. Private sector practice began as small surgeries run usually by one physician, and the emergence of the large hospitals and polyclinics started only in the early 1970s. Table 4 - 8 shows the growth in number of the hospitals and hospital beds in the private sector from 1970.

Table 4 - 8 The Growth of Private Hospitals

Year	No. of Hospitals	No. of Beds
1969	18	917
1970	19	944
1972	20	1,004
1975	22	1,195
1978	23	1,328
1979	22	2,019
1980	22	n.a
1981	26	2,685
1982	31	3,264
1983	32	3,340
1984	31	3,412
1985	40	3,993
1986	41	4,474
1987	43	5,019
1988	55	5,956
1989	n.a	6,445
1990	64	6,479

Sources: Ministry of Health Annual Medical Report, various issues, Ministry of Finance and National Economy, various issues of the Statistical year book and Statistical indicator

The table shows that in 1969, there were relatively few hospitals and beds. Facilities grew slowly and steadily throughout 1970s. With the influx of foreign labour and the increased demand for medical services, a rise took place in both the number of hospitals and beds in the private sector. Hospitals had grown by more than 190 % by the end of the 1980s, and the number of beds by more than 220 % per cent.

4.4 The Political Economy of the Health Service:

This section traces the pattern of increasing expenditure on the MOH over the last 30 years and the emphasis in this expenditure on high cost projects. For more than two decades after the unification of Saudi Arabia, it remained with insufficient resources. At a time when 90 per cent of the population were living as nomads and farmers, the government lacked the revenues to provide adequate health services for all the population. However, oil revenues made possible improvements in the living standards and services available to the people. The most substantial expansion was during and after the oil price boom of the 1970s. Revenues rose to 368 billion SR in 1981 - 1982, which permitted a large expansion of spending on projects related to social welfare, including health services. Subsequently, oil prices and production declined, government revenues fell, and there was a

consequent decrease in government expenditure. In 1984 - 1985, revenues fall sharply to 171 billion SR

Table 4 - 9 Government Expenditure During the Development Plans 1970 - 1995.

Plans	SR billion
First Plan (1970 - 1975)	80
Second Plan (1975 - 1980)	684
Third Plan (1980 - 1985)	1209
Fourth plan (1985 - 1990)	341.5
Fifth plan (1990 - 1995)	394.8

Source: Computed from MOP (1985, 1990).

4.4.1 Expenditure on Health Services:

As the health services in Saudi Arabia are provided by several governmental organisations and the private medical sector, in addition to the Ministry of Health, it is difficult to assess the total expenditure on health care in recent years. Figures can be obtained only for MOH expenditure, which represents the major part of total health spending; nevertheless even these data are sparse. Other governmental organisations do not give any figures for expenditure on their health facilities, because the provision of health care services is considered to be a secondary function of these agencies. Their health expenditure might be hidden under other expenditure categories, such as salaries, recurrent expenditure or operational and maintenance programmes.

The lack of data on national health expenditure is attributable to the limited national budget information for recent years. The first budget was not prepared until 1947 - 1948 and details for the early budgets were frequently unreliable. Budget data since 1960 have been more easily available, but unfortunately still do not give enough details of the expenditure on the public health in general. Even so, it is obvious that government expenditure on health care through the Ministry of Health has grown rapidly. For instance, the first budget of the Public Health Directorate in 1948, before the establishment of the Ministry of Health, amounted to only five million SR. By 1960 this budget had exceeded 50 million SR a year and was rising rapidly, if somewhat erratically. As table 4 - 10 shows, the MOH budget has continued to rise rapidly since the 1960s, reaching a peak in 1985, when the total figure was at 10,742,000 million SR.

Table 4 - 10 Growth of the MOH Budget. (OOO, SR.)

Years	MOH Budget.	Per cent of the total budget %
1960	58,000	3.3
1965	156,000	4
1970	177,000	2.8
1975	3,197,333	2.88
1980	5,656,400	2.31
1984	8,400,800	2.81
1985	10,742,900	4.1
1986	8,814,540	4.4
1987	7,072,933	n.a
1988	8,333,431	4.9
1989	7,735,000	5.5
1990	7,591,590	5.4

Sources: Ministry of Finance and National Economy; Central Department of Statistics; Statistical Year Book; Ministry of Health, various issues.

As table 4 - 10 shows, in 1970 the expenditure on health and medical care through the Ministry of Health alone was SR. 177,000,000, which jumped at the end of the first development plan to 1,163 million SR. in 1974, a 6 - fold increase in only five years. In the second plan there was no notable increase in the health sector. At the start of the third development plan, the figure was 10,742,900, representing 4.1 % per cent of the total budget. This rise was due to the new project assigned to be implemented during the plan's period, to build five hospitals in Jeddah, Jizan, Madina, Al- Hufuf and Al - Khubar, with a total capacity of 2,275 beds, at a cost of SR. 3,085,500,000, an average cost per bed of SR. 1,355,824.17 (MOH 1982). In the third plan, the pace of expenditure was almost constant. However, during the third and fourth plans there was more emphasis on health care and welfare.

Most spending by the Ministry of Health was directed to building new hospitals with advanced medical technology, requiring also more expenditure on the salaries of highly - trained personnel. The number of cases going to the west for treatment has been considerably reduced, but mortality and morbidity rates remain high. For instance, the infant mortality rate is 85 of 1000 live births (WHO 1985, p. 133) and life expectancy is 56 years. The main causes of morbidity and mortality include diarrhoea, respiratory diseases (including tuberculosis), malaria, childhood infectious diseases, road accidents, parasitic infections, metabolic diseases and cardiovascular diseases. The percentage of

infants immunised against diphtheria, pertussis (whooping cough) and tetanus (DPT) is 81 % per cent; against measles, only 79 % per cent; against poliomyelitis, 81 % per cent and against TB, 88 % (WHO 1985, p. 178).

Compared with the formidable expenditures on projects for curative care which will not reduce the rates of mortality or morbidity, little has been spent on preventive medicine and health education, although this would save considerable sums, and reduce mortality and morbidity to levels comparable with those of the developed world. In Riyadh, a large project is under construction, " King Fahad Medical City" at a cost of 2 milliards SRs (Alyamamah 1992). This project consists of 5 hospitals with a capacity of 1425 beds: a general hospital, a children's hospital, an obstetric and gynaecological hospital, a psychiatric hospital and a rehabilitation centre for physiotherapy. The Minister of Health, Faisal Al - Hujailan said in an interview in a Saudi weekly Magazine that:

" after finishing this huge project, Riyadh city will be the medical capital not only in the Middle East but also in the world" (Alyamamah 1992, p. 44).

This huge project, in a city which already has the lion's share of medical and health facilities, may be a showpiece, but will do little to raise the health standard of the population as a whole. It appears that the health authorities have little interest in preventive medicine. Priority should be given to offering a comprehensive health coverage for all the population within the Alma - Ata conference policy goal of attaining health for all by the year 2000, since the material (financial) facilities of the country are sufficient. Sebai argues that more than 80 % of the total expenditure of the Ministry of Health goes to cover hospital services, whereas more than 80 % of the health problems in a developing country such as Saudi Arabia could adequately be met by the adaptation of the PHC approach (Sebai 1983).

4.5 Health Service Network:

The health care system consists of three levels: primary health care, general hospitals and specialised hospitals. Preventive, promotive and curative medicine, as well as health education, are supposed to be provided through the first level, which is considered to be the gateway to the medical system. The second level of the medical and health network is mainly to treat cases incurable at the first level, and cases that need hospitalisation. However, these two levels are supposed to work in co -

ordination and support each other. Finally, comes the tertiary level, the highly specialised medical care services. The following sections give more detailed information about these aspects of the health system in Saudi Arabia.

4.5.1 Primary Health Care Centres.

According to WHO's definition of primary health care (PHC) (WHO / UNICEF 1978), these health centres should provide basic health care and constitute the first level of the health services network. They are the means through which the patient enters the medical and health care system. In some cases the patient might be referred to secondary (general hospitals) and tertiary (specialised hospitals) levels for further treatment, if needed. In 1979 WHO and the General Assembly adopted the Alma - Ata declaration and the general feasible strategies to attain health for all. All governments had to prepare their own national strategies. policies and plans of action to commence and sustain primary health care as part of a comprehensive national health system and in co - ordination with other sectors (WHO / UNICEF 1978).

Since Saudi Arabia is a member of the World Health Organisation, the health authorities in Saudi Arabia have decided to take definite measures to adopt and implement the PHC approach. Policy was intended to implement a comprehensive PHC rather than SPHC or BPHC. The first realistic step taken in this respect was at the beginning of 1984, with the establishment of 11 health centres, one in each of the country's health regions, as prototype PHC centres. It was decided that each of these centres would provide comprehensive health services according to the PHC approach, composed of curative, preventive, promotive and rehabilitative services. The services delivered through these health centres include: a well - baby clinic; maternal and child health clinic; a general clinic; a dental clinic; laboratory facilities; an environmental control mechanism; a health education system; a pharmacy; a filing department; and oral rehydration therapy.

4.5.1.1 The Development of Health Centres' Services.

Till 1979, health services used to be delivered through two separate approaches, curative and preventive. The curative medicine used to be offered from hospitals and 547 dispensaries, of which 196 were not fully functioning, and 296 health posts operated by health auxiliaries. The preventive

services were delivered by thirty health offices and twelve maternal and child health centres all over the country.

In 1980, the MOH embarked gradually on implementing the PHC approach. In this regard, the first step was a ministerial decree No. 257/ 1459/50 dated 17/8/1400 (1980), which intended to integrate the provision of curative and preventive medicine (MOH 1986). Accordingly, the existing health offices, maternal and child health centres and dispensaries were to be terminated and their services to be included with those of the dispensaries, which would then be known as " health centres". Health posts had to be promoted to health centres. The total number of these health centres at the time was 889. By 1983 the number had increased to 1250. These centres were classified into four categories: A, B, C, and D. Type A health centres were the largest, usually staffed by more than one physician and several health assistants, whereas type D were the smallest, staffed by only one physician and fewer health assistants. However, this classification was abolished (Sebai 1988), and new criteria introduced, based on population served: the largest centres served 7000 or more, whilst the smallest centres served 2000 (Al - Osimy 1991). By the end of the third development plan, in 1985, the number of health centres had reached 1430 (MOH 1980, 1986).

By the end of 1986, 1082 out of 1430 health centres in the country were practising the referral system and other primary health care tasks. The provinces of Hail, Al - Baha and Najran achieved the most progress in application of the primary health approach, for several reasons: first, the support and the enthusiasm of the provincial governors in implementing the approach; ⁵ second the regions concerned are not too large and third, private sector activities are not extensive.

As PHC services were expanded and the number of units increased, their services reached small communities. Because of the differences between communities in size and medical and health needs, the PHC facilities were re - classified into four groups, on the basis of size and quality of service provision and the size of the population covered. Group one serves communities of 500 - 5,000, group two, communities of 5,000 to 10,000, group three, populations of 10,000 to 20,000, and finally group four, 40,000 or over; the latter are generally situated in major cities (MOP 1980). More recently some PHC facilities in rural areas have been categorised as group five. Usually, these facilities have, in addition to the basic primary health care tasks, diagnostic and maternity facilities.

Furthermore, there are small mobile health units, mainly to deliver health and medical services to nomads who live in remote areas and small communities where no permanent medical services exist.

Before 1981, the primary health care centres used to be called health centres. From 1981, these units increased in number and are expected to provide curative and preventive services. Table 4 - 11 shows the trend in growth of these health centres during the last fifteen years. Whereas the number in 1978 was 847, by 1989 the number has increased by 193.5 % per cent.

Table 4 - 11 The growth of Primary Health Care Centres in Saudi Arabia

Year	No. of PHC Centres
1978	847
1979	824
1980	878
1981*	935
1982	973
1983	1084
1984	1119
1985	1324
1986	1431
1987	1437
1988	1477
1989	1639
1990	1668

Source: Ministry of Finance and National Economy, Statistical Indicators (1978, 1988, 1989, 1990); MOH (1986 & 1987), Annual Medical Reports and Ministry of Finance and National Economy (1990), Statistical Year Book. *6

Table 4 - 12 shows the uneven geographical distribution of the primary health care centres. Riyadh and Makkah regions have the lion's share of these facilities. Also, the private sector practices extensively within these two regions, while other regions have only one source of medical care, i. e. public. Thus, the health authorities need to re - distribute the health facilities according to the demand and the size of the population, and the accessibility to and availability of the other health levels, secondary and tertiary. The picture will be clear in the following section when hospital distribution is discussed.

Table 4 - 12 Distribution of PHC Centres by Health Administration Region in 1990.

Regions	No. of PHC Centres.
Riyadh	265
Makkah *	266
Al - Baha	76
Madinah	121
Tabouk	41
Eastern Province **	182
Asir	238
Najran	57
Jizan	123
Qasim	131
Northern Province	39
Al - Jouf	31
Al - Graiyat	15
Hail	83
Total	1,668

* Makkah region includes Jeddah area with 101 centres, Makkah with 74 centres and Taif with 91 health centres. ** Eastern Province includes Dammam area with 108, Al - Hassa region with 48 centres and Hafr Al - Batan with 26 health centres.

Source: Statistical Year Book 1410 (1990).

There have been several studies of the work in health centres in Saudi Arabia (Sebai et al. 1980; Sebai 1981, 1984; Banoub 1980) and the findings showed many problems. The health centres were frequently in rented buildings which were not designed to meet the needs of the service. The staff were almost all expatriates - Egyptian, Jordanian, Sudanese, Pakistani, Bangladeshi, Indian and Filipino - with little real understanding of the local culture and many with a shallow command of Arabic language. They had no vocational training for primary health care, no programme of continuing education, and few had access to modern medical text books or medical journals. The medicine practised was largely curative, mainly symptomatic; the average consultation lasted only two and a half minutes, and medical records consisted of one line entries in a ledger, showing the patient's name, age, nationality, diagnosis and treatment. No personal health cards were kept in health centres or with the patient, so that information was only available for the most recent visits (Banoub 1980).

Maternity and child health services, such as antenatal, postnatal care and immunisation were almost non - existent. Home visiting was not permitted. While the centres were adequately staffed, there was no concept of a team approach to prevent disease or promote health and there was no

attempt to involve the community in any health programme or health activities to rise their health awareness.

Although such health centres still exist, many changes have taken place, since the Ministry of Health adopted the new mechanism of the primary health care approach. However, Sebai (1988), found in a survey conducted under the patronage of the Ministry of Health that 66 % per cent of the health care centres were in rented buildings, 49 % per cent cleaned by contractors, and the remain 51 % per cent looked after by janitors. 61 % per cent were accessible by asphalted road. All the health centres were staffed by physicians, dentists, pharmacists, administrators, nurses, and assistants for pharmacists, but few had laboratory facilities. The majority of the health personnel and paramedical staff were still non - Saudis, so, language barriers still existed, particularly in rural areas. However the situation in the major cities, such as Jeddah, is little different. All the primary health care centres are in rented buildings, and lack some diagnostic facilities. This will be discussed in depth in chapter Six, on health care in Jeddah.

4.5.2 Hospitals:

Hospitals in Saudi Arabia are of two types, general and specialist. The former are classified as the secondary level of the health system network, while the latter are known as the tertiary level.

4.5.2.1 General Hospitals

There is no clear classification of hospitals, in terms of the degree of specialisation or the range of the services carried out. However, the available data serve as a means to categorise the existing hospitals in terms of their capacity, i. e. number of beds per hospital. Generally, hospitals provide curative and diagnostic services and before the primary health care approach was introduced, hospitals used to deliver primary medical care through out - patient clinics. They still perform this role, for those segments of the population which do not use PHC facilities. Moreover, access is easily obtainable through the emergency department without using the referral system.

The Saudi Arabian health system has witnessed a rapid expansion in general hospital facilities. In 1990, the number of Ministry of Health hospitals reached 163, with a capacity of 25,835 beds (Ministry of Finance and National Economy 1990). Table 4 - 13 shows the increase in number of hospitals and beds during the last decade.

Table 4 - 13 The Growth of Hospitals in the 1980s.

Year	No. Hospitals	No Beds
1981	70	n. a.
1982	72	14,333
1983	74	15,387
1984	86	17,961
1985	105	20,796
1986	141	23,862
1987	157	25,902
1988	162	26,315
1989	162	25,918
1990	163	25,835

Sources: Ministry of Finance and National Economy and Ministry of Health. Various issues of the Statistics Year Books and Annual Medical Report.

The growth of hospital facilities increased steadily during the first part of the 1980s. However, in 1985 the first jump was evident, as the number of hospitals increased by 19 % per cent. In the following year, a second jump occurred when the number rose by 36 % per cent to reach 141. The size of these hospitals varied greatly, depending on the medical services rendered. Hospitals with over 500 beds are frequently found in major cities such as, Jeddah, Riyadh, Makkah and Taif. The range of medical services provided through general hospitals depends on their size, the number of personnel and the location. Through the out - patient and in - patient clinics, these hospitals provide general surgery, gynaecology, obstetrics, urology, paediatric and maternity services.

The geographical distribution of these hospitals appears in table 4 - 14.

Table 4 - 14 Regional Distribution of Hospitals and Beds in 1991.

Region	Number of Hospitals	Number of Beds.
Riyadh	25	4858
Jeddah	11	2317
Makkah	7	1999
Taif	9	2290
Al - Baha	8	1056
Madinah	15	1987
Tabouk	7	641
Eastern Prov.	10	1733
Al - Hassa	4	682
Hafr Al - Batan	1	272
Asir	18	2236
Najran	5	626
Jizan	11	1383
Qasim	14	1839
Northern Prov.	4	577
Al - Jouf	4	480
Al - Graiyat	3	229
Hail	7	630
Total	163	25,835

Sources: Ministry of Finance and National Economy and Ministry of Health, various issues of statistical year book and annual medical report.

4.5.2.2 Specialist Hospitals:

Various services are delivered through these facilities, similar to those provided at the second level of the medical network, for example, obstetrics, gynaecology and paediatrics. These services to a great extent can be found in the general hospital. In other words, facilities are not evenly distributed; parallel institutions provide similar services under different classifications. There are 48 specialist hospitals with a capacity of 8,128 beds (MOH 1987, 1990). Table 4 - 15 shows the geographical distribution of the specialist hospitals and beds.

Table 4 - 15 Distribution of Specialist Hospitals and Beds of 1980s.

Region	No Hospitals	No Beds
Riyadh	10	2414
Jeddah	4	978
Makkah	4	638
Taif	4	1602
Al - Baha	2	228
Median	5	732
Tabouk	1	83
Eastern Prov.	2	356
Hassa	1	62
Hafer Al - Batan	0	0
Asir	2	207
Najran	2	105
Jizan	3	174
Qasim	4	329
Northern Prov.	1	30
Al - Jouf	1	100
Qurayyat	1	30
Hail	1	60
Total	48	8,128

Sources: Compute from various issues of the Annual Medical Report of the Ministry of Health.

18 hospitals provide paediatric care with a capacity of 3784 beds, 3 hospitals provide ophthalmology care with a capacity of 429 beds, 8 hospitals provide tuberculosis services with a capacity of 1123 beds, and there are 13 hospitals for psychiatric care with a capacity of 1584 beds. The latter service is available in most regions except Makkah, Tabouk, Eastern Province and Hafer Al - Baten which have no psychiatric hospital. There are 4 hospitals with a capacity of 548 beds to deal with tropical diseases and finally, one hospital to provide leprosy care, with a capacity of 200 beds is situated in Makkah region. (MOH 1987).

4.5.3 The Referral System:

Health care in Saudi Arabia, in theory, is planned to be hierarchical, so that a patient is referred to the upper levels from the first level, viz. the primary health care centres or out - patient clinic of a hospital, to the second level in the general hospitals, then to the tertiary level, the specialised hospitals. However, the position at the moment is not so clear. Any patient may go to several health

organisations. In order to gain access to the medical system a patient can go to his district primary health care centre, or to any other health centre in the area, or to the out - patient clinics of any hospitals, or to any other general hospital, if he feels that he might get better treatment.

This disorder in obtaining access to the medical facilities can easily lead patients to the wrong part of the medical system and certainly causes inefficiency, with overburdening of hospital out - patient clinics, and underutilising of district primary health care centres. It also causes some confusion to the patient and the medical personnel, as the patient can, without any difficulty or restriction, consult various medical organisations about the same illness.

This chaos occurs only in urban areas where the patient has a wide range of choices. In large cities there are the public sector, PHC centres, general hospital out - patient clinics and the University hospital. In the private sector, the patient can go to private health centres, polyclinics or collective clinics, general hospitals, specialised hospitals, a specialist practitioner or general surgery. In smaller cities the selection is limited to four choices: primary health care centre, general hospital, private health centre or general practitioner. In small towns and rural areas, patients have no choice; there is only the health centre. This shows the uneven distribution of medical facilities.

One reason for abuse of the facilities, is that the referral system does not restrict the point of entry to the medical network. There are several reasons for the inefficiency of the referral system:

1 - The health authorities have not yet made any serious attempt to prevent people from going direct to the general hospital without referral.

2 - The concept of primary health care has not yet been understood by both providers and receivers of the health services.

3 - There are no general rules to guide doctors in health centres on the use of the referral system. Some patients use the health centre only for referral to hospital, rather than as a source of treatment. However, some doctors in the health centres contribute to ineffectiveness of the referral system by giving in to patient's wish for referral, even when it is not needed.

4 - Because primary health care was originally developed through hospital out - patient clinics, many patients still go first to the hospital rather than to the district health centres.

5 - Many patients use the emergency department to gain access to hospitals rather than be referred from the health centres.

6 - Some patients still view the health centres with limited diagnostic facilities, as a path to the hospital, and prefer to go direct or ask the health centre doctor to refer them without any diagnosis.

7 - Some patients try to see specialists directly using any means, even irregular methods, or turn to the private sector, or choose the traditional healers.

8 - Finally, there is no co-ordination between hospitals and primary health care centres in an area on how to organise and share out the basic health care work. Some doctors do not consider the provision of health services through health centres effective and acceptable.

4.5.4 Traditional Medicine:

Apart from provision of medical care by the Ministry of Health, other governmental institutions and the private medical sector, traditional medicine still plays a notable role in the provision of medical services to a large proportion of the population in Saudi Arabia. Though the health authorities and the government do not recognise traditional medicine, the traditional healers practise all over the country and some of them enjoy a high reputation, not only in Saudi Arabia, but also in the whole region, and receive visitors from neighbouring countries seeking their help. A few authors have mentioned traditional healing in Saudi Arabia (Sebai 1983, Moloney 1984; El - Shafei 1985).

Traditional medicine gains its acceptance and reliability in the Arabian Peninsula because it was the only source of medical and health services available to the people until the early days of the 20th Century. Every tribe used to have one or two members who practised some sort of folk medicine, or if none of the tribe's members practised folk healing, they sought it from allied tribes.

No data are available on the number and geographical distribution of the traditional healers. However, indicators show that there is a large number of folk healers of both sexes, of different ages and backgrounds. Some of them inherited their profession from their ancestors, while others learnt from experience or from another practitioner. Since the government has neither recognised nor rejected the practice of folk healing, there are no laws or restrictions to organise this sector. However, the WHO has recognised the practice of such health services in some developing countries and called for them to be integrated within the health system. The Chinese experience shows that the success of

this type of service gives momentum to the existing practitioners to practise and to offer their services to the public.

Traditional medicine is popular amongst people of all population categories, including the educated, illiterates, rural, Bedouins, and of both sexes though women constitute the majority who consult folk healers. The folk medicine practised in Saudi Arabia can be classified into four types:

(i) herbal medicine; (ii) bone - setting; (iii) spiritual healers : practitioners in this category are mostly religious leaders, who recite verses of the holy book Qur'an and the prophet traditions (Hadith). They treat mostly mental and psychological illness; (iv) witchcraft: healers in this group use sorcery, spells and magic. Most of the practitioners are African. This type is unlawful and access to it is difficult, being through a third party, well known to the practitioner.

To conclude, traditional medicine is wide - spread and some of the methods used such as herbs, have proved effective. Therefore, it should be organised, licensed to restrict unscrupulous practitioners, and integrated into the health system.

4.6 Conclusion:

This chapter has reviewed the economic development and the health services and policies of Saudi Arabia. The rapid increase in the country's revenues led to health facilities being expanded in a very short time. The number of hospitals, health centres and hospital beds increased in a very rapid manner. The number of health personnel was raised in order to reduce the ratio of physician and nurses per population. However, geographical distribution of the health facilities is uneven between regions and cities. Large cities such as Riyadh and Jeddah got the lion's share of public health facilities and services even though they enjoy other health services sources, such as other governmental organisations and the private health services. In rural areas there is still a shortage of some of the primary health care facilities.

The government is trying to increase the ratios of physicians and nurses per population. This objective led the government to make contracts with physicians and consultants of different nationalities, which has helped to deliver health services but causes a communication problem, precisely, between physicians and their patients. To counter the shortage of medical personnel and reduce the dependence on expatriates, the government encouraged the university to establish a

paramedical college to award bachelor degrees to encourage Saudis to enrol in these college. This in the very long run will increase the number of graduate Saudi physicians.

Also, the development in quantity of medical facilities was associated with development in quality of medical care. The number of complicated surgical procedures carried out abroad has considerably dropped; most operations are now carried out in Saudi Arabia and few patients travel abroad.

The increase in health service facilities is appreciable and desirable, but as it was seen, the emphasis is on curative care rather than preventive medicine.

The Ministry of Health as a member state of WHO adopted the recommended policy to implement the PHC approach in order to achieve larger health service coverage and to contribute to the global social goal of "health for all by the year 2000". The implementation of the PHC approach did not immediately cover the whole country, but went through different stages until eventually the health authorities adopted the current approach as detailed above. The next chapter will review some aspects of the health service utilisation in relation to the existing literature on Saudi Arabia.

⁴ First population enumeration was conducted in 1930 in Hijaz region before the unification of Saudi Arabia.

⁵ Hail's governor Prince Maqran bin Abdulaziz, an ex - pilot, well educated, personally participated in the implementation of the PHC approach. Finally, he put all the region's administrative facilities under the disposal of the General Directorate of Health Affairs in Hail.

⁶ Before 1981, these health centres used to be called " Health Dispensaries and Health Posts".

CHAPTER 5 Provision and Utilisation of Health Services in Saudi Arabia:

5.1 Introduction

Most Third World countries, generally, lack organised information systems and official data, are often unorganised and inaccurate. Health is one of the areas on which accurate information is lacking. Therefore, researchers are faced with many barriers and difficulties when attempting to carry out any research in Third World countries.

Saudi Arabia lacks sociological studies on health affairs and people's attitudes, beliefs, utilisation and awareness of health and health care services. Most of the existing studies concerning health and health affairs in Saudi Arabia have been conducted by health professionals interested in finding out about medical status and conditions or the occurrence of particular diseases in Saudi Arabia, for instance Sebai (1983, 1984, 1985, 1988); Sebai, Abdullah and Swailem (1984); Badr and Qureshi (1981, 1982, 1984); Zakzouk and Sengupta (1984); Sebai and Shalaby (1984); Banoub (1984) and El - Shafei (1985). Some of these studies focused on epidemiology of diseases, road injuries and accidents and so on.

A few studies in medical geography have been carried out. This type of study usually tries to investigate and concentrate on distribution of health facilities, travelling time from and to these facilities, and pattern of health services (El - Bushra 1980, 1989; Al - Ghamdi 1981; Al - Saania 1983; Tamas 1986; Elzahrany 1989; Al - Ribdi 1990).

Some other studies have been conducted by researchers in the field of health and hospital administration. These studies emphasise the organisational and managerial aspects of the health organisation: structure, waiting time at the clinics, time consumption in hospitalisation, hospital bed occupation frequency (El - Toriki and Harastani 1984; Saeed 1986, 1990; Al - Osimy 1991; Alshammasi 1985).

It is not the interest nor the purpose and scope of this study to survey all the studies which have been conducted in Saudi Arabia, but to review critically a few studies which are of particular relevance to the present work. These cover three main areas: utilisation of health services; health conditions and health care and traditional medicine.

5.2 Provision and Utilisation of Health Service:

Service availability and utilisation have become an important topic in social science studies. Accessibility to medical and health services is critical and forms the cornerstone of utilisation of these services. Joseph and Phillips (1984) argued that PHC, to be successful and effective, must reach out to all those in need of it and achieve 100 percent outreach.

Different approaches have been used to evaluate and assess the efficacy and sufficiency of health care services. One of these approaches is the conventional approach which evaluates health care services in terms of personnel, such as physicians per population and the number of existing health facilities such as hospitals and health centres bed to population. This, the structural approach is mainly concerned with the availability of personnel and health facilities. Another approach measures the level of utilisation of the services either through hospital records, such as the number of admissions per 1,000 population, the average number of out - patient visits per person, or also through interviewing utilisers.

A number of studies in Saudi Arabia have focused on the provision of health services (particularly those involving primary health care centre) and the level of utilisation of these. The first study of this kind, by Al - Ghamdi (1981) tried to develop an approach for establishing public health centres so that they would be accessible within a time limit not exceeding ten minutes travel for each inhabitant in Jeddah. Al - Ghamdi pointed out that Jeddah had experienced rapid urbanisation, but there had been a lack of planning of social services, and health care services were inadequate (Al - Ghamdi 1981). Furthermore, location of health services within Jeddah was not based on population density or accessibility.

Al - Ghamdi's data, obtained by administering a questionnaire to a sample of visitors to health centres, showed that almost 42 % of the utilisers were labourers who were mostly non - Saudis, and 37 % were governmental officials. In terms of income, the study revealed that the majority of the utilisers were people of low income who could not afford to go to the private sector. 62 % of the sample lived in traditional houses, which were below standard in terms of health and hygiene conditions.

Travelling time ranged from less than ten minutes to more than twenty - five minutes. However, this information may be misleading as the study did not disclose the distance of health centres from

where the utilisers lived. This is important as the health facilities will attend to any patient, whether or not he / she lives in the same district. Also, at the time of the study, patient records had not yet been introduced. Thus, the time travel recorded could not be put in the context of the distance and the population to be served by each health unit. In contrast, the new approach of PHC uses a patient record system and is based on each facility serving a designated number of population.

Although some utilisers indicated a preference for the private sector, in fact only 12 % sought private health care, though some claimed to seek health advice from the family doctor. However, this term was not clearly defined, which caused some confusion. What was meant, was the private GPs. If we take this into account, the total utilisers of the private sector were 13 %. Al - Ghamdi's sample was selected from the population utilising the public dispensaries, so these 13 % were seeking extra health services, in addition to the public services. This might be for reasons such as inconvenient working hours, emergency cases, medical service not being available at the dispensary at the needed time and so on.

It should be noted that in most residential areas, there are both high income and low income people living side by side; no segregation between districts exists because of income or standard of living conditions. However, due to rapid urbanisation, some social groups are clustered in particular districts. Thus, Al - Ghamdi's sample was almost entirely drawn from a low income population category. Since the city health centres were built in these areas. As this group had little choice of health services, the only feasible option for them was the public service, which is free.

The study showed that 15.2 % of the sample used public hospitals. At that time, general hospitals used to deliver out - patient services, for any patient. This was before introduction of the referral system (see Chapter Six, health organisation in Jeddah) which restricts admission to hospital to patients coming from PHC centres through the referral system and provided that the needed services are not available at those centres. As a result, the percentage of utilisers of out - patient clinics has since been considerably reduced, because many services are delivered now through PHC centres and only follow - up services are delivered through out - patient clinics.

Al - Ghamdi (1981) reported on the conditions of the existing health centres, their locations, type of buildings, and availability of other related facilities. Most of the locations of the health centres

were not appropriately planned, and there were only seven health centres to deliver health care for the population of Jeddah, in addition to the services rendered through out - patient clinics. Most, if not all, of the health centres were accommodated in rented buildings, which were not designed to accommodate health organisations, and did not provide adequate, comfortable surroundings for health care. Facilities such as car parks were lacking, since most of the health centres were located in the inner city, so access to these facilities was very difficult.

Al - Ghamdi (1981), suggested that more health centres be built, because at the time of his study the available services were not sufficient and too much time was spent in travelling to them. The city was considered to be in need of 27 more dispensaries. Since Al - Ghamdi's study was carried out, urban expansion and internal population movement have continued. Jeddah has changed rapidly, and there are now more than fifty districts. Urbanisation and population movement in less developed countries are very rapid and changeable, in contrast to the developed world. This makes it difficult to predict the need for social services.

The second study was carried out by Al - Saania (1983), in Makkah city. He studied three hospitals and eight health centres, all the public health services which existed in Makkah in 1983. He explored the socio - economic, demographic characteristics and types of illness of the utilisers of these health service facilities. The findings of the study were very similar to those of Al - Ghamdi (1981). All the health centres were in rented buildings. Most of the utilisers came from the low income group. In occupational terms, government employees recorded the highest percentage, 33 %, while labourers represented 21 % and students 15 %. Regarding educational level, the largest group were the illiterate (23 %), then came those with secondary education (17 %), 16 % had intermediate level, and 15 % a university degree. The study also reported on morbidity in the city of Makkah and it indicated that 31 % of respondents sought treatment for gastro - intestinal diseases, 19 % for colds and influenza, 8 % for nose, ear, and throat and 7 % for dental treatment. In terms of transportation, 53% of the respondents indicated that they used their own car to get to the health facility, while only 14 % mentioned using public transportation. This clearly indicates the importance of the availability of parking facilities.

However, Al - Saania (1983) excluded females from his sample. This is a significant weakness. Any study of utilisation of health service facilities should include the gender factor, because in most societies, women constitute half of the population. Moreover, morbidity among females is higher than for males (Al - Walaai 1991); therefore females tend to be more frequent utilisers of health services.

The study did not mention the districts where utilisers came from, but reported that the majority of the population (55 %) lived in flats and 40 % in Arab houses, usually made of simple concrete. This suggests that these people on the whole did not come from wealthy districts.

The third study, carried out by Elzahrany (1989), also investigated the utilisation of health service facilities in Makkah city. In order to measure the level of utilisation, he divided the city into four major geographical areas: Central, Northern, Eastern - Western and Southern. He then collected data to examine the variation in level of utilisation of health service facilities among the populations of these different sections of the city, and to explore the significance of socio - economic, demographic and cultural factors, and morbidity rate in the utilisation of health care facilities in Makkah. Elzahrany's justification for dividing the city into these four sections was that the centre is the oldest part of the city, primarily inhabited by the descendants of early immigrants from Yemen (South and North) and Southeast Asia. A mix of high and low income groups live in this section. Most of the population of the Northern sector are immigrants from various rural areas in Saudi Arabia. The population of this sector enjoy an average standard of living. The Eastern - Western section is constituted of the wealthy suburbs in Makkah, whereas the Southern sector represents the lower socio - economic areas of the city. The population of this sector are descendants of immigrants from Africa (particularly sub-Saharan) and the Indian subcontinent (Elzahrany 1989).

His units of analysis were the three sources of health care service providers: the first was public services hospitals, PHC centres and other governmental services provided by sources other than the Ministry of Health; the second unit was private sector hospitals, clinics and GPs' clinics; the third was traditional healers. The study reported that public services, particularly hospitals, were the major providers of health care services. The level of utilisation among sectors varied. The Northern sector was characterised by a higher level of utilisation than the other sectors. Utilisation of PHC centres

was highest in the Northern sector, then came the Southern section. Utilisation of the private health services in Makkah was lower than that of the government health services, and most of the utilisers of the private sector were from the Eastern - Western areas, where the population were generally better-off and could afford to go to the private sector.

However, many factors affect the level of utilisation and the types of health services utilised. Makkah is 65 kilometres away from Jeddah, and many of Makkah's inhabitants went to Jeddah to seek health care in the private sector. Makkah's private sector was still in its infancy, compared to the situation in Jeddah. Moreover, at the time of the study, hospitals delivered primary health care through out-patient clinics and there was no referral system. Thus, it is believed these factors influenced the level of utilisation of health service facilities among the population of Makkah. The study suggested that massive health education programmes should be developed, particularly for the population of the poor areas. These programmes would aim to change people's attitudes and behaviour toward health, disease and medicine.

A fourth study, carried out by El - Torky and Harastani (1984), explored patient's waiting times at out-patient clinics in some of Riyadh hospitals. Their study was conducted before the introduction and enforcement of the referral system. However, the results of the study showed that prolonged waiting time at the out-patient clinics could be ascribed to many factors: lack of appointment system at the clinic; failure to adhere to a first come first served basis, owing to favouritism; language barrier between patient and non-Arabic-speaking physicians; low physician / patient ratio, physicians' late arrival; not enough information signs to guide patients; some patients preferring to be seen by a particular physician. It was hoped and expected that this problem would disappear with the implementation of the new policy of PHC centre, when the PHC centre's physician provides basic health care and complicated cases can be referred to the second level - hospitals for further follow-up and medical examination.

5.3 Attitude and Outlook of the Public.

Recently, much attention has been given to examining consumers' attitudes and satisfaction with the available services. This approach is based on the utilisers' opinions of the health services which they receive. Consumers' satisfaction has been examined by many researchers in developed countries.

For example, Fisher (1971) as discussed earlier (see Chapter Three). More widely there is increasing interest in the level of people's health awareness and in their beliefs regarding the causation of health and illness (some of the latter will be discussed in traditional medicine)

It is very important to distinguish between patients' satisfaction in developed and developing countries. In the former, the health services have been established for a long time, whereas in developing countries, health care systems are still in their infancy. Developing countries such as Saudi Arabia may learn from the developed world's experience and use scientific methods of analysis and research techniques to evaluate and improve the health situation in their countries.

A few studies concerning health service facilities and consumers' attitude, satisfaction and beliefs (Sebai 1983, 1984, 1988; Al - Mubarak 1989; Al - Osimy 1991; Al - Baz 1992) have been carried out in Saudi Arabia. The first of these was " The Health of the Family in a Changing Arabia, a Case Study of Primary Health Care", conducted in two stages, in 1967 and 1981, by Sebai. The study was conducted in a small town, Turaba, in the western region of the country, chosen because it combined three communities of population of different types of settlement: settled population; semi - settled population; nomadic population. The study examined the influence of the health knowledge, attitudes, practices and socio - economic and environmental factors and available health services on the health conditions and status of children in the three societies.

From an epidemiological point of view, the study disclosed that the most common diseases among the children in the three communities were diarrhoea, coughs, fever and eye disease. There was no difference between the children in the three communities in the incidence of diarrhoea. However, coughs, fever and eye disease were significantly higher in the semi - settled and nomadic communities. Breastfeeding was the predominant method of feeding for children up to two years of age, though one of the main differences in the nutrition of children between the three communities was that in the settled community, powdered milk was becoming more popular, as it was considered an indication of modernisation.

The health services available to Turaba people were of two types: the Health Centre and folk medicine delivered by native practitioners. The health centre was run by a Pakistani physician, pharmacist and female nurse and a Jordanian male nurse. The only Saudi was the sanitary assistant.

The study reported that the time spent by the physician with each patient was two minutes. Lack of regular transportation between the health centre and other remote areas made it difficult for the people in those areas, particularly women, to utilise and benefit from the services. The Health Centre activities were confined to curative services. No attention was paid to community - based activities in health education, environmental sanitation, nutrition or maternal and child health programmes.

The study shed some light on people's apprehension of the cause of illness. People in the three communities were asked about the aetiology, treatment and prevention of tuberculosis, mental disorder, syphilis, fever, diarrhoea and bodily aches. The results disclosed that the people believed there are two main causes of diseases: supernatural power : God, Jinn and Evil Eye; physical agent : cold, heat and fatigue. They saw God as the primary cause of all diseases, though they believed that for most diseases, there are intermediate causes such as Jinn or cold. Multiple causation is the pattern. Bedouins believe that every human being has a companion Jenni of the opposite sex. Sometimes the Jenni falls in love with his or her human partner and tries to enter his or her body. As a result, mental disorder occurs.

The study concluded that the health practice of the people in Turaba largely reflected their fatalistic attitude to life. Multiple causation and lack of specificity or scientific reasoning, were the main features of the beliefs in the three communities. Their sources of information were sharp observation, long experience and personal communication, rather than regular education or mass media programmes (Sebai 1983).

Al - Saania (1983) attempted to assess people's satisfaction with the health service and posed some questions concerning status of health services, cleanliness, organisation, interaction with the receptionists, availability of medication at the health units and parking areas. But, he presented his findings in this regard in general statements rather than in numerical form, which creates difficulties in comparing with other studies.

Al - Mubarak (1989) conducted a study intended to investigate consumers' health awareness and their satisfaction with the public health services delivered through PHC centres as well as the utilisation of these services. The study was carried out in the Eastern province of Saudi Arabia, in four different locations: two villages and two cities. The sample size was 120 respondents, divided

equally between the sexes. The study reported a low level of utilisation of health service facilities. More than 63 %, mostly female, visited the health centre only if they felt severe pain or illness, while 45 % of the male sample reported that they would first use previously dispensed medication when they felt ill, before going to the health centre. Women used the private sector more often than men. Also, the study showed that people with a higher level of education made more use of health facilities than less educated people.

In terms of health awareness, the study reported that the majority of the respondents showed some theoretical awareness of the value of activities such as taking exercise, or following a particular diet, to keep fit and healthy, but in practice, they did not carry out these activities. 75 % of the respondents indicated that some forms of traditional medicine are useful, and 35 % stated that they visited traditional medical healers. 35% of professionals indicated that traditional medicine succeeded in treating particular diseases.

The study raised a very interesting point regarding community participation. Both professionals and consumers expressed the feeling of neglect by the health authority, on both regional and national levels. Participation in planning and decision - making did not exist. The professionals indicated that they just did as they were instructed, while the consumers had no say about the health services delivered to them. This, to a great extent, can be attributed to the political system, as well as the centralisation of decision - making.

Although the aim of this study was to explore consumers' satisfaction with the available health services, unfortunately the researcher did not succeed in obtaining any result regarding consumers' satisfaction and did not list any questions related to such phenomena. However, the study provided interesting results on utilisation and peoples' participation in decisions concerning their health and life.

To explore family health care and awareness, Al - Abdulatif (1989) conducted a study in Riyadh city to identify the relationships between factors such as mass - media, income, level of education, socio - cultural and physical environment and their influences on health awareness. The researcher chose three different districts in Riyadh city, the capital of Saudi Arabia: Al - Ulayah, King Saud university campus and Al - Oud districts. The study justified the selection of these three districts because of the differences of income, physical environment and level of education between the three

selected areas. She pointed out that her aim was to include one old district and two new, so as to measure the variation in health conditions and awareness between the population, and to facilitate comparison of social and physical characteristics among the population of these districts.

The study concluded that mass - media play a crucial role in promoting health awareness, and TV is the most influential medium, then radio. TV plays a major role in improving health awareness, not because of low level of literacy, but because TV provides pictures and words together, which makes the educational process simpler. Radio and newspapers address few people and provide only one aspect of communication; voice or text. Papers and leaflets are not enough to raise health awareness in societies with a high percentage of illiteracy.

The study reported a relationship between level of education and health awareness. However, the researcher's findings on this point may be suspect, because she tested health awareness by asking about the practice of certain preventive measures which many people might have recognised as "ideal" or "educated" practice, even if they did not take such measures themselves.

Therefore, they may have ticked "desirable" responses in order to avoid appearing ignorant. It would have been better if the researcher had selected some kinds of diseases and asked how the respondent would react toward such diseases. Then she could have drawn a general conclusion about the relationship between level of education and health awareness. Furthermore, it is not always true that the higher the level of education, the greater a persons' health knowledge and skills. In a country like Saudi Arabia, there is a hidden cultural agenda. Most of the people in King Saud staff campus, for example, are of Bedouin background; they have achieved a high level of education, but are still to a great extent, influenced in their decision - making by the local cultural characteristics, tending to utilise traditional medicine, and have a large number of children (the researcher chose number of children as an indicator of health awareness, expecting that educated people would tend to have only two or three children). As Marriott (1955) pointed out, to understand the people's choice of treatment, cultural factors need to be understood.

Physical environment has a strong effect on health conditions in general, but to attempt to identify the effect of area, type and size of house, in Saudi Arabia, as Al - Abdulatif did, may be misleading. This factor has less influence than might be supposed, because any Saudi citizen,

particularly in Riyadh, can obtain an interest - free loan from the Saudi Housing Fund to build a house in the location, style and size of his choice.

Another study, which was mainly concerned with the availability of health care facilities and patients' satisfaction, is "Evaluation of the delivery of primary health care services at three PHC centres in Riyadh city", carried out by Al - Osimy (1991). The main objectives of the study were to assess the extent to which the available resources at PHC centres correspond to the standards laid down by the Ministry of Health and to explore consumers' satisfaction with the services available at PHC centres. Three PHC centres were selected to conduct this study. The researcher found that there was variation in the number of families registered and served by each centre, and there was variation among the three centres in terms of personnel, equipment and facilities. The majority of the personnel working in the three centres were non - Saudi, and some of them had problems in communication with the served people, because of lack of familiarity with the Arabic language. In terms of experience in PHC, not all of them had attended PHC training courses. Most of the equipment, whether in clinical or support areas, did not meet the MOH standards.

The study revealed that most of the utilisers of these three PHC centres were females (80 %) , Saudi (70 %) housewives in the age group of 14 - 29 years old, and they used private transportation to go to the centre. The sample bias is obvious. This is because the researcher was female and gender segregation as well as the cultural aspects made it difficult for her to have contact with men; when administering her questionnaire, she was in the female waiting room. Also, she was present during the morning shift, when she would be more likely to see female visitors to PHC centres than male. So, it would be unwise to presume that women did constitute the majority of utilisers of these three centres.

The results of the study showed that consumers were not satisfied with the following items in all the three PHC centres: waiting time; physical examination; vital signs taken; adequacy of staff and equipment; health education, which was given by nurses only; the use of examination bed for physical examination; time taken for laboratory tests; sufficiency of medicine in the centre; availability of public telephones; follow - up of missed appointments, and posters used in the centre as well as informational signs for utilisers' guidance.

The researcher reported that most of the consumers expressed a feeling of discontent regarding the lack of an organised system to process patients' entry to the clinic. There was no card numbering or queuing. Consumers demanded an increase in working hours, particularly during the afternoons, and wanted more physicians, nurses and dentists, and / or more reliable supply and availability of medicines in the pharmacy. They also complained about the way physicians conducted examinations, and felt that they were not taken sufficiently seriously.

Overall, it was considered that the main problems were overcrowding in the centre, physicians' and nurses' attitudes, lack of emergency services during the night, lack of space in the centre, insufficient medicine, superficial physical examination, and lack of social workers (Al - Osimy 1991).

Another study was carried out in Riyadh, to investigate patient satisfaction among the utilisers of the public health service, by Al - Baz (1992). The main aim of the study was to identify factors affecting patients' satisfaction with PHC services. These factors were divided into two main groups, one related to the service delivery system and the other to patients' sociodemographic status.

The study reported that the characteristics of the health care delivery system had a stronger impact on utilisers' satisfaction with the public health services than did utilisers' sociodemographic factors. These system factors were, for example, the physical environment of the health centre, accessibility of the health care system, waiting time, length of examination time, fragmentation of the health care services and lack of sufficient medical equipment and medicine. The study reported that long waiting time at the PHC centre was a result of overcrowding and shortage of health professionals. Similar results have been reported by other studies (Sebai 1981, 1988; El - Torky and Harastani 1984; Al - Osimy 1991).

Another essential factor affecting patients' satisfaction is the physical environment of the health care centre. The study found that the better the physical environment, the greater utilisers' satisfaction. The inappropriateness of the physical environment can be explained by the fact that most of the PHC centres are not in buildings designed to accommodate health facilities (Sebai 1981, 1988; Al - Ghamdi 1981; Al - Saania 1983, Elzahrany 1989; Al - Osimy 1991; Al -Baz 1992 and researcher's observations). The use of rented buildings also leads to health centres being moved from place to

place, because of such factors as increased rent or expiry of a lease. Also, PHC centres are often in dead - end streets, with no parking area available. Al - Baz (1992), showed that absence of public transportation decreased satisfaction of utilisers, particularly women, as women can not drive in Saudi Arabia. All of these factors affect the utilisers' satisfaction.

The study also reported that differences in language, culture and tradition created communication problems between the providers of the services and the recipients, leading to dissatisfaction among the latter. Similar results regarding communications have been reported by Sebai (1981, 1984, 1988); El - Torky and Harastani (1984); Al - Osimy (1991).

The referral system, a key ingredient of the PHC approach, as PHC is the entry point to the other levels of health care, was discussed and the study showed that this system has been abused. Rather than being a mean to provide comprehensive health care, the system was introduced in 1988 to prevent patients from going directly to specialists in hospitals without coming through the PHC centres. Some of the problems of the referral system related to the reluctance of the PHC centres' physicians to refer patients to specialists. This reluctance may be attributed to two factors:

- 1 - The Health Authority instructed PHC physicians to reduce referrals as much as possible to cut down health care expenses.

- 2 - Physicians at the PHC centres avoid referring patients because they are afraid they will be seen by the specialists as unqualified or incompetent, and be dismissed from the work (Al - Baz 1992).

The influence of utilisers' sociodemographic characteristics were less marked than the characteristics of the system of delivery of health care services. However, some patients with poor health indicated that they were not satisfied with the services and complained about the shortage of medicine and equipment in the PHC centres. Others used the centres only to have measures of vital signs taken; if they felt that they needed treatment, they went to the private sector.

Looking at the effect of marital status on the satisfaction of the utilisers, it was found that married respondents showed more satisfaction than unmarried, probably because of the social and psychological support they receive from their spouses; the unmarried were not very satisfied with the services, because of lack of family support and comfort.

The study showed that satisfaction decreased as level of education increased. More educated people tend to be more critical and to question everything, while people with less education may be satisfied with any level of health services, because they have not learned to expect anything better. This does not mean, however, that there is no dissatisfaction among utilisers with less education. Al - Osimy (1991), for instance, found dissatisfaction with the service among people with a low level of education.

The study showed gender had no significant effect, and the researcher attributed this to the availability of a reasonable number of female physicians. This could be true, but Al - Osimy (1991) reported dissatisfaction among her sample who were mostly female (as discussed above). So, generalisation is risky in such cases. This area needs to be further investigated.

Finally, the study highlighted a very important factor, that of social workers. Al - Osimy (1991) noticed there were no social workers. Al - Baz (1992) reported that among the 56 PHC centres in Riyadh, only 18 had social workers. Of these, three were male. In a society like Saudi Arabia, for cultural reasons, female social workers cannot deal with male clients, and vice versa.

5.4 Traditional Medicine:

Although there is an increased international interest in traditional medicine, it still needs more investigation and study. The few available studies have been concerned with studying cultural aspects, rather than exploring the practice and content of traditional medicine. However, there has been some marginal mentioning of utilisation or practice of traditional medicine by researchers exploring health care systems in developing countries, or interested in such topics as utilisation of health services; or choice between traditional and modern medicine.

In 1990, Al - Amri conducted a study to explore university students' attitudes towards traditional medicine, and to investigate factors that influenced them to seek health care within this medical system. The study showed that 77 % of the sample indicated that they sometimes benefited from traditional medicine, while 7 % per cent said traditional medicine is not good or fruitful. Also, Al - Amri (1990) reported that there was a positive relationship between the place of origin and utilisation of traditional medicine; persons with rural background were more likely than the urban to accept and utilise traditional medicine. A very interesting result was that whereas males with higher levels of

education became reluctant to use traditional medicine, females showed the opposite tendency, and those with higher levels of education made greater use of traditional medicine.

Although the study reported on the status and practice of traditional medicine in Saudi Arabia, it was constrained by research area and time. The researcher was mainly concerned with herbal medicine and whether it had any harmful effects. He did not succeed in exploring the overall practice and utilisation of traditional medicine, because he only addressed one aspect of it. Most of the discussion was concerned with taking herbs in treatment, rather than actually seeking treatment from traditional medical practitioners. Al - Amri did not discuss the various types of traditional medicine, or the types of diseases for which people sought treatment in the traditional medical care system.

5.5 Conclusion:

Saudi Arabia, as is the case with most third world countries, has undergone rapid urbanisation. This urbanisation has led to vast difficulties in planning and implementing social service policy and strategy including health care services. Studies have revealed that almost all health centres are located in unsuitable locations and lack facilities such as car parking areas and medical equipment. The units often can not readily be seen and distinguished by potential users, and most health centres are in dead end streets, which causes many difficulties. Often, these centres are accommodated in buildings that were not built to serve as health units. Therefore, most of these buildings, if not all, make the delivery of the health services uncomfortable for both the providers and the recipients. Disabled people, pregnant women and the elderly, underutilise the service because of problems of transportation and accessibility.

Distance and travelling time to health units are very important factors in impeding or increasing people's utilisation of the health services. These two problems are often the result of lack of planning. The implementation of the new approach of PHC may lead to less travelling time as each unit is planned to operate in a particular district serving a designated number of population and will use a patient record system. However, there is a problem of people's preference for a particular physician. This could be eliminated by using a similar system of GPs records to that used in UK, every patient within the health centre can choose by which doctor he or she wants to be seen.

Lack of satisfaction with the health services was seen to result from a variety of factors. One is the failure to take into consideration the diversity of subcultural variation such as the Bedouin beliefs as to the causes of diseases. Another is the problem of communication between the providers and the utilisers of the services. Many doctors do not speak the same language as their patients; this has been one of the most frequent causes of complaint. Other deficiencies reported include lack of information signs and preventive education posters. A referral system has been introduced to channel the services and to make a link with the other health service facilities. This is believed to be an essential feature of the PHC approach. However, some physicians and patients abuse the system, because of misconceptions as to its function.

Characteristics of the health care system, such as the physical environment of the health centre, accessibility, availability of medicine and equipment, and others, have been shown to have a stronger influence on satisfaction than the sociodemographic characteristics of utilisers. Utilisers' dissatisfaction with the available public health services, as shown in the previous sections, may lead many people to switch to the private sector or to the traditional practitioners. Therefore, great efforts are needed to correct the deficiencies in the health delivery system.

The above reviewed studies covered several areas concerning the provision and utilisation of health service in Saudi Arabia. However, they have many shortcomings which left room for the present study. Only three of the researchers cited (Al - Mubarak 1989, Al - Osimy 1991, Al - Baz 1992) have studied the PHC approach since its introduction in Saudi Arabia. Both Al - Osimy and Al - Baz studied the PHC approach from a managerial perspective, concentrating on issues relating to management rather than social factors. Attitudes toward PHC approach were not explored by any of those who studied PHC; they concentrated on the availability and satisfaction with facilities at health centres. Moreover, the relationships between satisfaction, attitudes and behaviour were not explored, so the present study tried to explore the relationships and affect of satisfaction on attitudes and behaviour as well as the interaction between attitudes and behaviour of the respondents.

Sebai (1983) was a pioneer in studying people's attitudes towards health, and their beliefs regarding causes of illnesses, but unfortunately no other study has followed up his work. Although Sebai studied attitudes, his aim was to investigate children's medical status rather than attitudes thus

his study was very limited in this regard. Al Mubarak (1989) tried to explore people's attitudes toward health awareness but his study was limited to people's practice of a few activities related to health awareness, such as practising any type of sport or following a special diet for fitness. This study has tried to fill the gap by exploring from a wider perspective people's attitudes towards PHC and other practices such as health awareness and use of health facilities, as well as traditional medicine.

Al - Ghamdi's (1981) study, the only previous one carried out in the same city, was carried out when there were only seven health centres in Jeddah and also before adoption and implementation of the PHC approach and implementation in Jeddah. Since then, urban growth and other changes will have rendered his findings obsolete. Other studies have been carried out in different parts of Saudi Arabia. Al - Saania (1983) and El - Zahrary (1989) examined the utilisation of the health facilities in Makkah city. However, both of them based their analysis on medical records and number of visits. The number of visits does not necessarily tell what type of illness prompted attendance, and many visits may be made for minor reasons, such as injection or dressing. Thus, the current study examined use of the health centre for particular types of diseases.

All previous studies were carried out in at public health services facilities and none attempted to study non - utilisers of the public sector. The private sector has been neglected by previous studies in Saudi Arabia. This study included some of the non - public sector utilisers and tried to find out about them and their attitudes and behaviour. Although the number of non - public sector utilisers was small, they revealed major statistically significant differences in attitudes, behaviour and practices between public sector utilisers and non utilisers.

However, all of the previous studies along with the present will contribute to the health literature in Saudi Arabia, and, it is hoped, ultimately the health situation of the population.

In this and previous chapters, we have discussed issues which form the theoretical and contextual background of the present research. The remainder of this thesis will be devoted to description and discussion of the researcher's empirical work in Saudi Arabia. This is introduced in the next chapter by background information and an account of the health services in the site of the study, the city of Jeddah.

6.1 Introduction:

Jeddah is an ancient city. Its location on the coast of the Red Sea, in the Western province of Saudi Arabia and its proximity to the two holy cities, Makkah 65 kilometres and Madinah 350 kilometres, contribute to its present importance as it is the main air, sea and land gateway for pilgrims coming to perform Hajj, the fifth pillar of Islam. Another crucial factor in the importance of Jeddah is the political dimension. Before the unification and proclamation of Saudi Arabia, upon the proclamation of Arab independence from the Ottoman Empire in 1916, Jeddah became the political capital for the Hijaz Kingdom during the reign of Sharif Hussain Ibn Ali. The city was the government seat from the unification of the country until 1955, when all the ministries were moved to Riyadh, except for the Ministry of Foreign Affairs. The foreign embassies and missions remained in Jeddah until 1985, when the Ministry and all the embassies were moved to Riyadh. Now, every embassy to Saudi Arabia has a consulate in Jeddah.

As the largest port on the western coast of Saudi Arabia, Jeddah has become a centre for the provision of services, as well as of commerce, industry and culture. 80 % per cent of the Kingdom's imported goods, food and raw materials come through Jeddah's Seaport. Jeddah's factories, on the other hand, meet a major part of the country's requirements for various goods and products. The city is also a very active commercial and financial centre because of its open door policy and as the location of most banks and financial establishments. There are several educational institutions in Jeddah, including King Abdulaziz University, Red Sea Foundation (Ministry of Information N. D). Girls Education College, Junior colleges for both boys and girls and a number of international organisations (Ibid. p. 91).

The current area of Jeddah is 1,200 square kilometres (463 square miles) (Ministry of Information N. D. P 27), of which 560 square kilometres are built on (Al - Mahrajan 1990). For comparison in 1947, the total area of Jeddah was one square kilometre. In 1947, Jeddah's population was 30,000 people, but by 1970, the figure had risen to 350,000 inhabitants. In the beginning of the eighties, the population was estimated at about one million. However, now the number is about 1,500,000 people (Al - Mahrajan 1990). The native people of Jeddah are mostly Arabs, but the

sacred places have attracted many people from the Islamic world, including Indians, Indonesians, Turks, Persians and Africans.

6.2 Jeddah: A Brief Overview

Jeddah at present is made up of 50 districts. These districts vary in their size, organisation, planning, population density and availability of social services such as health centres and schools. The boundaries between districts are not very clear, despite a project to rename the districts and streets with the aim of making their utilisation easy for everyone, particularly those who provide public services such as transportation, health care, and security. Even now, many residents can not distinguish to which district they belong, particularly if their accommodation or property is located in an area which is situated between two districts.

As a result of Jeddah's Renaming Project, small districts were incorporated into large districts nearby. For instance, Al- Saheefah has become part of Al - Kandarrah. However, although the name no longer officially exists, residents of what was known as Al - Saheefah continue to use it in formal and informal transactions and even as a postal address, and it is generally recognised and accepted. However, in relation to services such as health care, the inhabitants must now choose between one of the neighbouring PHC centres, Al - Kandarrah or Al Amariah, whichever is nearer their home. The situation is similar in other districts in Jeddah also.

Jeddah City as a whole can be readily divided into two parts, old and new. The old section contains 22 districts, all of which existed before the oil price boom of the mid 1970 s. The other part of the city, called " new Jeddah " (Jeddah aljadidah) is estimated to cover more than seventy percent of the area of the city. This part, so far, consists of 28 districts, though this number may be expected to increase with the progress of urban development and expansion. City expansion has taken two directions: northwards and eastwards. Expansion occurred in these directions because on the West, the Red Sea is situated, so any residential areas develop eastwards from the sea side. Moreover, recreation centres and resorts are established on the Corniche at the seashore. To give a clear picture of the city, therefore, the main features of both the old and new areas need to be described.

The main features of the new districts are :

1 - Streets are wide, not less than 10 metres in width

2 - There is a good proportion of open areas and green parks to give an attractive view, facilitate ventilation, and in some districts to provide play facilities for children.

3 - The distance between houses or blocks of houses is sufficient to allow easy vehicular access, so that in an emergency, for example, the fire - brigade or ambulance would face no difficulties in gaining access to the scene of the incident.

4 - 90 % of the new districts contain uniform areas of either modern or traditional house styles. These villas are well - constructed and concrete has been used in their building. Some new districts, particularly in the South and North East, contain some shanty houses (Arab houses) made of mud, bricks and cement. No concrete is used in building these houses, which are usually only two storeys high - ground and first floor only. The municipal authority in these two areas is remote from the people and its intervention always comes late because most of these houses are built during weekend holidays - Thursday and Friday. Sometimes the authority turns a blind eye to what is going on in those districts, because of the people's socioeconomic status.

5 - In most, if not all, new districts, there are schools for boys and girls of all ages, and adequate shopping facilities, but unfortunately, no land has been allocated for health care facilities. Consequently, most of the primary health care centres are in rented houses or buildings. Jeddah is not unique in this respect; the other cities and towns in Saudi Arabia have the same attitude. Whether the responsibility lies with the Ministry of Health, Municipality or City Planning Council, it seems that health authorities prefer to rent rather than to buy and erect a permanent health post in each district.

In the South, the Cities Planning Department, which is a governmental organisation, has allocated a large plot for industrial purposes. Thus, all factories, workshops, maintenance agencies and warehouses have been accommodated in that area of the city. As a result, it has become unpopular as a residential area because of the inevitable air and noise pollution.

Common features of the old districts are:

1 - Streets are narrow, and many are dead ends. Streets tend to be crooked and impenetrable.

2 - There are no public parks, so children usually play in the street at risk of their lives, since there is no speed limit for vehicles.

- 3 - There is no harmony in construction; it is not uncommon to see a high rise building of eight floors and next to it a small, two - storey house, or a modern house next to a mud one.
- 4 - The area is very crowded, so that during the rush hours of the early morning and afternoon, driving is difficult and delays are common.
- 5 - Houses are, in some areas, so close together that in the event of any emergency such as fire, the emergency services can not easily gain access; moreover, neighbouring houses are jeopardised.
- 6 - Regarding services, girls' schools are generally situated in well - designed buildings, but the majority of boys' schools are in inconvenient rented buildings. No buildings have been designated for health services. Health centres run from rented buildings; standards and facilities are variable.

Population characteristics in relation to their residential areas can not easily be precisely defined. Indicators such as land price, house construction and location, may be helpful in determining the district's general characteristics, but they are not reliable. Contrary to what might be expected, land cost is higher in some old districts than in the new ones, because most business offices, high streets and marketing areas are located in the centre of the city (Al - Balad). If house construction, appearance and location are taken as auxiliary indicators and are used to categorise residents, no clear conclusion will emerge, because citizens can obtain an interest - free loan from the Saudi Construction Development Fund to build a modern house in a new district. Thus, type of house does not necessarily indicate socioeconomic status in terms of income, employment, or education level.

Socio-economic characteristics such as income, level of education, employment status, nationality, are also imprecise and unreliable ways of categorising the residents of a district. However, some generalisations may be made. Generally speaking, districts such as Al - Hamra, Al - Andalus, Al - Zahra and Al - Khalidiah are, to a large extent, the better - off residential areas. Most of the dwellings in these areas are villas and palaces. Populations of such districts are usually high - ranking government officials or wealthy businessmen. These sections of the population never utilise the

public health service facilities; they prefer to go to private clinics and hospitals, or to specialised government facilities headed by relatives or friends.

A number of districts tend to accommodate what we may call the " middle class". although the term does not exist in Saudi Arabian society or culture. Because of the sensitivity of social stratification and the ideological aspects associated with it, many societies deny its existence. Nevertheless, the social reality of any society reveals some type of stratification system, even if the society is unconscious or unaware of it. By " middle - class" is meant here, people of moderately high income and education, employed, for example as managers, teachers, nurses, paramedical personnel and merchants (Jary and Jary 1991). Many are non - Saudis, who either rent accommodation or live in housing provided by their employers. " Middle class" districts include Al Nuzhah, Al Aziziah, Al Faisaliah, Al Salamah, Al Rehab, Al Naeem, Al Nahdhah, Al Mashruo, Al Marwah, Al Kandarrah, Al Sharafyah, Al Bugdadiyah East and Al Bugdadiyah West.

Most manual workers, such as technicians, electricians, and mechanics, whether Saudi or non - Saudi, are more likely to live in the following districts: Bri Mallik. Guleel, Al Mahjar, Al Sabeel, Petrumen, Al Thalabah, Al - Hendawayah, Al Bukharyah. Al Saheefah, Al Amariah and Al Quraiat.

Al Jamaah, Al Nuzlah Alsharqiah, Al Nuzlah Alyamaniah, Al Thaquor, Al Mattar Algadeem, Madaien Al Fahad, Al - Rawaby, Al - Mashruo, Al Wazariah and Al Ballad, house predominantly Saudi nationals who are either self- employed or public sector employees.

This is only an approximate categorisation, as there is no recognised class system in Saudi Arabia; nor is it desirable to categorise the population on a large scale without concrete data as to their income, level of education, employment etc. Moreover, it is possible to find in a single district, members of all the above mentioned categories, living side - by - side.

6.3 Health Organisation in Jeddah.

As mentioned above, the history of modern medical services in Saudi Arabia has not yet been documented. Therefore, the actual start of practising modern medicine is unknown. But, Hijaz region, particularly Makkah, Jeddah and Madinah, experienced some aspects of the modern medicine services before any other cities in the country, due to several characteristics, such as their religious importance, history and location on the trade routes. The oldest health post called Al -

Quban in Makkah was built during the Ottoman reign, and provided health services until the early days of the formation of the Kingdom. That health post was part of a multi - function building : the first part was used as a school, the second as a mosque and the remaining part as a health centre ⁷. Most of the available literature concerned with health services in Hijaz region marks 1881, as the date of the emergence of modern medicine, because in that year the first hospital was built in Makkah (Jiad Hospital) (Jamjoom n. d). That hospital still exists with the same name, and provides its services in the same place.

As far as Jeddah is concerned, several historians have commented on conditions and provision of health services in the city. Nasif (1930) and Al Ansary (1982), for example, mentioned that in 1911, there were available some sources of medical care such as " quarantine", where the pilgrims used to be inspected, and in case of outbreak of any communicable diseases, were isolated and treated for a period of time until further examination proved to the health authority that the individuals concerned were free of disease. In 1955, the Saudi Arabian health authority built a new quarantine on an area of 229,000 square metres, furnished with all necessary equipment and with a capacity of 70 beds, to screen and treat pilgrims and provide some aspects of health care to residents. Jeddah had also other sources of medical care. One of these was through foreign embassies, some of which provided health care for their people as well as the population of Jeddah (Al - Magrabi 1982).

Nowadays, the situation is different. Medical care is provided by the public and private sectors. In the public sector, the MOH takes the lead in provision of medical and health care, without discrimination between the people. The other government organisations and institutions deliver medical care mainly for their employees and their dependants, then on a limited scale make their facilities available to the public. The following section will cast some light on both public and private sectors.

6.3.1 Public Sector:

The provision of medical and health services in Jeddah comes, like that in most of the Kingdom's major cities, through both the public and private sectors. MOH is the major provider of medical services in the public sector. It delivers medical and health care services through a network of facilities at three levels: primary health care, general and specialist hospitals respectively. In addition to

the MOH, there are several other governmental organisations and institutions providing a range of medical care varied in type, limit and accessibility.

6.3.1.1 Primary Health Care:

In Jeddah region, which includes in addition to Jeddah city other small cities, towns and villages such as Rabigh, Al - Leath, Al - Qunfadhah and Adham, there are 101 Primary Health Care Centres (Ministry of Finance and National Economy 1990), 68 of which are located in Jeddah city to deliver medical and health care to the people. These health centres are distributed all over the city, at least one health centre in each district. However, there are a few districts which have more than one unit, because of the population density and the size of the district. The number of these health centres is increasing as the city is developed and new districts emerge. These primary health centres provide a wide and diverse range of health and medical care services. Because the Saudi health authorities have adopted a comprehensive PHC approach (Al - Swailem and Al - Mazrou 1986), the services provided by primary health care must include at least: appropriate treatment for common diseases and injuries; maternal and child care; immunisation against the major infectious diseases; promotion of proper nutrition; prevention and control of endemic diseases; education concerning prevailing health problems; promotion of mental health and provision of essential drugs (WHO / UNICEF 1978). However, in Jeddah, primary health care centres, to a great extent, concentrate mainly on curative medical care and ignore the other essential elements of the comprehensive PHC approach, such as promotion, prevention, rehabilitation, health education and nutrition control. Often, these health centres are administered by a physician who in addition to his medical task assumes administrative responsibility. Sometimes a civil servant may direct the health centre, or if there is a health inspector, he might in addition to his duty, carry out other tasks, such as records and reception.

A few health centres are furnished with the necessary equipment and facilities to provide several types of medical care services. Table 6 - 1 shows the number and percentage of health centres which provide various types of medical care.

Table 6 - 1 Distribution of PHC Centres According to the Type of Medical Facilities.

Index	No. of PHC.	%
Number of PHC Centres	68	-
Provides Dentistry Service.	30	44.8
X - Ray	32	47.8
Laboratory	51	76.1

Source: Ministry of Health, Annual medical report, various issues.

All PHC centres provide general medical treatment and some centres have the staff and facilities to provide a limited range of specialist services, such as gynaecology and obstetrics, dentistry and paediatrics. The philosophy of the provision of these types of medical care through PHC centres, is that the MOH view these units as equivalent to the family doctor in UK (Al - Hujalan 1993) .

These centres are run by 317 physicians of whom 253 are GPs, 43 dentists and 5 internal disease specialists, 8 paediatricians (MOH 1987). 4 % per cent of the total number of the 317 physicians is Saudi Arabian. The majority are Arabs from Egypt, Sudan and Syria, while a few are from Pakistan and India. Each PHC centre has a pharmacy to dispense drugs to patients free of charge. As mentioned above, most, if not all, the health centres are in rented houses, which were not built to accommodate health facilities. Furthermore, most of these health centres are not easily accessible, and some are in crowded areas with no parking facilities.

Individuals and families who wish to use these facilities must register with the health centre in their district. For Saudis this involves presentation of some official documents, such as proof of identity and residence. A telephone or electric bill is also required. For non - Saudi Arabian citizens, similar documents are required and in addition, a letter of confirmation from the individual's employer or sponsor ⁸ to indicate that he has no medical coverage and the number of employees in the firm is less than twenty persons. However, registration with health centres is not open to all nationalities. Utilisation of health and medical organisations in Saudi Arabia, even of MOH facilities as a rule is restricted to Saudis only. Non - Saudis, whatever their economic status, usually opt for the private sector, unless they work in the government apparatus, when it is possible for them to utilise the public sector. When an individual or family registers with the PHC centre, then they gain access to the other levels of the medical and health network.

6.3.1.2 General Hospitals:

The second level of the network is the general hospital. In Jeddah, there are five general hospitals run by the MOH, with a capacity of 1452 beds. King Abdulaziz Hospital is the newest one, opened in 1990, and the largest in terms of capacity and number of medical personnel. It is operated by a British company. The hospital is built on a huge area, more than 220,000 square metres. It is equipped with advanced medical technology and highly qualified medical personnel both natives and foreigners. The hospital provides a wide range of general and specialised medical care. It has a link with the Faculty of Medicine in King Abdulaziz University, for training students. Moreover, members of the Faculty practice in the hospital and carry out some operations. King Fahad and Al - Shatty hospitals are also considered as teaching hospitals, because students from the Faculty of Medicine, at King Abdulaziz University, train and practice at these two hospitals. Table 6 - 2 shows the distribution of general hospitals in Jeddah, with their bed capacity.

King Abdulaziz Hospital is located in the south of the city; in the north, King Fahad general hospital is situated; Al - Shatty and King Saud Hospitals are located in the west, and in the east, Al - Thaquer is situated. Each hospital will work with a number of the PHC centres in the same geographic area. For example, all the PHC centres in the north part of the city will be linked to King Fahad General Hospital. However, this does not mean that PHC centres will be confined to one particular hospital and can not refer patients to other hospitals in the city.

Table 6 - 2 Distribution of the MOH Hospitals in Jeddah by Number of Beds.

Hospital	No. of Beds
King Abdulaziz	440
King Fahad	602
Al - Shatty	162
Al - Thaquer	160
King Saud	70
Total	1,434

Sources: Ministry of Health (1987), Annual Medical Report; Ministry of Finance and National Economy (1990) Statistical Year Book.

The five general hospitals in table 6 - 2 are unequal in bed capacity and are also different in the number of medical personnel and types of provision of medical care. For example, Al - Thaquer

hospital, with its limited facilities, is unable to provide the range of medical care delivered by King Abdulaziz or King Fahad Hospitals. The two latter hospitals provide a wide range of general as well as specialised medical care.

6.3.1.3 Specialist Hospitals:

Specialised medical care is provided through the tertiary level of the health service system. There are seven hospitals which provide specialist medical care. Table 6 - 3 shows these hospitals and the type of medical care delivered through them. As mentioned above, some general hospitals in Jeddah provide specialised medical care. As it appears from table 6 - 3, the target patients of these hospitals are special patients who need a particular kind of medical care or advice.

Table 6 - 3 Distribution of Specialist Hospitals in Jeddah by Type of Medical Care and Number of Beds.

Hospital	No. of Beds
Maternity and Paediatric	627
Ophthalmic	128
Maternity and Child Care	150
Psychiatric	178
Al - Aziziah Psychiatric	100
Quarantine	179
Al - Amal (Hope)	—
Total	1,362

Sources: Ministry of Finance and National Economy, (1990) Statistical Year Book; Ministry of Health (1987), Medical Annual Report.

The maternity and paediatric hospital was established in the early 1960s in Al - Amariah district in a rented building and in the late 1970s was moved to its new location in Al - Hamra district. In its current premises, the hospital is equipped with a large capacity. It offers out - patient clinics as well as in - patient facilities. It is linked with PHC centres by the referral system. The second maternity and child care hospital, as it appears from table 6 - 3, has a smaller bed capacity, therefore cannot provide medical care on such a large scale. However, this hospital caters for delivery, including deliveries with complications, and follow up. Through out - patient clinics, several types of medical services for children are provided.

The third specialised hospital is ophthalmic. It operates in and out - patient clinics not only for the population of Jeddah, but also for the surrounding areas, of the western province. This hospital is one of only three of its type in the Kingdom. This hospital is also used for training medical students from King Abdulaziz University, Faculty of Medicine.

Because of rapid urbanisation, Saudi Arabia has experienced an increased number of psychiatric illnesses, giving rise to a need for psychological treatment. The health authority has established this type of service in several cities. At first, these hospitals were popularly thought of as treating only "crazy people" and any person referred to one thought that the doctor was making a fool of him, but these hospitals are now well recognised and no stigma is attached to anyone who goes to receive treatment from them. In Jeddah there are two hospitals with a total capacity of 278 beds. As well as providing psychiatric care, they treat people who want to give up smoking.

The quarantine hospital deals only with infectious diseases, particularly during Hajj seasons. This source of care was established in the late nineteenth century, but the first quarantine in Jeddah was built in 1911. After the introduction of vaccination and the improvement in the pilgrims' health, this hospital was used only in emergency, e. g. outbreaks of cholera. However, nowadays this source of medical care is used to receive any referred cases of communicable diseases from other hospitals or PHC centres in Jeddah.

Al - Amal hospital is a new source of medical care which deals with the increasing numbers of drug addicts. In addition to members of the public seeking help with drug problems, the hospital received referrals from the police when they arrest addicts, as some consider people who take drugs to be sick and in need of medical and psychiatric treatment. Length of stay depends on the individual situation and level of addiction, as does the treatment.

There are other specialist centres, which through their out - patient clinics deliver particular medical care: the diabetes and hypertension centre, the toxic centre and a centre for early detection and treatment of cancer

6.3.1.4 Other Government Health organisations.

As in other cities of Saudi Arabia, there are other government organisations and institutions providing health and medical care services to their staff and their dependants, and on a limited scale, to the public. These are as follows:

The National Guard delivers medical services to its staff and their dependants as well as to the public through King Khalid Hospital which is equipped with 310 beds. This hospital is run by 100 doctors, 525 nurses, 207 technicians and 263 civil employees. Admission for the public is made through health units belonging to the National Guard. After an initial examination patients who need further care might be referred to the hospital, which is situated 25 kilometres outside the city. This hospital provides a wide range of medical care including specialised care.

The second provider is the Ministry of Defence and Aviation, which has one huge hospital in Jeddah, but treats only members of the military and their dependants.

The third source of medical care is the King Abdulaziz University Hospital, which renders medical services to the university's staff and their families, as well as to the public. Essentially, this hospital is a teaching and training hospital for the Faculty of Medicine in King Abdulaziz University. Therefore, most of the staff and the providers of medical care in this hospital are lecturers, resident doctors or graduate students. The hospital provides primary and secondary medical care through in and out - patient clinics, and has a capacity of 234 beds to deliver in - patient care. This hospital is run by 157 doctors, 76 of which are Saudis, while 81 are non - Saudi Arabian.

Fourthly, the Ministry of Education has two school health units, to provide primary health care for students as well as other members of the Educational General Directorate in Jeddah. Doctors of these units sometimes visit schools to conduct general check - ups, or to immunise the students against diseases. Also, the General Presidency for Girls Education has one health unit in Jeddah to deliver health care and to refer students to the Ministry of Health hospitals for further care.

6.3.2 Private Sector:

The private medical sector in Jeddah is one of the oldest providers of health care in the country and larger than that in other cities. In recent years, this sector has witnessed a massive enlargement, in both hospitals and single clinics. The private medical sector in Jeddah exceeds all the other providers

of medical care, even the MOH, in terms of the number of facilities of all types and levels of medical care services. For instance, the MOH runs 12 general and specialised hospitals in Jeddah, while the private sector runs more than 26 hospitals, MOH delivers primary health care through 68 health centres, whilst the private sector operates 82 health centres. So, the private medical care sector in Jeddah flourishes. This section will outline some aspects of this sector.

6.3.2.1 Private Clinics:

The private clinics in Jeddah can be classified into general and specialised practice. The former are usually run by one general practitioner, who may be Saudi or non - Saudi, as the regulations of the MOH permit non - Saudis to practice, and a male or female nurse. In 1986, the number of these clinics was 41 and by 1987, it had increased to 53. These clinics usually operate from flats situated in residential buildings and it is a common to find several clinics working in one building. The specialised clinics are similar to the former in various respects, except that they provide all types of specialised medical care. Frequently, the providers of this type are consultants or specialists. In 1986, the number was 119, and the following year, it reached 133. There are also collective surgeries; a new phenomenon, in which a group of three or more specialists work together from one clinic to deliver several kinds of specialised medical care, usually integrated with each other, or for several doctors to provide the same type of medical care. The number of these clinics is modest, only 14 clinics, as it is a relatively new service. These clinics usually have diagnostic facilities such as laboratory x - ray and ultra sound, while the former two do not possess such facilities. Thus, they co - operate with external laboratories and patients are usually referred to private hospitals for x - ray or ultra sound scans.

6.3.2.2 Private Health Centres:

There are 82 private health centres in Jeddah. Table 6 - 4 shows the growth of this sector during the 1980s.

Table 6 - 4 Growth of Private Health Centres in Jeddah during 1980s.

Year	No. of Health Centre	No. of Doctor
1980	4	n.a *
1981	9	n.a *
1982	18	115
1983	20	192
1984	26	257
1985	31	268
1986	26	211
1987	52	360
1988	57	543
1989	64	606
1990	75	749
1991	82	751

* Number of doctors is not available because it was included with the total number of doctors who work in private hospitals.

Sources: Ministry of Health, Annual Medical Report; Ministry of Finance and National Economy, Statistical Year Book, various issues and unpublished Report by the General Directorate of Health Affairs in Jeddah.

Table 6 - 4 reveals several features. At the beginning of the decade, the number was modest. After a steady increase to reach 31 in 1985, the number reduced to 26 in 1986, because some health centres were expanded, and upgraded to hospitals. In 1987, the number doubled, and by 1991 had reached 82. The increase in these facilities reveals the strong demand for their services. It is a healthy phenomenon to have a large number of health and medical facilities, enabling the public to choose where to seek medical treatment, but when the two systems, public and private simultaneously coexist, without proper supervision and control, the profession becomes a matter of business rather than concern for the provision of high quality health care, because the field attracts many investors, who have no medical background. Therefore, the MOH, as the supervisor and reference body for health organisations in the private sector, must make periodic visits to these facilities and investigate them. People rarely complain about misuse or malpractice in these facilities, and rather than report any cases, they prefer to switch to other medical facilities in the private sector.

The majority of these health centres provide specialist and general medical care. However, paediatrics, gynaecology and obstetrics, general or internal medicine and dentistry predominate. Most of these health centres have diagnostic facilities, such as laboratory and x - ray facility. Usually, there are two female physicians to deal with women who do not want to be seen by a male doctor,

particularly in the case of gynaecologists or obstetricians, though some prefer to be seen by a man, so it is common to find two gynaecological and obstetric clinics, one run by a male and the other by a female.

6.3.2.3 Private Hospitals:

In the late 1950s, the first private hospital in the country was established in Jeddah, by Dr. Khalid Idress. It specialised in gynaecological, obstetric, and paediatric care. The latter clinic was run till the late 1970s by a Lebanese missionary nun. At the same time, another Lebanese hospital was opened, Al Mustashfa Al - Labnani, which provided a wider range of medical services. In the mid - 1970s this hospital closed.

In the late sixties several hospitals opened in Jeddah to provide a wide range of general and specialised medical care, and with the increase in oil revenues, along with the influx of foreign manpower, this sector blossomed till the number peaked at 26 in 1990. Also, a number of health care centres were converted to hospitals, with enlarged facilities, more staff and a wider range of medical care provision. The 1980s witnessed the rapid growth of hospitals in Jeddah. Table 6 - 5 shows the development of number of hospitals and bed capacity.

Table 6 - 5 The Growth of Private Hospitals and Number of Beds in Jeddah During the 1980s

Year	No. of Hospital	No. of Beds
1980	9	n. a *
1981	10	1,031
1982	11	1,201
1983	12	1,225
1984	13	1,296
1985	18	1,499
1986	19	1,784
1987	20	1,906
1988	23	2,252
1989	24	2,357
1990	26	2,281
1991	27	2,337

* Data not available,

Sources: Ministry of Health; Annual Medical Report; Ministry of Finance and National Economy Statistical Year Book, various issues.

Table 6 - 5 reveals the growth in the number of hospitals in Jeddah from nine in 1980 to 26 in 1991, an increase of more than 188 % during the decade. Also as a consequence, the number of beds increased considerably, more than doubling, from 1031 at the beginning of the 1980s, to 2,281 beds in 1990.

More than 90 % per cent of the private hospitals in Jeddah are accommodated in permanent premises which were purpose - built, thus they are well designed and facilitate service provision. Most of these hospitals are equipped with highly qualified personnel, mostly specialists or consultants from the Arab world, Western countries and from other countries such as Pakistan and India. Furthermore, these hospitals sometimes invite consultants specialising in a particular area of medical care to visit the country and to work for a short time, a month or so. The arrival of such specialists is announced in local newspapers and usually interested people have to book in advance before their arrival.

These hospitals possess sophisticated medical technology which enables them to provide advanced medical care, and to carry out delicate operations, which has resulted in a reduced number of patients seeking medical care in western countries. Moreover, the management and organisation of the services in private hospitals attracts many people who can afford to purchase such services. The appointment system makes access easier in the private sector, although in some specialised hospitals, it takes more than two weeks to see a doctor. Although the treatment in private care is expensive, many patients even from outside Jeddah, come to seek medical care in these facilities.

To conclude, Jeddah enjoys the provision of medical care services through more than one source, like many other cities in the country, but the distinguishing feature of Jeddah is that the private sector delivers a wide range of medical care. The health authority in the country overall has adopted a comprehensive PHC approach and its implementation in other cities has been relatively successful. Jeddah so far has shown far less promise of success in implementing of this approach than for example, Hail, Najran and Al - Baha. There are several reasons for this. Firstly, the PHC Directorate in Jeddah, which is a division of the General Directorate of Health Affairs in Jeddah, seems to be less interested in applying the approach in Jeddah, despite its success in smaller towns. Secondly, the existence of the private sector, with many facilities offering every type of service, may

handicap implementation, because many people prefer to go to the private sector. People see it as having better facilities and better communication with the medical personnel since medical personnel in the private sector usually give the patient more time in examination and diagnosis. Thirdly, administrative barriers may hinder the implementation of the programme. Fourthly, removal from one district to another makes continuity in receiving and benefiting from such facilities limited. Fifthly, the frequent changes in the personnel running the health centres reduces continuity of contact and communication with the beneficiaries.

This outline of the development of health service organisation and main characteristics of the health service facilities in Jeddah leads us to the empirical investigation of people's utilisation and attitudes toward the health services in Jeddah.

⁷ This was told by informants who lived in Makkah during that period.

⁸ Sponsor (qafil) usually refers to Saudis who provide employment to and legal protection for expatriate workers including the arrangement of entree visas and work permits.

CHAPTER 7 Methodology and Characteristics of Respondents

7.1 Introduction

This chapter will discuss the preparation for the field study, and will give an outline of the procedures that were undertaken in order to carry out this study. The choice of the study's site, the questionnaire design, the sample selection, pilot study, main study, difficulties encountered during the whole process and data analysis, will all be explained.

In most research the choice of methodology is determined by the nature of the study and the site of the study. Thus, the nature of the society in this study dictated the methods that were used to collect the data. Collecting data about developing countries is a nightmare, because on an individual level, people are not familiar with survey methods, while officials, for their part, put many obstacles in the way of the researcher. Some officials, because they do not want to help or participate in the research process, make excuses, claiming that this type of information is very sensitive, and therefore, they can not provide the researcher with any information. In addition, available information about many developing countries is scarce, as is well known among researchers.

7.2 Brief Background and Justification for Choosing the Study Site.

Jeddah was chosen as a study site, to investigate the provision and utilisation of health services, for several reasons: it is a cosmopolitan city; and within it, modern and traditional health service systems coexist: the modern medical system practised through both public and private sectors with different levels and specialities, and traditional medicine provided by traditional healers, who practise almost all types of traditional healing. Moreover, being a native of Jeddah, the researcher had already acquired some knowledge of the city and understanding of the people and the available health services, as well as their locations. Also, the social and cultural characteristics, and the city's social structure, were familiar.

Jeddah is one of the largest cities in the country, and because of its location, its people enjoy a good opportunity to come into social and cultural interaction with others, who visit the city for many purposes, such as work, pilgrimage (Jeddah is the gate to the holy city of Makkah), or to study in its university or colleges. These factors enrich Jeddah's culture and should widen the people's understanding and awareness of other cultures and lifestyles (see Chapter Six).

Jeddah's population embraces many of the socio-cultural characteristics of the population of Saudi Arabia as a whole since many people have come from different parts of the country, and different backgrounds, to work, study or take advantage of the many facilities available, particularly during the period of economic expansion following the oil price boom.

The 1960s and 1970s witnessed strong emphasis on expanding the delivery and coverage of health care services to rural, nomadic and peripheral areas, because the vast majority, 85 %, of the population of the third world live in these areas. During that time less attention was given to the health conditions in urban areas, particularly among slum dwellers.

Since the declaration of Alma - Ata 1978, most initiatives and literature relating to PHC have concentrated on health care and health services in rural and peripheral areas. This was not the result of the declaration itself, which emphasised that governments should incorporate and strengthen primary health care within the national development plans, with special emphasis on both rural and urban development programmes (WHO / UNICEF 1978). This recommendation was further reflected in the World Health Organisation's global strategy of " Health for All by the Year 2000", which explicitly emphasised urbanisation and its problems (WHO 1981b).

The subsequent discrepancy in attention given to urban and rural areas may be due to the fact that many have seen that cities have benefited disproportionately from the distribution of health facilities and resources, and have thus been deceived as to the difference in the general health conditions between urban and rural people. Cities impress inexpert visitors by their prestigious towers and commercial centres, but in the cities of the third world in particular, there are many slums and shanty areas where people have a low quality of life, and little access to social services, such as health care, education and social security.

For all these reasons, Jeddah was chosen as an example of one of the third world cities, to explore and report on delivery of health services, people's attitude towards and utilisation of health services in the city, in the hope that it would highlight some aspects of health service and problems in third world cities at least in the Arab world. Furthermore, since the implementation of PHC approach in Jeddah in the late 1980s, the approach has not yet been examined.

Recently, health authorities and planners have begun to recognise the importance of clients' attitudes towards the health service delivered. If they hold negative attitudes or are dissatisfied with the health services, there may be a need for reorganisation to remedy defects. This study therefore aims to explore people's attitudes towards the implementation of the PHC approach in Jeddah and their expectation of this approach, in the light of their utilisation of the general and special services provided by PHC centres.

7.3 Preparation for the Field Work

At the beginning of this study, official statistical data were collected concerning the health facilities in Jeddah, from the General Directorate of Primary Health Care Affairs. These data cover areas such as number of facilities, distribution, location and staff for each hospital and health centre. Some information regarding the private health sector was also obtained from the General Directorate of Health Affairs; other data were collected from the private health sector, through different sources. Many interviews and discussions were held with prominent figures and officials in both the General Directorate of Health Affairs in Jeddah and the General Directorate of Primary Health Care Affairs, also in Jeddah, particularly the technical and statistical departments. Also, discussions and meetings were held with some administrators and managers of PHC centres, as well as with some health personnel practising in these health centres, such as paramedics, clerks, receptionists etc. All these interviews and meetings were semi - structured, in that the interviewees were allowed to express themselves as they wished, but before any meeting or interview took place, a list of topics was prepared, which needed to be discussed, so if the researcher noticed that any of the scheduled topics was not discussed, he tried to direct the discussion towards that topic. In many cases, because the interviews were informal or arranged by personal contact, interviews were interrupted by members of the organisation staff, visitors, telephone calls or the need to handle clients' problems.

During the period of the main field work, a training course was held for the practitioners in the PHC centre. The researcher was allowed to attend some sessions of that course, which lasted for one week.

Visits were also made several times to most public general and specialist hospitals in Jeddah, so as to find out how they work with the PHC centre and how the referral system works.

Other governmental health organisations in Jeddah were visited to collect data on them, and to see who are their clients, the standards of health services and the relationships between them and the Ministry of Health's health facilities.

7.4 The Questionnaire.

The main instrument used to collect data for this study was the questionnaire, in two forms (written and oral). The former was distributed as a self - administered questionnaire; in the latter form, it was used as an interview schedule. However, other methods were also used, such as participant observation to help in collecting as much relevant data as possible, in order to have a wide perspective and knowledge.

The questionnaire is a useful means of collecting data but has to be adapted to the situation in which it is to be used. Thus, in societies where the level of illiteracy is high, it would be inappropriate to use a postal questionnaire for people to fill in themselves. It is preferable to administer the questionnaire in an interview situation.

Before designing the questionnaire, other survey questionnaires for studies that have been carried out in Saudi Arabia or elsewhere were examined.

One hundred and forty three questions were formulated for the questionnaire, to explore people's attitude towards the Primary Health Care Approach. The questions covered the respondents' socio-economic and socio - demographic characteristics, their attitudes towards the primary health care approach, their choice between private and public health sectors, their choice between traditional and modern medicine, utilisation of PHC centres, both generally and for specified purposes, level of health awareness, perceived nature of interaction between doctors and patients, and finally, the role of the media. A copy of the questionnaire, in its English version, is included in Appendix A.

7.5 Pilot Study

Before the field work was conducted, a pilot study was carried out, which took almost one month to be accomplished.

Prior to the fieldwork, the questionnaire was translated from English to Arabic. This was done in order to obtain successful responses from the subjects, since the majority of them were unable to communicate in English. After translation was done, copies of the questionnaire in both Arabic and English versions were given to experts in language in King Abdulaziz University to approve the

translation. Also, copies of the questionnaire were submitted to the Sociology Department in the same university. Their constructive comments and criticism were taken into consideration in finalising the questionnaire for the pilot study.

To gain access to the PHC Centres of Jeddah, the General Directorate of Health Affairs in Jeddah was contacted for permission. After permission was given, three contrasting PHC centres around Jeddah were selected for collection of samples. These health centres were selected for two main reasons. First, they were widely separated, one being in the north, the second in the centre and the third lying in the south of the city. Second, these areas were characterised by marked differences in the income and educational level of people.

The pilot study was carried out with forty respondents (including both males and females), from different socio - economic and demographic backgrounds. The sample of the pilot study were of two categories: registered and unregistered with the PHC centres. The pilot study's main objectives were to determine whether or not the questionnaire was clear and understandable in its wording and structure, and secondly, to find out whether the questions were socially, culturally and religiously acceptable. The pilot study revealed that some questions needed to be deleted and some others modified to be understandable. The most important change was the deletion of a number of questions relating to visits by PHC personnel, because it became apparent that no such visits had been made.

7.6 Data Collection

In order to measure people's attitude towards Primary Health Care, two categories of people were selected. These were :

I. Primary Health Care registered people who benefit from such services.

II. Unregistered people who try to seek medical care through some other sources, for example, the private sector. This category were included because they have been neglected in previous studies and because this study wanted to explore people's attitudes towards PHC approach among all categories of the population in Jeddah not only of those registered with the health centres. Moreover, there were questions concerning health awareness and health education as well as the use of health centres. Also, this study tried to examine the effect of mass media on patterns of behaviour. Thus, to

generalise from the results of this study it felt that it was necessary to include non - registered so as to make the sample more representative of the population as a whole.

Individuals in the first category was contacted at the Primary Health Care Centres.

The method used to select the sample in each case was to make a systematic random sample, taking as a starting point the first client, and every tenth client thereafter. This method was used for both samples, registered and unregistered. However, if the person concerned was under 20 years old, he or she was excluded and the next person selected instead. This was because the questionnaire contained questions related to child health care, and maternity care, of which respondents less than 20 years old would be unlikely to have knowledge. Moreover, sometimes it occurred that the person approached was reluctant to participate.

In some health centres, it was difficult to follow the systematic sampling system, because in some health centres, few people attended for health care. This also meant that the number of respondents was not equally divided among all the health centres.

People of the second category were interviewed by several means. If there was a private health clinic in the district, the respondents were selected from that health clinic, using a systematic random approach, but, if there was no health unit in the district apart from the PHC centre, the attempt was made to meet unregistered respondents at the largest mosque in the vicinity of the health centre. After prayers, individuals leaving the mosque were asked, outside, whether they were registered at a health centre, and whether they would be willing to be interviewed. In a similar way, approaches were made to people at the main entrance to a large supermarket.

Some non-registered respondents took the questionnaire with them to their home which necessitated contacting them at their homes but this caused some difficulty. Some of these people, moreover, responded in a negative manner, for instance: i) some were reluctant to respond if the man of the house was absent; ii) some felt that, since they received no benefits as such from the PHC, therefore it was not worth talking about it; iii) doubt was raised by some people, as to whether the study was part of a national Census. When assured it was not, they indicated that they were satisfied with the care provided by the private health sector, and that everybody could have better health care provided that they were ready to spend more money at private health clinics.

Obtaining access to female patients was one of the major problems encountered during this study. This was particularly due to the cultural influence, according to which it is considered unacceptable for a women to have direct communication with a male who is not a relative. An effort was made to overcome this difficulty by interviewing female patients through the mediation of other females (my sister and wife, who were specially trained for this purpose and instructed to follow the same procedures in selecting the interviewees). It was important to include women in this study because most of the previous studies did not include them, and because they are a very important subgroup of PHC centres users so their attitudes and satisfaction with the health services and the type of difficulties they experienced needed to be explored. Therefore it was necessary to include female in the sample.

Interviewing non-Saudis was a further problem. If they could not speak Arabic or English it was impossible to administer the questionnaire. Consequently, only Arabic and English speakers were interviewed, which meant that some nationalities were underrepresented.

For collecting the data the city was divided into two parts: old and new (see Chapter Six), and the data were collected from thirty two Health Centres around Jeddah; fifteen in the old part, fifteen in the new section of the city, and one which is divided into two parts (Bin Mallik); the district of Al - Muhamadyah was included as it has no health centre. The same procedures as for the pilot study were adopted to gain official permission from the General Directorate of Primary Health Care Affairs in Jeddah, to carry out the main study in different health centres in Jeddah.

Before interviewing any respondent or giving out any questionnaire, the nature and the aims of the research were explained to respondents. Also, they were informed that the research was not concerned with any government organisation, and would be used for academic purposes only. This was to relieve them of any responsibility and to encourage them to express their attitudes towards the public health services freely, without fear of any reprisals. After everything had been explained to the respondents and they had agreed to participate, the researcher read the questions to respondents and recorded their answers as they were given.

The length of the questionnaire itself created some difficulties in interviewing people, since many patients and their companions could not spare enough time. In most cases, however, a successful

attempt was made to persuade them to respond. If respondents wanted to fill the questionnaire by themselves, alone, without being interviewed, a copy of the questionnaire was given to the respondents after clarifying any misunderstanding and hence, the researcher's role in such circumstances was only to observe and wait in case any ambiguity emerged and explanation was requested. Some respondents preferred to take the questionnaire home with them to complete it and return it later to the health centre or for the researcher to collect it at their homes or place of work. In such cases, respondents were asked to give their address or telephone number if possible. The researcher tried as far as possible to interview individuals alone.

The researcher's work started at the health centre, which he attended from 9.00 a.m. until 1.00 p.m. and from 4.00 p.m. to 7.00 p.m., every day except Thursday, when there is a morning shift only. Registered respondents were met during these hours.

Non - registered respondents were met after 7.00 p.m. and on Thursday afternoons, when registered respondents had been dealt with. Because of the more limited opportunities for contact, the number of non - registered respondents was relatively small.

During the course of this study it was noticed that people seldom visited the Health Centres in Northwest. Choice was, therefore, concentrated mostly on other areas around Jeddah. In some other areas of the city, where the work- load was not heavy, much time was spent with the health personnel, discussing the PHC approach and their perceptions and expectations. Most interviews with clients were carried out in areas where the population density is very high and the work load very heavy. Thus, the number of the sample was not evenly distributed among the health centres, though there was an even balance between old and new districts.

Regarding sample size, this study conducted successful interviews with 289 registered and 65 non - registered respondents.

7.7 Data Analysis

After each day's fieldwork, the questionnaires for that particular day were coded. All the coded raw data were brought to Hull for further analysis and to use SPSS (Statistical Package for Social Sciences) for statistical interpretation. At this stage, however, a difficulty was faced due to "IF" questions which needed to be recoded. At the beginning, the Hull University Main Frame Computer

centre was used. The SPSS package for Windows was used, when it was introduced. Then, the data were consolidated.

The nature of the data (nominal or categorised) limited the researcher to using only those statistical tests most commonly used and applied in social science research. The data were analysed in terms of frequencies and percentages, and Chi - square technique was used to find out whether there were any significant relationships between socio - demographic or economic factors, and other dependant factors. A few open - ended questions and " other" stated questions were calculated manually and coded to calculate their frequency and percentage, which was also done manually.

7.8 Problems Encountered during the Field Work.

Some third world societies are not yet quite familiar with survey or research procedures. People living in such societies are, to a great extent, reluctant to co-operate or participate in any research, for various reasons. Information regarding matters such as income, age, women's working status, number of children, family size and their working status, is regarded as private. Some respondents were probably superstitious, and feared " eye envy", if they revealed information about their income and its sources, or number of children and family size. Women's working status is a sensitive issue for some people, as traditionally, women did not work, and many people still regard it with disfavour. Thus, if a daughter or wife worked, some men would not admit it, for fear of compromising their status as breadwinners. Others fear to express their actual attitudes or opinions towards any governmental organisation, because they do not want to have any responsibility or liability in front of any governmental bodies and they believe that the information they provide might be used against them. Some respondents thought that the researcher was a member of government staff, so they were keen to highlight issues which were unrelated to the research.

Some respondents think that the researcher is a member of the investigated organisation, and try to please him by giving what they think is the desired answer, particularly as they fear that any criticisms they make will be attributable to them and result in their receiving unfavourable treatment in future. Such people needed to be reassured, before they felt able to answer truthfully. Some respondents, when they find that research is for academic purposes, want to help the researcher and ask, what answer is the good one, so they can choose it in the hope that this will help the researcher

to pass his or her exam. All these answers affect the result and analysis of the data, though every effort was made in the present study to overcome such misapprehensions.

One of the difficulties encountered during the field work, was that many official health organisations ask for a formal reference letter to identify the researcher and introduce him and his topic to these organisations. Usually, any researcher should present such a letter from his / her reference organisation, i. e. his university, institute or the research sponsor's organisation. In the researcher's case, this was a major problem, because the General Directorate of Health Affairs in Jeddah at the beginning asked for such a letter, and if the researcher could not produce it, he would not be allowed to carry out the study. Because the researcher has no grant from any government agency, this was difficult and also raised some doubt and scepticism. However, through personal contact, the researcher succeeded in overcoming this problem, although it restricted his activities to limited numbers of public health organisations. For the private health sector, many means were used to get access: through personal contact, through private organisations which treat their employees and through individuals who have medical records with the hospital or the private health centre.

Another problem was encountered, that when the researcher wanted to gain some information from the files (medical records) of the health centres' utilisers, those files were not complete; some of them contained only partial personal information, for example with regard to socio - economic status. Other files were empty apart from the name and the number. Some others held some information written in a few lines, for only one or two visits. This reduced the reliability of the patients' medical records available at the health centres. This can be attributed in part to staff carelessness and the absence of inspection from the General Directorate of PHC Affairs in Jeddah, and also to the fact that implementation of PHC in Jeddah is comparatively recent. Over time, the situation may be expected to improve.

Having outlined the methodology used in conducting this study and collecting the data, we proceed in the following section to indicate the socio-economic and demographic characteristics of the sample.

Before we proceed to the description of the respondents' characteristics, it is worth mentioning that it was difficult to check how far the sample was representative of the population of Jeddah,

because there is no official statistical data to show the population structure of Jeddah. However, it is clear that the sample was biased toward males rather than females because of the religious and cultural considerations mentioned above. Non - Saudis were also underrepresented because of official restrictions on non - Saudi using the public health services and because of language difficulties with some non - Arabic speaking subjects who had to be excluded.

7.9 Demographic and Socio - Economic Variables

Socio - economic and socio - demographic factors are likely to have an important influence on the utilisation of health services and behaviour patterns of the utilisers. An understanding of who utilises these facilities may be of help in planning what services and facilities are needed, and also in identifying groups of non-users whose needs may need to be addressed, or who may be targeted in information campaigns. For these reasons, the study subjects' age, marital status, level of education, income, nationality, family size, types of housing, property ownership status, place of birth and occupation are discussed here. The following discussion of the socio-demographic characteristics of the sample will cover two groups, because the sample was drawn from two categories of population: those who were registered with and utilisers of the health centres, and those who were non-registered and non - utilisers.

7.9.1 Age:

Age is an important factor influencing the behaviour patterns of the utilisers of the health services. The age structure of the sample is shown in Table 7 - 1. The distribution of respondents reflects a common feature of the population structure in most developing countries in that the majority fall into the younger age - groups. Saudi Arabia is no exception. The birth rate is one of the highest in the world, because Arab culture tends to favour having many children.

Table 7 - 1 Distribution of Respondents by Age .

Age Category	Registered		Non-Registered		Total	
	No.	%	No.	%	No	%
20-30	80.00	27.70	12.00	18.50	92.00	26.00
31-40	121.00	41.90	31.00	47.70	152.00	42.90
41-50	59.00	20.40	20.00	30.80	79.00	22.30
51-60	24.00	8.30	2.00	3.10	26.00	7.30
Over 60	5.00	1.70	0.00	0.00	5.00	1.40
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	18.40	100.00	-	100.00

The age distribution of the respondents indicates that the largest group, 43 %, fell into the 31 - 40 years old category, while the second group, which accounted for 26 % of the sample, was aged 20 - 30 years. Hence, these two groups accounted for more than two thirds of the total sample in our study. 22.3 % of the sample population were aged 41 - 50, 7.3 % of the age 51 - 60, and the smallest percentage, 1.4 %, was contributed by elderly people, over 61 years old. This distribution largely reflects the population age structure of Saudi Arabia, where the majority (69 %) of the population are under 40 years old. Some recent studies showed a similar age structure to that found here, as reported by Al - Sanaaia (1983); Sebai (1984); El - Zahrany (1989) and Nur (1989). For example, Al - Sanaaia (1983), reported that 1.9 % of his sample were aged 60 and over; 6.6 % were 50 - 59 years old and 20.2 % were 40 - 49 years old.

Many studies have considered age in relation to the utilisation of the health services. It is presumed that the higher the age the greater the utilisation of the health services, since advancing age tends to be associated with certain diseases. While this is generally the case, in developing countries this does not mean that a high percentage of utilisers of the health services will be old, indeed most will not because of the young age structure of developing countries due to high birth rate and lower life expectancy, so that fewer people reach the age of 65 (see Chapter One).

Looking at the distribution of registered respondents by age in the same table, it can be seen that all age categories utilised the health centre, to some extent, and the distribution closely reflects the general pattern of the age structure of the population in developing countries, in that young ages account for the highest percentage of utilisers of health services. Some studies have attributed the high percentage of people under 40 years old using the services to the fact that they are of working age and therefore, have to take care of their health (Al - Khalifah et al. 1993), but in fact, this high percentage may reflect nothing more than the age structure of the population as a whole.

Health authorities should take into consideration the age structure of the utilisers in order to provide the health services they need; the needs of younger people are not the same as those of older ones. Furthermore, those who make less use of the available health services could be targeted for

encouragement to make use of the services and this would come as a result of further health education.

7.9.2 Gender:

The distribution of the sample in terms of their gender shows that the majority were male, constituting over 80 % per cent of the sample and almost 20 % were female. Table 7 - 2 below shows the gender distribution of the sample.

Table 7 - 2 Distribution of Respondents by Gender

Gender	Registered		Non-Registered		Total	
	No.	%	No.	%	No.	%
Male	227.00	78.50	57.00	87.70	284.00	80.20
Female	62.00	21.50	8.00	12.30	70.00	19.80
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	-	100.00	-	100.00

The high percentage of males in the sample reflects the fact that Saudi Arabia is a patriarchal society, where the man plays the central role in most activities. Men usually accompany their children to the health clinics. There are constraints on women travelling unaccompanied and women are not allowed to drive by the law. The low percentage of females in the sample can also be attributed to two other factors. One is that most of the health centres are run by male doctors and many women do not like to be seen by a male doctor. This finding has been reported in many studies, for example, Benyoussef and Wessen (1974), Mann (1989) and Nur (1989). The second reason is that for religious and cultural reasons, it is not easy for a male researcher to meet and interview women to whom he is not closely related. This was one of the difficulties reported above.

However, looking at the figures for registered and non - registered respondents, the table shows that the disparity between number of males and number of females is considerably larger in the non-registered category than the registered category, suggesting that the number of males who are not registered, is not simply a reflection of the general sample distribution. It may indicate that men are comparatively less inclined than women to use the health centres. This may indicate that they prefer to use the private sector, or that they make less use of health care in general.

7.9.3 Marital Status:

Table 7 - 3 shows the distribution of the sample according to their marital status. The majority of the sample, 86 %, were married. 11% were single or unmarried, 9 % divorced and there was only one widowed. The divorced and widowed categories could be included with the married, in the sense that they had at some time been married and all said they had children. Their utilisation of the health service facilities, like that of the married respondents, was often not for themselves, but to accompany a child or a grown - up son or daughter.

Table 7 - 3 Distribution of Respondents According to Marital Status.

Marital Status	Registered		Non-Registered		Total	
	No.	%	No.	%	No	%
Married	250.00	86.50	55.00	84.60	305.00	86.20
Single	30.00	10.40	9.00	13.80	39.00	11.00
Divorced	8.00	2.80	1.00	1.50	9.00	2.50
Widow	1.00	0.30	0.00	0.00	1.00	0.30
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	18.40	100.00	-	100.00

A similarly high percentage of married population in Saudi Arabia was found by many other researchers. For example El - Zahrany (1989) reported 96 % married; Al - Baz (1992) reported 76 % married and Nur (1989) reported 65 % married and 26 % single.

The high proportion of married people amongst the population in Saudi Arabia reflects religious teachings and Arabic culture, whereby the family is one of the very important social institutions in the society. Therefore, young persons are encouraged to establish a family, even while they continue to live in the extended family house. People in both urban and rural communities usually marry relatively young. However, the percentage of early marriage in rural and nomadic societies is higher than in urban, because women in urban societies are becoming increasingly eager to stay longer in education and enter the labour force.

The distribution found here is therefore expected in a country which favours early marriage, and where the divorce rate is very low. Unfortunately, although divorce cases should be registered with the court, no nation-wide statistical data are available, though it is known that the rate is still very low in comparison with other countries. Nur (1989) in a study carried out in three Saudi Arabian

communities, urban, rural and village, reported that only 2. 0% of his sample were divorced. Widows accounted for 6.7 % of 3332 subjects, and the rate was higher in urban than rural and nomadic communities. The relative increase in divorce rate in urban societies is attributable in part to the social changes that are taking place in the society which have notable impact on life - styles, including women's greater economic autonomy, and conflict between their roles as working women, mothers and wives.

The distribution found here for the married, however, may in addition to reflecting the marital status of the population as a whole, suggest that married people visit health centres and out - patient clinics more than the unmarried, who use in - patient clinics more than the married. Many studies have shown a higher percentage of unmarried people utilising in - patient clinics than out - patient clinics (Mckinlay 1973, Calnan 1983 and see Chapter Three).

Moreover, married people will utilise health services for antenatal and obstetric care, and for their children's health needs as well as their own. Thus, the high percentage of married population among the utilisers occurred for a number of reasons: they constitute the majority of the population; they make the most use of the health service facilities, either for themselves or their children; and they need different kinds of health services. For this reason, their attitudes, satisfaction, acceptance and opinions of the health services facilities are very important to any study of the utilisation of the health services.

7.9.4 Family Size:

Family size may be a very important factor in determining level of utilisation and satisfaction. Individuals with small families are less likely to make use of the health services, but it is more easy to satisfy them, because their needs are less than those of members of large families.

Table 7 - 4 Distribution of Respondents by the Size of the Family

Family Size	Registered		Non-Registered		Total	
	No.	%	No.	%	No.	%
2 - 4	43.00	14.90	13.00	20.00	56.00	15.80
5 - 7	136.00	47.10	38.00	58.50	174.00	49.20
8 - 11	86.00	29.80	10.00	15.40	96.00	27.10
11 - 13	20.00	6.90	3.00	4.60	23.00	6.50
More than 13	4.00	1.40	1.00	1.50	5.00	1.40
Total No.	289.00	-	65.00	-	354.00	-

It is seen from Table 7 - 4 that the predominant family size in this survey was 5 - 7 members; those constituted 49 % of the sample. The table shows that almost 16 % of the sample had 2 - 4 family members, 27 % had from 7 - 11 persons, 6.5 % had 11 - 13 members and 1.4 % had families of more than 13 persons.

Arabs in general like to have large families because in the old days this symbolised power as well as bringing in more income and providing extra hands to work in rural communities. Thus, the larger the family, the more powerful it became. The preference for large families still exists in contemporary Arab society. Another factor in large family size is that the extended family system still exists in Saudi Arabia. Some families still live together with their adult children and their grandchildren in one house, perhaps because the parents are getting old and need someone to look after them; or the son is the only child and therefore continues to live in the family home.

El - Zahrany (1989) found that 49.4 % of families had from 5 - 9 members, 34.7 % had 1- 4, and 16 % had more than 9 persons. In rural and nomadic communities, families tend to be larger. For instance, Al - Ribdi (1990) found that in the five communities he studied, 9 % of families had 1 - 2 person; 2 - 5 persons had constituted 17 % ; families of 6 - 10 persons were the majority (44 %); and 30 % had 11 or more family members. The differences between the findings of these studies may be attributed to the location of the studies and the types of community, as well as the differences in subcultures. Nur (1989) found the tendency towards nuclear families to be higher in urban than rural areas, it was 70 % in urban and 55 % in rural, while the overall average percentage of the nuclear families was 60 %.

The comparison between the two categories shows that those with larger families were more likely to utilise the PHC centre.

7.9.5 Number of Children

There is a correlation between family size and number of children in the family. As mentioned previously, families with more children are likely to need more health care and to utilise the health services more. This means that, in areas where there is a preference for large numbers of children,

more investment in health and education, i. e., more health centres, hospitals, health personnel, schools and teachers, are needed.

Table 7 - 5 Distribution of Respondents by Number of Children

Number of Children	Registered		Non-Registered		Total	
	No	%	No.	%	No	%
One Child	19.00	7.40	9.00	16.40	28.00	9.00
Two Children	48.00	18.80	9.00	16.40	57.00	18.30
Three Children	54.00	21.10	19.00	34.50	73.00	23.50
Four Children	57.00	22.30	11.00	20.00	68.00	21.90
More than Four Children	78.00	30.50	7.00	12.70	85.00	27.30
Total No.	256.00	-	55.00	-	311.00	-
%	82.20	100.00	17.70	100.00	-	100.00

As shown in Table 7 - 5, families with more than four children were the largest group represented in the study sample, constituting more than 27 % of the sample. Families with three children accounted for more than 23 %; families with four children represented almost 22 % of the sample. The percentage of families with one child was 9 %; most people in this category had been married only a short time. The pattern of number of children in this study reflects the common tendency in Jeddah in general. However, the number of children per family differs from region to region, particularly from urban to rural or nomadic areas. Nur (1989) showed different patterns in contrast between rural and urban areas.

The study found a strong relationship between women's working status and number of children. 14.5 % of the working mothers had more than four children, while for non-working mothers, the percentage was 31.5 %. For women with four children, the percentage among working women was 21.1 %, while for non-working women the percentage was 22.1 %. Working mothers with one child accounted for 11.8 % while for non-working mothers, it was 8.1 %. So, working women tend to have fewer children than non - working women. Many Saudi women are now finishing their education and entering into the labour force, delaying marriage and child - rearing. Moreover, when married, they tend to have fewer children, in order to be able to balance the time and attention needed in their two roles. Thus, increasingly, the size of the family and the number of children will be

decided by women's working status, which will have significance for the population growth in Saudi Arabia, and for the planning of social services, including health.

Returning to Table 7 - 5, families with four or more children are more likely to be registered with the health centre and to use the public services. Those with only one child appear less likely to be registered.

The number of children is an important indicator of the types of health services used and the services and facilities needed at the health centre. Children have special health needs because they are more vulnerable to contract diseases than the adults; and their health service needs are also different from adult needs, because of the particular ailments to which they are prone.

7.9.6 Nationality:

In Saudi Arabia, due to the shortage of Saudi Arabian manpower, the implementation of the ambitious development plans necessitates the presence of a high percentage of non - Saudi employers who work in various public and private sectors. These non - Saudis are of varying nationalities, and come from both developed and developing countries.

Table 7 - 6 shows the percentage of Saudis to non - Saudis. More than 79 % of the sample were Saudis, while only 21 % were non - Saudis. This reflects the overall distribution of population in Saudi Arabia, where the ratio is 4:1.

Table 7 - 6 Distribution of Respondents by Nationality.

Nationality	Registered		Non-Registered		Total	
	No.	%	No.	%	No	%
Saudi	231.00	79.90	49.00	75.40	280.00	79.10
Non-Saudi	58.00	20.10	16.00	24.60	74.00	20.90
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	-	100.00	-	100.00

Comparing this study's data with other studies, Al - Saania (1983) reported 60 % of his sample were Saudis and 40 % non - Saudis. El - Zahrany (1989) in Makkah, found that 80 % were Saudis and 20 % were non - Saudis, Al - Osimy (1991) in Riyadh, found that 70 % of those utilising the PHC centres were Saudis.

From Table 7 - 6, the comparison between registered and non-registered shows that non- Saudi respondents were slightly more likely not to be registered with the health centre. In general, most non - Saudis who use the health centres are those who are not covered by health coverage from their work. The Ministry of Labour and Social Affairs has stipulated that every firm, enterprise, or organisation employing more than twenty persons, should provide them with medical care, either within the company's private clinic, or by contracting with the private medical sector (see Chapter Four). This means that non - Saudis have limited access to the public health services. However, in the case of small firms or shops, who have just a few of employees, their employees can go to the public health sector. Also, all non - Saudis who work for the government are entitled to have access to the public sector.

Al - Baz (1992) reported that the Al - Riyadh Directorate of PHC was enforcing a rule that only Saudis and government employees should receive treatment in health centres. He asserted that the policy was implemented because the Health Directorate was under pressure from owners of private clinics and hospitals to force non - Saudi workers to purchase health services from the private sector.

Al - Khalifah et al. (1993) found that citizens of North Yemen, Egypt, Syria, Palestine, Pakistan, Jordan, Turkey, Bangladesh, Eritrea and the Gulf States are more frequent utilisers of the public sector, whereas those from Lebanon, South Yemen, Philippine, Somalia, Western countries and certain other Asian countries were more likely to use the private sector. In fact the former have the right to utilise public health services, while the latter do not; therefore, they go to the private sector. All non - Saudis in this study were Arabs from Sudan, Egypt, Yemen (North and South), Somalia, Syria , Palestine, Lebanon and Jordan. Other nationalities were not interviewed because of the language barrier. The researcher found it difficult to communicate with people who did not speak good Arabic or English.

7.9.7 Place of Birth:

The place of birth is a good cultural indicator. Within a country there is cultural diversity among communities. People who live in a city enjoy more of the social and economic development activities than those who live in rural or remote areas. Therefore, their attitudes toward many social services

and activities are somewhat different from those of their rural or nomadic counterparts, who live in communities with less communication with the outside world (Benyoussef and Wessen 1974). Urban populations are, to some extent, expected to have different attitudes and practice towards modern health care, although the spread of education in Saudi Arabia has attempted to close the gaps among the various communities in the society. Nonetheless, some Saudis, even with high levels of education, still hold a tribal mentality and attitudes towards many aspects of social life. Thus, place of birth may be an important factor in health attitudes and behaviours.

Table 7 - 7 Distribution of Respondents by Place of Birth

Place of Birth	Registered		Non-Registered		Total	
	No	%	No	%	No	%
Urban	221.00	76.50	53.00	81.50	274.00	77.40
Rural	68.00	23.50	12.00	18.50	80.00	22.60
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	-	100.00	-	100.00

Table 7 - 7 shows that more than 77 % of the respondents had urban backgrounds, i.e. , were native to Jeddah or had immigrated to it from another city or village. Almost 23 % of respondents stated that they were born in rural areas and immigrated to Jeddah to live and work. The majority of Saudis who live in Jeddah now consider themselves as natives of the city. However, because the result of the general census has not yet been published, it is not certain what is the social structure of Jeddah's population as a whole, in terms of urban, rural and nomad, though it is very likely that some localities are dominated by population of one type of background, e. g. rural or urban.

The place of birth or the background of the utilisers may have some influence on patterns of behaviour towards the health care services. It seems from Table 7 - 7 that those of urban background may have been more likely to opt for the private sector, than those of rural social background, who were more inclined to utilise the public health service.

The effect of rural or urban background has been reported in other studies, for example, Benyoussef and Wessen (1974), found that the ratio of rural to urban population using the health services was 1: 2.

7.9.8 Education

The distribution of the sample in relation to their level of education shows that a high proportion of the respondents have some kind of formal education. Before interpreting and commenting on the result in Table 7 - 8, a brief explanation of the Saudi education system is necessary. Formal education in Saudi Arabia is started at age six years. A child at this age is enrolled in a primary school for six years; then goes to an intermediate school for three years; after that to secondary school for another three years; then university or college. However, there are also some people who have not acquired any type of formal education, though they can read and write. Another group who have a great deal of knowledge, particularly in Islamic studies, acquired their learning from traditional sources such as Qura'nic education circles. This group of people cannot only read and write but may actually be teachers or scholars in their own field. However, because they do not hold any official degree they classify themselves and are classified officially as " can read and write". For purposes of analysis and statistical interpretation the educational status of the respondents was categorised into four categories: low education includes illiterate, can read and write and those with primary school (six years) education only. Thus, the " read and write" category includes those with little education of any kind, and those with extensive but non - formal education. Intermediate encompasses those who have finished nine years of education; secondary, those with twelve years and high education includes those who had been to tertiary institutions: junior college; technical colleges, where teachers are trained and paramedical personnel are produced; or university.

Table 7 - 8 Distribution of Respondents by Level of Education

Level of Education	Registered		Non-Registered		Total	
	No.	%	No.	%	No	%
Low	62.00	21.50	8.00	12.30	70.00	19.80
Intermediate	69.00	23.90	11.00	16.90	80.00	22.60
Secondary	110.00	38.10	27.00	41.50	137.00	38.70
High	48.00	16.60	19.00	29.20	67.00	18.90
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	18.40	100.00	-	100.00

Table 7 - 8 shows that almost 20 % of respondents had a low level of education; more than 22 % had intermediate schooling; almost 39 % had secondary schooling and 19 % had received higher education .

It is somewhat surprising that only 20 % of the respondents reported a low level of education, since there is a high level of illiteracy in Saudi Arabia. However, this applies more in rural and nomadic remote areas, and more among females than males. Moreover, due to the high status now given to education and the increased level of enrolment in formal education, the level of illiteracy is decreasing. Al - Saania (1983) found that the percentage of people with low level of education was 34.4 % and with an elementary education was 15.8 %; 16.2 % and 16.9 had intermediate and secondary level schooling respectively; those with higher education (university level) constituted 16.3 % of his sample. In another study, Nur (1989) reported that among males, 76 % had attended at least 8 years of education; the proportion for females was 56 %. The illiteracy rate was 24 % for males and 44 % for females, over the three communities of study, but in the urban community, the rates of literacy were 91 % for males and 76 % for females. All three studies seem to indicate that there is a relationship between education and utilisation of health services.

Table 7 - 8 shows that among both registered and non-registered respondents, the largest group was those with secondary education. However, among the registered respondents, the smallest group was those with high education, while among the non-registered it was those with low education. It may be that those with higher education were more likely to use private services, particularly as education may well be related to income. Al - Khalifah, et al. (1993) found that utilisation of private services increased with education.

Nonetheless, the majority of utilisers of the PHC services had some kind of formal education (consistent with De Kadt 1983 and Skeet 1984), which confirms the importance of education in promoting the nation's health, and also implies that it is possible to use written materials of various kinds to spread health education, which will increase the health awareness among the population.

7.9.9 Occupational Status:

The occupational distribution in Saudi Arabia is very interesting, being linked with the economic and social changes taking place in the country. The change in occupational status is in parallel with

the improvement in social and economic status of the country. Since the discovery of oil in commercial quantities, new types of job have been created.

Table 7 - 9 Distribution of Respondents by Occupational Status

Occupation	Registered		Non-Registered		Total	
	No.	%	No.	%	No	%
Employed	224.00	77.50	56.00	86.20	280.00	79.10
Self - Employed	29.00	10.00	7.00	10.80	36.00	10.20
Jobless	6.00	2.10	0.00	0.00	6.00	1.70
Housewife	30.00	10.40	2.00	3.10	32.00	9.00
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	18.40	100.00	-	100.00

Table 7 - 9 shows that the respondents of the questionnaire were from various occupational categories. 79 % were employees in both public and private sectors; self - employed and businessmen constituted 10 % of the sample; jobless or unemployed represented a very small percentage, only 1.7 % and 9 % were housewives. Regarding the percentage distribution of employees between the two sectors (not shown in the table), 72 % were public employees and 27.9 % private sector employees. The self - employed category covers many occupations ranging from running a shop to work in services sector such as plumbing, carpentry, or taxi driving.

Comparing with other studies, Al - Saania (1983) found 33.4 % of the sample were public employees; 5.4 % private employees and 30 % were self - employed. The jobless percentage was 1.2 %. Al - Ribdi (1990) reported that 34.3 % were public employees; 11.2 % private employees and 28.7 % self - employed. However, El - Zahrary (1989) reported, in his study in Makkah, that most utilisers of the public health services were government employees who constituted 44 % of the sample; 25 % were self - employees, including businessmen and workers; the proportion of unemployed was reported at 7.5 %, 9.3 % were businessmen and 15.7 were labourer (workers).

The high proportion of employed respondents who were not registered with the health centre and thus did not use the public health services may be due to the fact that many large corporations and semi-governmental organisations provide some medical coverage for their employees. Naturally, those who were jobless would tend to utilise the public service, because it is free. Al - Khalifah et al. (1993) found similar results, that the jobless were less likely to visit the private health sector;

housewives were more likely to visit the public health service than private, and employees were more likely to use private than public services.

7.9.10 Income:

Income may be a crucial factor in determining the utilisation of health services. Those with higher incomes are expected to be more likely to use private sector health care. However, income is a matter on which people are often reluctant to give exact information, because they are afraid of envy or they do not want to disclose their economic status. Some who fear envy report a lower income than they actually receive. Therefore, to avoid any embarrassment and encourage response, income was categorised into six broad categories. But for statistical analysis these categories were reduced to three groups, as shown in Table 7 - 10.

Table 7 - 10 Distribution of Respondents by Income in SR.

Income in Saudi Riyals	Registered		Non-Registered		Total	
	No.	%	No.	%	No.	%
Low *	191.00	66.10	18.00	27.70	209.00	59.00
Middle +	85.00	29.40	34.00	52.30	119.00	33.60
High @	13.00	4.50	13.00	20.00	26.00	7.30
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	18.40	100.00	-	100.00

* Less than 5,000 SR. + from 5,000 - 9,000 SR. @ More than 9,000 SR.

The distribution of the sample in relation to income shows that the largest proportion (59 %) of the sample, were of low income, more than 33 % had middle income and 7.3 % indicated that their income fell in the high income category. The table shows that more than 66 % of the utilisers of the PHC centres fell in the low income category, whereas the majority (52.3 %) of non-registered were of middle income.

The income distribution shown here suggests that public health service utilisers in Saudi Arabia are more likely to be of low income, as many studies have shown. For example Al - Ghamdi (1981), Al - Sanaaia (1983), Nur (1989), El - Zahrany (1989), Al - Osimy (1991), Al - Baz (1992) and Al - Khalifah et al. (1993). As with education, it is expected that those with higher income will be more likely to seek health care. However, they will not necessarily use the public health services. People with a high level of income may be unprepared to wait for a long time at the public health

services, since they have the means to purchase private care. This does not mean, however, that they never use the public health services.

7.9.11 Type of Housing:

Table 7 - 11 reveals that 11.6 % of the respondents stated that they lived in villas, while the majority, 63.8 % , indicated that they lived in flats and 24.6 % lived in Arab houses. The three categories need some clarification. " Arab house" is a term which can cause some confusion to researchers, because some consider the Arab house to be one built of mud in the traditional way, while others use the term to apply to any house that is neither a flat nor a villa. Such houses are usually made of concrete but in a similar style to the older mud house. This type of housing is usually occupied by one (generally extended) family. Villas are mostly built in Jeddah's new districts, while the Arab house is usually in older districts of the city, though a few exist in some new districts.

Type of housing is one of the socio - economic factors that to some extent indicates the general physical environment, which may have health implications in terms of ventilation, light, sanitation, level of crowding and so on. Therefore, families living in villas which are well - ventilated, light and spacious have an advantage, in health terms, over those who live in an old traditional Arab house in a crowded area, where light, sun and air penetrate into the house only with difficulty.

Table 7 - 11 Distribution of Respondents by Type of Housing

Type of Housing	Registered		Non-Registered		Total	
	No	%	No	%	No	%
Villa	31.00	10.70	10.00	15.40	41.00	11.60
Flat	179.00	61.90	47.00	72.30	226.00	63.80
Arab House	79.00	27.30	8.00	12.30	87.00	24.60
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	-	100.00	-	100.00

The majority of the PHC utilisers, 61.9 % , lived in flats, 27.3 % lived in Arab houses and 10.7% lived in villas, whereas among non-utilisers of the PHC centre, more than 15 % lived in villas; more than 72% in flats and 12 % in Arab houses. The greater tendency of Arab house dwellers to use the public services may be because they would be likely to be in the lower income categories. Those living in a villa may be more able to afford private care. These findings are similar to those of

previous studies. For example, Al - Saania (1983) reported that the majority, 55.1 %, lived in flats, while 39.5 % of his sample lived in Arab houses. El - Zahrany (1989) found that 11.6 % lived in villas 55.3 % lived in flats and 29 % lived in Arab houses. Al - Ghamdi (1981) in his study in Jeddah, found a slightly different picture, most of the public health centre clients in Jeddah were residents of Arab houses (61.9 %); flat residents constituted only 30.2 % and villa dwellers, 3.7 %. The differences between my findings and these of Al - Ghamdi may be attributable to the expansion in housing and the improvement in the state's economic situation since the time of his study.

7.9.12 Property Ownership

Table 7 - 12 shows the ownership of the housing and it reveals that 53 % of the respondents stated that they owned their property, while almost 47 % indicated they lived in rented houses or flats. Other studies had slightly different findings regarding patterns of residence. Al - Saania (1983), for example, reported that 40 % of his sample owned their property and 59 % rented. In a large city investment in housing is a very good business, because many of the dwellers are not permanent residents. All non - Saudis live in rented properties, because they are not legally entitled to own property. Al - Ribdi (1990) reported that more than 75 % of his sample indicated that they lived in owned property and only 16 % of the respondents said that they lived in rented houses. This is because his study was carried out in small communities in Al - Qasim region, where the majority of the population had their own houses, either old family property or built with the aid of government loans.

Low proportion of respondents have their own property because some Saudis if they are not of Jeddah native they may have their permanent resident in their cities, towns or villages.

People who live in owned property (55 %) and are registered with the health centre will keep visiting the same PHC centre, and their medical records will be up- dated as long as they keep visiting and the health centre is not transferred to other premises. People who live in rented houses (45 %) are more likely to move from one district to another, where they may register with the local PHC centre as a new client, with new information. This is a waste of time and money. This occurs because there is no co-ordination between the PHC centres in this respect. It is left to the utilisers to realise the

importance of keeping medical records and transfer them to the PHC centre in the new place of residence.

Table 7 - 12 Distribution of Respondents By Property Ownership

Property Ownership	Registered		Non-Registered		Total	
	No	%	No	%	No	%
Owned	159.00	55.00	29.00	44.60	188.00	53.10
Rented	130.00	45.00	36.00	55.40	166.00	46.90
Total No.	289.00	-	65.00	-	354.00	-
%	81.60	100.00	-	100.00	-	100.00

7.10 Conclusion

This chapter has outlined the methodology used to carry out this study. Reasons for choosing the site, the instrument used to collect data, techniques used for selecting the sample and for collecting and analysing the data, have all been described.

Having discussed the methodology, it was necessary to present a description of the socio-economic and demographic characteristics of the sample. The findings reflected the predominant patterns of age structure in most developing countries in general, where young ages predominant, while there are fewer elderly people. More married people were included than unmarried, again reflecting the high proportion of married population in Saudi Arabia, since it is culturally desirable to get married at an early age, for both males and females. The predominant family size was of 5 - 7 persons per family, which in most cases would be a nuclear family, with four children and their parents.

Regarding gender, it can be said to some extent the study was biased in this respect, i. e. the majority of the sample were male. This is because of the difficulty of gaining access to female respondents for non-related male researcher. An attempt was made to overcome this problem, but it was not possible to enlist equal numbers of both sexes. This problem could be overcome if a joint study were carried out by both male and female researchers.

The findings show that most of the health centre registered were of low income. Regarding occupational status, the majority, 79.1 %, were employees in the public sector, few self-employed and housewives. As it is known that the public sector does not provide any health care for its

employees, it is unsurprising that the majority of the health centre utilisers were employees in the public sector. Regarding type of housing, it was found that the majority of the sample live in flats and this is consistent with other recent (but not earlier) studies as mentioned above. Property status indicated that more of the registered owned their accommodation, which implies that changes of address are less likely, so their registration with the health centre and interaction with the health personnel will be more stable and intimate than if they moved from one area to another.

A general implication of this pattern of socio - demographic and economic characteristics is that in Saudi Arabia, as in many developing countries, health care provision must meet the particular needs of a youthful population. The high proportion of married people registered means that maternity care should be available at every health centre, as indicated theoretically in the Alma - Ata Declaration. In Saudi Arabia, health policy has emphasised the importance of maternity care and its availability in every health centre (see Chapter Nine), an approach justified in view of the findings of this and other studies, regarding socio - demographic characteristics.

The large proportion of utilisers of the health centre reporting a low monthly income is a typical pattern; low income people usually tend to use the public sector. Low income is often associated with low level of education. People with low levels of income and education will be less likely to be in a position to participate in or influence health policy, though they are the main users of the public services.

Nationality is very important. Many Saudis complain of the extent to which the public health services are used by non-Saudis, although there are some restrictions to limit the number of non-Saudis. The findings of this survey revealed that the majority of the utilisers were Saudis and with low income.

Number of children suggested that the more children there are in the family, the more likely it is that the family will use the health centre. This implies that, like maternity care, paediatric care must be available at every health centre.

Having outlined the methodology used and the socio - economic and demographic characteristics of the sample, we now turn to the people's attitudes and knowledge about PHC approach and their actual utilisation of the PHC centre. First, the following chapter will discuss the

general use of the PHC centre, while chapter 9 will be concerned with special use of the health centres.

CHAPTER 8 Attitude Towards and Knowledge About PHC and The General Use of the Health Centres:

8.1 Introduction

Previous chapters have discussed and outlined the main characteristics of the health services and the policy in Saudi Arabia in general and in the study site in particular. Data obtained in the empirical study will be presented and interpreted in this and the following chapters. This chapter is divided into two main sections. The first covers the respondents' attitudes towards and knowledge about PHC and the second discusses the general utilisation of the health centres in Jeddah. Data analysis in this chapter will use in the first section the whole sample (354) while in the second section the general use of the health centre will be confined only to the registered (289) with the health centre.

8.2 Attitudes Towards PHC Approach

This section will discuss some aspects of people's attitudes towards the PHC approach; their expectations and types of difficulties facing them. In the discussion which follows in this and subsequent chapters, a set of questions concerning aspects of attitudes and behaviour will be discussed, either correlated with socio - economic and demographic characteristics of the sample or correlated with each other, to find the effect of attitudes on behaviour and / or the effect of behaviour on attitudes. The relationship between attitude and behaviour is reciprocal; both of them influence the other. Attitude orientates the individual's behaviour, while the behaviour forms people's attitudes towards other aspects.

8.2.1 Knowledge of the PHC Approach.

Since the start of implementation of PHC in Jeddah the General Directorate of Health Affairs, represented by the General Directorate of PHC Affairs, has been trying to establish a health centre in almost every district in Jeddah. However, there are still a few districts with no health centre and the population of such districts go to seek medical treatment in the nearest district. Despite the existence of PHC centres in most districts, a few respondents (less than 6 %) did not know about the PHC approach at all, and were confused between PHC as a new approach towards delivery of health care services, and the already existing health centres. Table 8 - 1 shows the means through which people learnt about the PHC approach.

Table 8 - 1 Distribution of the Respondents in Relation to the Means by which they learnt about PHC approach.

Means	Frequency	%
TV	251.00	70.90
Radio	56.00	15.80
Press	158.00	44.60
Friends	124.00	35.00
Relatives	101.00	28.50
Others	60.00	16.90
Total questioned = 354 Multiple Responses		

Multiple responses are calculated by dividing the total frequency of each item by the total number of respondents who answered that question and then multiplying the result by 100 to give a percentage.

Table 8 - 1 reveals that TV was the main channel through which people found out about the PHC approach; 71 % or 251 of respondents indicated that TV was the main source of their information. Newspapers accounted for more than 44 % because for a limited time, an introductory campaign about the PHC programme was carried out through newspapers, magazines and other mass - media. A further 35 % received their information about the programme through their social and personal contacts with friends in work or social gatherings; while 28.5 % of the respondents knew about the approach through personal contact with their relatives; only a few respondents (15.8 %) learnt about the PHC approach through radio. Less than 17 % of the respondents indicated "others". These other sources included through a visit to a general hospital, when they were asked to contact the PHC centre in their districts and come through the referral system; through the annual health campaign; through leaflets distributed during the annual health campaign; from their children's school, and through a visit to a health centre for child vaccination.

There are a number of reasons behind the domination of TV as a source of information. It is a main source of entertainment, and links the viewers with the outside world through its programmes and news desk, so, it attracts a large proportion of the population. This suggests that careful utilisation of TV, particularly in the health field, would help to improve health awareness and conditions through health education. Newspapers and magazines were also an important source of information, so health messages through the printed media would also help to motivate people to adopt particular patterns of behaviour.

Comparing with recent studies, Al - Abdulatif (1989), found that 67 % of the respondents indicated that TV played a strong role in improving health awareness. Al - Mubarak (1989) found that 73.3 % of his sample got their health information through TV; 36.7 % by newspapers; 35.8 % through radio and 22.5 % from their friends and relatives together.

An attempt was made, using cross - tabulation, to determine whether there were relationships between the respondents' socio-demographic characteristics and the most effective means used in introducing the PHC approach. The findings revealed significant relationships with three socio-demographic characteristics: level of education; gender and social background. Table 9-2 summarises the relationships between level of education and source of information.

Table 8 - 2 Means of Learning about the PHC Approach by Level of Education

Means	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
TV *	81.40	78.80	65.00	62.70	251.00	70.90
Radio	14.30	12.50	13.90	25.40	56.00	15.80
Press @	24.30	48.80	48.90	52.20	158.00	44.60
Friends	42.90	33.80	30.70	37.30	124.00	35.00
Relatives +	41.40	23.80	25.50	26.90	101.00	28.50
others	24.30	17.50	15.30	11.90	60.00	16.90
Total No.	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.60	18.90	-	-

* Chi-square = 10.68206 D. F. = 3 Significance = .01358
 @ Chi-square = 14.85640 D. F. = 3 Significance = .00194
 + Chi-square = 7.29655 D. F. = 3 Significance = .06302

Table 8 - 2 reveals that there were significant relationships between level of education and three sources: TV, press and relatives. The higher the level of education, the less likely the respondent was to have obtained information through TV, and the more likely to have obtained it from newspapers. Relatives were more important as a source of information for those with low education, than others.

Gender was the second feature that showed relationships with the means used to introduce PHC. Significant relationships were found for two means: TV and friends. It appears that more females than males obtained information from TV. Friends also played a role in spreading the information about the approach, again more among females than males.

Table 8 - 3 Means of Learning about the PHC approach by Gender.

Means	Gender %		Total	
	Male	Female	No	%
TV *	66.90	87.10	251.00	70.90
Radio	15.50	17.10	56.00	15.80
Press	45.40	41.40	158.00	44.60
Friends @	32.00	47.10	124.00	35.00
Relatives	26.40	37.10	101.00	28.50
Others	16.50	18.60	60.00	16.90
Total No.	284.00	70.00	354.00	-
%	80.20	19.80	100.00	-
* Chi-square = 11.15300 D. F. = 1 Significance = .00084 @ Chi-square = 5.62676 D. F. = 1 Significance = .01769				

The third socio - demographic factor which showed a relationship with the means of knowing about the approach was social background. There was a significant difference between urban and rural population in obtaining information from TV. Table 8 - 4 summarises the chi-square result.

Table 8 - 4 Means of Learning about PHC Approach by Social Background.

Means	Social Background %		Total	
	Urban	Rural	No	%
TV	67.90	81.30	251.00	70.90
Total	274.00	80.00	354.00	-
%	77.40	22.60	-	-
Chi-square = 5.36274 D. F. = 1 Significance = .02057				

People with rural backgrounds were more likely to have TV as their main source of their information and news, because when they were in their place of origin, they had limited sources or access to the outside world, and TV and radio were the more dominant means. Thus, it is not surprising that they indicated that TV was the main source that informed them about the implementation of the PHC approach.

8.2.2 People's Expectations

Data were also collected to find out about people's expectation of the implementation of PHC approach. In general, positive attitudes were held towards the approach. 79.4 % or 281 of the

respondents expected that the implementation of PHC approach would improve the health situation and provide better health services, while only 19.2 % indicated that the implementation of the PHC will not bring any changes in the delivery of health care services, or in the population's health conditions. Only 1.4 % had no idea.

Table 8 - 5 summarises the main responses of the people who had positive attitudes towards the PHC approach and expectations of it. The responses were calculated on a multiple response basis; that is, every respondent was allowed to choose more than one answer. Therefore, the total responses reached 1,166. These responses reflected people's optimism about the PHC approach and allocation of health centres in each district.

Table 8 - 5 Distribution of Respondents by Opinions about PHC Approach

Index	Frequency	%
It provides easy access to health care	180.00	50.80
It works on community involvement	79.00	22.30
It meets basic health needs	155.00	43.70
Every resident will have a medical profile	250.00	70.60
Its geographical distribution eases its utilisation	225.00	63.50
It meets the lay person's health needs	105.00	29.60
It improves the interaction between patients and doctors	145.00	40.90
Other	27.00	7.60
Total Questioned = 354 Multiple Responses		

It can be seen from Table 8 - 5 that having medical records was associated with approval of the PHC approach, by most people. 70.6 % or 250 of the respondents believed the implementation of the PHC programme will improve health conditions because it offers every resident a medical profile which will help to accelerate diagnosis and aid prescription of the appropriate medication; more than 63 % of the respondents expected the approach to improve the quality of health care services because geographical distribution will make it easy to benefit from the health services; while 50.8 % of the sample believed the PHC approach will provide easy access to the health care services for every individual in the society. Further, more than 43% thought the approach will meet at least the basic health needs of every district. Almost 41 % of the respondents considered the approach will provide a good opportunity of interaction between the providers and receivers of the services and this

would lead to a mutual trust between patients and doctors. In fact, this is one of the core elements of the PHC approach - trust and interaction.

However, only 29.6 % or 105 of the respondents expected the programme to meet the ordinary person's health care needs. This relatively low percentage can be understood in the context of the current situation of many of the health centres, which suffer from acute shortages of equipment and health personnel (to be discussed below). Such factors undoubtedly would contribute to a low perception of the current PHC centres and their ability and capacity to satisfy the needs of individuals. In fact, more than 75 % of the respondents indicated that they were not satisfied with the health services that were delivered by the health centres at the time of carrying out this study.

7.6 % of the respondents indicated that the implementation of the approach also has advantages other than those listed. They suggested the PHC centres will save time and money because the treatment takes place where patients live, so there is no need to go to hospital or spend money on transportation; PHC centres will reduce dependence on private hospitals which have become commercial institutions; they avoid crowding at the hospitals; they will lessen the pressure on the public hospital services, which will give consultants time to provide better services; PHC approach helps the poor and the needy, and offers them access to the health care services. Some respondents thought the allocation of a health centre in each district would encourage people to visit health centres either generally or in an emergency. Others emphasised that health centres provide an answer to the increasing cost of medical services.

The people with negative attitudes towards PHC were not necessarily disputing the philosophy or policy of the approach, but reacting to unpleasant experiences with the health personnel or the fact that the present reality of the health centre did not match their expectations. However, there were various views. Some were based on actual contact with the health centre, while others were in part due to the comparison between health centre capacity and the out - patient clinics in any public general hospital or private hospital. Some of these negative views concerned the crowding in the health centres; the bureaucratic procedures in opening medical records, tendency to treat everything with the same pain-killer, and the fact that rather than being a first contact which facilitates the

utilisation of the health services, health centres were becoming gate - keepers to filter people who would or would not to go to hospitals.

An attempt was made to find out whether there were significant relationships between various attitudes including modern medicine, folk medicine, referral system registration, satisfaction and certain questions such as PHC approach will provide a health coverage for all the people or it will meet the lay person's medical needs. Also another attempt was made to find whether there were statistically significant relationships between behavioural questions such as utilising maternity care, child vaccination, use of dental care and these two questions such as the PHC approach will provide a health coverage for all the people or it will meet the lay person's medical needs. However, the cross - tabulation did not reveal any significant differences.

Respondents were asked to express their opinions on particular statements that are frequently repeated among the people about the provision of the health care through PHC centres.

Table 8 - 6 Distribution of Respondents' Opinions about PHC coverage.

Scale	Frequency	%
Strongly Agree	91.00	25.70
Agree	136.00	38.40
Disagree	72.00	20.30
Strongly Disagree	46.00	13.00
Do not know	9.00	2.50
Total	354.00	100.00

Table 8 - 6 reveals that more than 38 % of the respondents agreed with the statement that the PHC approach will provide health coverage for all the population and improve their access to the other public health service facilities, and almost 26 % expressed strong agreement with the statement. However, more than 20 % of the respondents were somewhat pessimistic, disagreeing with the statement and 13 % strongly disagreed with the idea. These two categories together accounted for more than 33 % of the total respondents. These negative opinions may reflect the failure of PHC centres to carry out activities to inform and educate the population, and to change the common image people already had about the public health services. The health centres might attract more people and

build a positive image by organising lectures and seminars and generally improving communication with utilisers, through different means of communication. Other reasons for pessimism include the impression that the health centres are filters or barriers to determine who can use the other health facilities. Furthermore, many of the health centres are considered to lack equipment and staff, and are viewed as first - aid posts, free dispensaries, or vaccination centres.

The crosstabulation of respondents with regard to whether the implementation of the approach would improve the health condition of the people and would provide easy access to other health service facilities (Table 8 - 7), indicated that less than 32 % of those who believed the implementation of the approach would improve the health condition, strongly agreed that the approach will provide health coverage for all the population and improve their access to other public health services. Of those who did not think that the implementation of the PHC approach would contribute to the improvement of the health conditions, more than 42 % stated that they strongly disagreed with the idea that the approach would provide health coverage for all the population and simultaneously would ease access to the other facilities. Those who did not know or were undecided, were very few in number; thus, they had no influence on the overall responses.

Table 8 - 7 Opinion about PHC Coverage by Expectations of PHC

Opinion	Expectation %			Total	
	Yes	No	Undecided	No.	%
Strongly Agree	31.70	2.90	0.00	91.00	25.70
Agree	45.60	7.40	60.00	136.00	38.40
Disagree	14.90	44.10	0.00	72.00	20.30
Strongly Disagree	5.70	42.60	20.00	46.00	13.00
Do not Know	2.10	2.90	20.00	9.00	2.50
Total	281.00	68.00	5.00	354.00	-
%	79.40	19.20	1.40	-	100.00
Chi-square = 128.18017 D. F. = 8 Significance = .0000					

The study found that there was a significant relationship between the satisfaction with the approach and expectation that it would provide health coverage for all the population and improve their access to the national medical network. Table 8 - 8 reveals that more than 38 per cent of those satisfied with the health services, strongly believed that the approach will improve the access to the

other health facilities, and provide health coverage for all the population, whereas more than 42 % of the dissatisfied did not agree. Overall, the majority (75.7 %) were dissatisfied and strongly disagreed that the PHC will improve the access to the other health facilities and provide health coverage for all the population.

Table 8 - 8 Expectation of PHC Approach by Satisfaction with Health Services.

Expectations	Satisfaction %		Total	
	Yes	No	No.	%
Strongly Agree	38.40	21.60	91.00	25.70
Agree	53.50	33.60	136.00	38.40
Disagree	2.30	26.10	72.00	20.30
Strongly Disagree	1.20	16.80	46.00	13.00
Do Not Know	4.00	1.90	9.00	2.50
Total	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00
Chi-square = 46.14223 D. F. = 4 Significance = .00000				

It appears from Table 8 - 8 that the majority of the respondents who were dissatisfied with the health services delivered from the health centres, did not agree that the implementation of the PHC approach will lead to health coverage for all the population and improve their access to the other health service facilities. This finding is consistent with the view mentioned above, that the health centres have become simply gate-keepers to the other medical facilities.

This study found that there was a statistically significant difference between registration and respondents' opinions of PHC approach (Table 8 - 9). Most of those not registered did not agree or strongly agree that the implementation of the PHC approach would lead to wider access to health facilities. Of the registered, 30 % strongly agreed and 45 % agreed that the PHC approach would achieve this, leaving a minority who were suspicious of its ability to do so.

Table 8 - 9 Opinion of PHC by Registration.

Opinion of PHC	Registration %		Total	
	Yes	No	No.	%
Strongly Agree	29.80	7.70	91.00	25.70
Agree	45.00	9.20	136.00	38.40
Disagree	15.20	43.10	72.00	20.30
Strongly Disagree	7.60	36.90	46.00	13.00
Do Not Know	2.40	3.10	9.00	2.50
Total	289.00	65.00	354.00	-
%	81.60	18.40	-	100.00
Chi - square 83.11800 D. F. = 4 Significance = .00000				

Moreover, there was a statistically significant difference between the registered and non registered in terms of expectations of PHC. 88.6 % of those registered expected the approach would help in improving health conditions, while 38.5 % of the non - registered shared the same idea, and more than 61 % of non registered did not expect the approach to improve health conditions (Table 9 - 10).

Tables 8 - 10 Expectations of PHC by Registration.

Expectation	Registration %		Total	
	Yes	No	No.	%
Yes	88.60	38.50	281.00	79.40
No	9.70	61.50	68.00	19.20
Do not know	1.70	0.00	5.00	1.40
Total Number	289.00	65.00	354.00	-
%	81.60	18.40	-	100.00
Chi - square = 92.18470 D. F = 2 Significance = 0.0000				

8.2.3 Medical Records.

The introduction of the new policy of family medical records coincided with the emergence and promotion of PHC strategies in Saudi Arabia. Before, this patients used to go to any health source to receive medical treatment. They were often not known to the health providers, and so every time they sought medical treatment, they had to open a new record. Now, with the PHC strategy, this waste of time and resources could be eliminated, by proper use of the medical record system. Most respondents were appreciative of the record system. Almost 82 % of the respondents felt that they would benefit from having a medical record and only 18 % showed a negative attitude. The 82 %

who expressed a positive attitude towards medical records gave various reasons for having medical records. Table 8 - 11 summarises the main advantages for having medical records with the health centre.

Responses in Table 8 - 11 worked out on the base of an open ended question and categorised into several categories as listed in the table.

Table 8 - 11 Distribution of Respondents Opinions of Advantages of Having Medical Records with the Health Centre

Advantages of Having Medical Records	Frequency	%
Save time, effort and wondering where to go	25.00	7.06
Facilitates diagnosis	38.00	10.70
Provides information about the patient	32.00	9.00
Facilitates the follow - up process	47.00	13.20
Records the medical and health chronology of the family	46.00	12.90
Preventive, rather than curative approach	13.00	3.67
To benefit from the health centre's services	21.00	5.90
To survey the most wide - spread diseases	11.00	3.10
To facilitate the referral to hospital	20.00	5.64
To know the people's medical needs	12.00	3.38
To increase the interaction between patient and doctor	10.00	2.80
Discover new diseases	15.00	4.23
Total questioned = 354 Multiple Response		

The largest category, 13.2% of the respondents, believed the usefulness of having a medical record is to facilitate the follow - up process, whenever the patient needs any further treatment, by keeping the doctor up- to - date with the health condition and medical history of the patient, and medication. This was closely followed by the 12.9% of who saw benefit in records the medical and health chronology of the family. 10.7% stated that the aim of the family medical records is to facilitate and help the diagnosis, while 9% stated that it contains useful medical information about the patients, which helps the doctor to make right decision and diagnosis. A few respondents, 3.67%, viewed the medical records as complementary to PHC's function, of providing preventive medical care. 3.10 % of the sample considered the medical records a good means to provide the health authorities with an overview of the wide - spread diseases in the country, while 3.38 % of the respondents considered the medical profiles as good informative indicators to provide the health

authority in the city or in the region with full detailed information about the people's health conditions, as a basis for planning health service provision. 5.1 % of the sample stated that medical records will help in the discovery of any diseases in any particular districts, for example where there is a concentration of a particular ethnic group, so the health centre could provide relevant warnings and education. Those three opinions constitute almost 13.6 % of the respondents who provided answers that beyond the PHC approach and how they view the PHC approach and how it would work. 6.8% of the sample regarded the medical records as a means to facilitate and prompt the referral producers to the second or third levels of health care system. 3.4 % of the respondents believed the policy of having a medical records will foster good relations between the patients and the doctors, as a relationship of knowledge and trust is built up. Finally, 7.2 % opened the medical profile only to benefit from the services in the health centres.

Those who expressed negative attitudes toward the medical records, also held such attitudes towards the health centre and the services delivered through it in general. Some of them complained that when the medical record is opened, a proper general check - up is not conducted, so that the record develops in a piecemeal and random way as information emerges on subsequent visits. This opinion was supported by the fact that only 23.9 % of the respondents had had a medical check - up, when they opened medical records, and even this was not a comprehensive one. Others feared that the new policy of medical records was a way of filtering those who would benefit from the public health services and those who would not. The introduction of medical records for every utiliser of the public health centre is a very good practice in itself, but it needs to be activated by the health authority to keep- up with expectation of the public in general.

The impact of socio-economic characteristics on the respondents appreciation of the medical record was clear in respect of two variables: marital status and income. Married respondents were more appreciative of the medical records than the single. Table 8 - 12 shows that more than 83 % of the married respondents supported the idea of having medical records while for singles it was 69.2%.

Table 8 - 12 Advantages of Medical Records by Marital Status

Have Medical Record	Marital Status %		Total	
	Married	Single	No.	%
Yes	83.50	69.20	290.00	81.90
No	16.50	30.80	64.00	18.10
Total Number	315.00	39.00	354.00	-
%	89.00	11.00	-	100.00
Chi-square = 4.76561 D. F. = 1 Significance = 02903				

The appreciation of having medical records was overwhelming among all income categories. Surprisingly those with low income were the most appreciative.

Table 8 - 13 Advantages of Medical Records by Income

Having Medical Record	Income %			Total	
	Low	Middle	High	No.	%
Yes	88.00	73.90	69.20	290.00	81.90
No	12.00	26.10	30.80	64.00	18.10
Total Number	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00
Chi-square = 13.21340 D. F. = 2 Significance = .00135					

Strangely, those with high income were less likely to support the idea of having medical records than the other income categories. Those who have high income may be expected to have higher education or awareness, which would affect their attitudes towards many health behaviours. However, income in Saudi Arabia is not necessarily associated with level of education, as there are many people involved in business who have a low level of official education but have a high level of income. It may also be that those with high income in the sample were less appreciative of the medical records because they had sufficient awareness or experience to recognise the deficiencies in the way the system is operated. They may also be in a position to compare with the private sector system.

The correlation between satisfaction with the health services at the health centre and having medical records is significant. Table 8 - 14 shows that although both satisfied and dissatisfied users

were generally appreciative of the idea of keeping a medical record for every person, dissatisfied users were rather less appreciative of the record system.

Table 8 - 14 Advantages of Having Medical Records by Satisfaction.

Having Medical Record	Satisfaction %		Total	
	Yes	No	No.	%
Yes	97.70	76.90	290.00	81.90
No	2.30	23.10	64.00	18.10
Total Number	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00
Chi-square = 19.03489 D. F. = 1 Significance = .00001				

8.2.4 Attitude towards Facilities and Services in Practice.

People's attitude toward the staff and facilities available at the health centre plays a major role in their acceptance of the delivered health services. Responses to the statement: " Services in PHC centres are not as they should be, there are shortages of facilities, equipment, medicine and staff" reveal that even among those who had positive attitudes towards the role of PHC, many were dissatisfied with availability of equipment, medicine and staff. Table 8 - 15 summarises their answers.

Table 8 - 15 Distribution of Respondents' Opinions about the Availability (shortage) of Facilities in the Health Centre.

Opinions	Frequency	Percentage
Strongly Agree	168.00	47.50
Agree	148.00	41.80
Disagree	25.00	7.00
Strongly Disagree	6.00	1.70
Do not Know	7.00	2.00
Total	354.00	100.00

It appears from Table 8 - 15 that the majority of the respondents considered that the health centres suffer from shortages of necessary equipment, facilities, medicine and staff; almost 42 % expressed agreement, and 47 % expressed strong agreement on this point. Only a minority disagreed or strongly disagreed: 7 % and 1.7 % respectively.

The shortage of facilities alienated many utilisers of the health services. As we have seen, when people were asked if they were satisfied with the health services delivered at the PHC centres, almost

76 % of the respondents said they were not, while only 24.3 % of the respondents indicated that they were satisfied. Some of the respondents told the researcher that if they needed to have an X - ray, they were referred to another health centre where the equipment and facilities are available, or to a general hospital, but they did not like this, because of the lack of co - ordination between their health centre and the institution to which they were referred, resulting in waits of two or three hours. Therefore, they preferred to go to a private hospital for X - rays or tests and then take their reports to the health centre. Other respondents said that in some cases they had to go to a private pharmacy and buy medicine which was not available at the centre's pharmacy. The shortage of facilities and health personnel made respondents doubt that the health centre would meet the lay person's needs, as mentioned above. Similar findings were obtained in other recent studies, such as Sebai (1981, 1984, 1985); Banoub (1984); El- Torky and Harastani (1984); Al - Mukadam (1987); Al - Osimy (1991); Al- Baz (1992).

Shortage of facilities at the health centres has an impact on user's satisfaction. Table 8 - 16 reveals that almost 95 % of the dissatisfied agreed, strongly or generally , about the shortage of facilities, compared with 72 % among those who were satisfied. The percentage of strong agreement among the dissatisfied was 56 %, compared with only 21 % among the satisfied. Slightly more than a quarter of the satisfied, and only 3 % of dissatisfied, agreed in varying measure, about shortages. Thus, it can be said that the shortage of the facilities had a strong influence on consumers' general satisfaction. This may in turn lead to underutilisation of the health centres and it may call into question their credibility, particularly as the health centre's clients are likely to compare its facilities with those of hospitals, or of clinics in the private sector.

Table 8 - 16 Opinion of Shortage of Facilities by Satisfaction.

Opinion	Satisfaction %		Total	
	Yes	No	No.	%
Strongly Agree	20.90	56.00	168.00	47.50
Agree	51.20	38.80	148.00	41.80
Disagree	20.90	2.60	25.00	7.10
Strongly Disagree	5.80	0.40	6.00	1.70
Do Not Know	1.20	2.20	7.00	2.00
Total	86.00	268.00	354.00	
%	24.30	75.70	-	100.00
Chi-square = 61.91050 D. F. = 4 Significance = .00000				

Table 8 - 16 shows those who were undecided were very few, which increases our confidence in the above findings, since they were based on the responses of the great majority.

The location of the health centre is very important. If the health centre is located in an accessible position, easy to reach, not too far from utilisers, people are likely to be more satisfied. When people were asked if the location of the health centre in their district was inconvenient, they answered as shown in Table 8 - 17.

Table 8 - 17 Distribution of Respondents Opinions of Convenience of Location of PHC Centre

Opinion	Frequency	Percentage
Strongly agree	135.00	38.10
Agree	156.00	44.10
Disagree	46.00	13.00
Strongly disagree	15.00	4.20
Do not know	2.00	0.60
Total	354.00	100.00

The table shows that more than 38 % of the respondents strongly agreed that the location of the health centre in their district was inconvenient, more than 44 % or 156 of the respondents agreed, while only 13 % disagreed and 4.2 % expressed strong disagreement.

It was thought that there might be a significant relationship between location of the health centre and socio - economic characteristics or with attitudes questions such as satisfaction, but the result of the cross - tabulation tests revealed no such significant relationship. However, though no significant relationships of this kind were found, the health centre's location is believed to have a very strong influence on the level of utilisation of the health services. Many studies have emphasised the importance of the location of the health facilities in relation to utilisation (Sebai 1984, 1988, Banoub 1984, Joseph and Phillips 1984, Al - Ghamdi 1981, Al - Saania 1983, Morley et al. 1983, El - Zahrany 1989, Phillips 1990, Al - Osimy 1991, Al - Khalifah et. al 1993). The private health sector has paid much attention to this point; thus, all its facilities are situated in prominent locations, accessible to public transportation, on main roads or in well known catchment areas, with neon signs

to advertise the building and clear signs to direct visitors, whereas the public facilities (health centres) are located in dead end streets with no clear signs or neon lights to guide the users.

8.2.5 Attitude toward Working Hours

The health centre's working hours can have strong impact on the level of utilisation of the health services. Fiedler (1981) emphasised this point. It is usually the providers of the health services who set the working hours, not the recipients of the services. Hibbard and Pope (1986) stressed the importance of the working hours for the elderly, particularly in the absence of public transportation. If the working hours do not suit the utilisers, then the health centre will be overcrowded at some times, while at other times, probably the health personnel will be underworked.

In this study many respondents, almost 53.5%, indicated that the health centre's working hours were suited to their working hours, while 45.2% stated that they were not, and therefore they had difficulties when going to the health centre (to be discussed below). When asked if the current working hours need to be changed, 68.5% of the respondents replied in the affirmative, and only 31.5 % of the respondents saw no need for change. Various suggestions were made regarding working hours. Some respondents suggested increasing the period of current working times; others suggested increasing the working time in the afternoon period only; the majority suggested increasing the working time until 10 p.m., with on - call facility for emergency till 12 p.m., particularly in areas where the general hospital is far away and not easy to reach. Others argued that the working time should be from 8 am until 9 p.m., with on - call services 24 hours a day.

If working hours were extended and organised appropriately, utilisers would be more satisfied with the health services in the centre. One way of doing this would be to introduce an appointment system, where every visitor wanting to see GPs or any other specialists in the health centre should have an appointment; general services can be delivered by nurses, and emergency cases can be seen by a doctor. This study found that the appointment system did not exist. 90.3 % or 262 of the respondents indicated that they did not make any appointment when they went to the health centres. However, in some health centres, where obstetrics, gynaecology and dentistry were available, the type of treatment dictated the practice of an appointment system. Ante - natal care was provided with

frequency of appointment varying according to the stage of pregnancy. Dentists made appointments according to the work load - sometimes the next day.

Application of an appointment system would reduce crowding at the health centre and reduce the time spent waiting to see the doctor. In this study, waiting time was one of the common complaints about the health centre. The waiting time varied between the health centres, depending on many factors: the number of physicians at the health centres, the availability of diagnostic facilities, types of service delivered by the centre, availability of paramedical staff and the number of people served by the health centre. Wait time ranged from 25 minutes up to 120 minutes. 18.3 % of the registered respondents indicated that they waited for about 30 minutes before seeing the doctor, 27 % indicated that they waited 45 minutes; 41.5 % stated that they waited for 60 minutes; 1% waited for 75 minutes, while 8 % of the utilisers indicated that they waited 90 minutes and 1.7 % said that they waited 120 minutes. Comparing with other studies, El - Torky and Harastani (1984) found that only 8.83 % of the respondents waited less than 15 minutes at the outpatient clinics in Riyadh; 25.26 % waited from 15 - 30 minutes, 20.53 % of the respondents waited from 30 - 45 minutes, while 45.38% indicated that they waited over 45 minutes.

8.2.6 Types of Facilities Used

Respondents were asked where they sought medical treatment before the introduction of the PHC programme. The choice was left open so respondents could choose more than one place; therefore, the calculation is based on multiple responses. Table 8 - 18 summarises the findings.

Table 8 - 18 Distribution of Respondents by Health Sources before PHC Programme

Place of medical care sought	Frequency	Percentage
Public hospital	188.00	53.10
Private hospital	241.00	68.00
Public health centre	111.00	31.30
Private health centre	195.00	55.00
Folk healer	67.00	18.90
Used home remedy	80.00	22.60
Total questioned = 354 Multiple Responses		

More than 53 % or 188 of the respondents stated they used to seek medical treatment in public hospital; a higher percentage, 68 %, went to private hospital; 31.3 % of respondents indicated they

used to go to public health centres, while private health centres were used by 55 %. Folk healers used to be seen by 18.9 % of the respondents and 22.6 % of the sample indicated they used to use home remedy. The public sector, both hospital and health centres, before they were converted to PHC centres, accounted for 33.9 % of the total responses, while the private sector attracted almost half the total responses. These figures suggest that before the implementation of PHC approach, the health services in the public sector were limited, while people found it easy to go to private health services because they were available in almost every part of the city, in the form of hospital, health centre, polyclinic, single clinic, or GP. Private services were also preferred as being less crowded (see Chapter Three). Folk healers were popular for treating fractures and some types of illness, while some visited religious healers, particularly for psychological diseases such as eye- envy or possession by Jinni. People who used a home remedy might take traditional medicine or modern medicines such as painkillers, for simple illnesses such as influenza , headache, toothache and so on, but this does not mean they never went to either private or public health services.

Even after implementation of the PHC programme in Jeddah, many respondents preferred to be treated in the private sector. Table 8 - 19 shows that under 17 % of the respondents indicated they preferred to go to the public hospital when they had a serious problem, while nearly three quarters of the sample (72.6 %) favoured private hospital and 9.9 % indicated private health centres; only 0.6 % of the respondents would go to the public health centre.

Table 8 - 19 Distribution of Respondents by Place for Treatment of Serious Problems

Health source	Frequency	Percentage
Public hospital	60.00	16.90
Private hospital	257.00	72.60
Public centre	2.00	0.60
Private centre	35.00	9.60
Total	354.00	100.00

Although many people complain that the private sector health services are business oriented, still, the majority of people prefer to go to the private sector. Many people still hold a negative image of the health services in the public sector, or are impeded by bureaucratic procedures from utilising the public health services. For example, in a teaching hospital, outpatient clinics start at 2 p.m. and there

is no appointment system. Patients come to the clinics but do not know when they will be seen, so they have to wait till they are called. Again, inpatient clinics restrict visiting from 4 p.m. until 6 p.m., which is inconvenient for many people, while in the private sector visiting is open from 10 am until 10 p.m.. Table 8 - 20 shows respondents' reasons for preferring the private health sector.

Table 8 - 20 Distribution of Respondents by Reasons of Preference for Private Health Services

Reasons for Preference	Frequency	Percentage
Better health services	246.00	69.40
No long waiting	131.00	37.00
Easy to make an appointment	185.00	52.20
Communication with staff friendly	237.00	67.00
The only health source near my home	35.00	9.80
Close to my work	26.00	7.30
All friends and relatives go	58.00	16.30
Provided by my work	33.00	9.30
Other	192.00	54.20
Total questioned = 354 Multiple Responses		

As it appears in the Table 8 - 20, 69.4 % of the sample indicated that they favoured the private rather than public health sector because they believed the health service in the private sector is better than the public. Almost 67 % of the respondents preferred the interaction and relationship with the health personnel and paramedical staff as well as other employees in the private health sector, 37 % stated the reason was because there is no waiting or no long waiting at the clinics before seeing the specialists. For 52.2 %, their reason for preferring the private sector was that at the private sector it was easy for them to make an appointment, even by telephone. A very small percentage of the respondents, 9.8 %, stated the reason was the proximity of the health source to their homes or that it was the only health source at their district, whereas 7.3 % indicated the convenience of a location close to their work - place. 16.4 % of the respondents chose the private sector because all their friends and relatives went there. For 9.3 %, their reason was that they were provided with medical coverage by their work. However, 54.2 % indicated other reasons such as having gone to the private sector for a long time; being seen by specialists and consultants; or being given more time and attention and a more thorough examination in the private sector than the public sector. Al - Osimy

(1991) found in her study that many consumers of the public services complained about the short time given to the patient and that doctors at the health centres were not thorough about physical tests.

Others preferred the private services because there is no crowding in the outpatient clinics, the place is well organised and clean, a wide range of equipment is available, as are various specialities, and some respondents indicated that they had medical records with the private hospital, and therefore preferred not to change.

Comparing with other studies, Al - Shuruq (1992), found in United Arab Emirates that 80 % of the respondents preferred the private health services to the public. Al - Khalifah et al. (1993) found that one of the reasons why people preferred the private sector was that female doctors were more likely to be available, and many Saudi women prefer to be seen by a female doctor, Banoub (1984) reported a similar result.

Some other studies found that Saudis prefer the private health services because of the additional facilities and services available in the private health sector, such as single room, telephone, TV with multi channels, visiting time from ten am until ten p.m., which are not available in the public. Other studies pointed to the preference for private health services due to the neglect of some patients and favouritism shown to others, in the public clinics (El - Torky and Harastani 1984; Al - Mukadam 1987; Al - Khalifah et. al 1993).

The good relationship with the health personnel in the private sector was one of the major reasons that attracted many people to the private sector. Al - Khalifah et al. (1993) and Al - Nunu (1992) reached a similar conclusion. Al - Khalifah et al. (1993) found that 50 % of his sample gave this as the reason for going to the private sector.

Satisfaction with the health services at the health centres was explored in relation to the type of health services used. The result of the cross-tabulation revealed that there was a significant relationship between the type of services used and satisfaction with the health services delivered at the PHC centres. Table 8 - 21 summarises the answers.

Table 8 - 21 Type of Health Facilities used by Satisfaction with Health Services.

Type of health services	Satisfaction %		Total	
	Yes	No	No.	%
Public hospital	22.10	15.30	60.00	16.90
Private hospital	70.90	73.10	257.00	72.60
Public health centre	2.30	0.00	2.00	0.60
Private health centre	4.70	11.60	35.00	9.90
Total No.	86.00	268.00	354.00	-
Chi-square = 11.9924 D. F. = 3 significance = .01070				

At the same time, Table 8 - 21 reveals that the private health sector is considered the first priority when seeking treatment for serious medical problems. Both those satisfied and dissatisfied with the health services provided at the health centre expressed their preference for the private sector. A very interesting finding is that even among those who were satisfied with the health services delivered at the health centres, only two respondents indicated that they would go to the health centre when they had a serious problem. This attitude raises questions as to the reliability and credibility of the health services at the PHC centres. There appear to be a variety of reasons - overcrowding, shortage of medical personnel, working hours and shortage of medicine as well as the relationship between patient - doctors - which all combine to create a negative attitude toward the health centre. Beyond this, it seems possible that PHC centres are seen as appropriate only for minor care. Moreover, some people registered with the health centres to enable them to use the other public health facilities, rather than because they were satisfied with the health services at the health centre (see below). However, if the health centre authorities took steps to improve the standards and facilities at the health centres, this would probably increase satisfaction and encourage more people to use the available facilities.

8.3 General Use of the Health Centres

Whereas the above sections discussed the findings regarding people's attitude toward PHC approach in Saudi Arabia, the discussion in this section will concentrate on the general use of the health centre services. Utilisers' general characteristics will be discussed in relation to some socio - demographic characteristics, to find out if any correlation exists between them. However, although the chapter focuses on those who were registered with the health centres, the information about respondents is taken from the respondents themselves, not from health centre records. Because the

implementation of medical records is still new, the available data at most of the PHC centres visited were insufficient for further analysis and discussion of the level of the utilisation of the health centres' services. Another reason for not using the data at the health centres is that some people use the health centres, though not registered with them. Accordingly, the registration figures at the health centre do not necessarily represent the actual number of utilisers of the health services. On the other hand, registration with the health centre means a person has obtained access to the public health services. So all those who are registered with the health centres and have medical records may be considered to be utilisers of the available services delivered through PHC centre. The following section will discuss registration, reasons, procedures and difficulties for registration.

8.4 Registration:

Table 8 - 22 shows the percentage of respondents registered with the PHC centre. Almost 82 % of the sample indicated that they were registered with and received medical treatment from the health centres; on the other hand, more than 18 % stated they were not registered with the health centres and they received their medical care through the private sector. Of those who were not registered with the health centres, only 10 % were provided with medical care by their employers. Of this ten per cent, 40 % indicated that the health coverage provided by work covered the respondent alone, while 60 % of them said that the coverage included their dependants. Some respondents indicated that their work paid for their health treatment in the private sector, provided the expenses did not exceed two months' salary. However, medical treatment in the private sector is very expensive, and a visit to a private hospital costs almost twice the GP's fees; two months' salary of an ordinary employee with a relatively small salary and large family would not cover their medical needs or expenses. Thus, some private sector employees go to public health services for health care, because their income is very low in relation to general living standards in Saudi Arabia.

Table 8 - 22 Distribution of Respondents by Registration Status

Registered	Frequency	Percentage
Yes	289.00	81.60
No	65.00	18.40
Total	354.00	100.00

To register with a health centre, the applicant should present certain documents to prove identity and eligibility. 98 % of the registered respondents indicated that they had been asked to provide some documents in order to register with the health centre. 32.6 % presented their rental contract; 16 % provided evidence of property ownership and 69 % provided some other appropriate document instead of or as well as these.

When a person wants to register, a form is filled in, which contains three parts. The first one contains some socio - economic information about the person such as name, age, gender, date of birth, nationality, ID no., marital status, occupation, and number of children. The second part concerns family health history such as TB, diabetes, hypertension; skin diseases and others, while the third is concerned with previous diseases, operations, drugs, allergies and other illnesses. For children, there is a separate chart containing relevant information such as details of the mother's pregnancy, delivery, birth weight, types of feeding and dates of vaccinations. The child's growth is also monitored.

After registration, the client should have (theoretically) a comprehensive physical examination (general check - up). When registered respondents were asked if they had had a general check - up, only 23.9 % of them confirmed that they had had such an examination; while more than 76 % indicated that they had not had a general medical check - up.

8.4.1 Reasons for Registration

Table 8 - 23 shows the main reasons behind people's registration with the health centres. Almost 82.4 % of the respondents stated that they registered with the health centre, because it is the only means of having access to other health facilities. A further 53.9 % or 156 of the respondents registered because they could not afford health care from the private sector. Less than 50 % believed the PHC approach might improve the provision of the health care services; more than 28 % registered because they had been advised to do so by friends and 27.3 % or 79 respondents had been advised by relatives; almost 34 % of the respondents stated that they were encouraged to register because all their relatives and friends were registered and went to the health centres.

Table 8 - 23 Distribution of Respondents by Reasons for Registration.

Reasons for Registration	Frequency	Percentage
Better provision of health services	141.00	48.80
The only mean to have access to other health facilities	238.00	82.40
Can not afford private sector	156.00	53.90
Advised by friends	83.00	28.70
Advised by relatives	79.00	27.3
All friends and relatives registered	98.00	33.90
Total questioned = 289 Multiple Responses		

The 82.4 % who registered because it was the only means of having access to the other health facilities, reflect the regulations introduced by the General Directorate of Health Affairs in Jeddah, by which general hospitals in the city should not admit any patient unless he / she was referred from the health centre in his district. Therefore, most of the people who receive treatment in the public sector have to register with the health centre.

Economic factors were mentioned by more than 53 % of the registered respondents. As indicated previously, almost 66 % of the respondents were of low income. The cost of health services is increasingly high and few people can afford to use the private health services.

The findings as to the role played by personal and social contacts in encouraging people to register indicates that careful selection of representatives to participate in planning and implementation of the health care programmes, could be influential in improving the health conditions and raising health awareness.

8.4.2 Period of Registration

The period of registration with the health centres varied and ranged from 4 to 40 months. The majority had been registered for at least 12 months. The variation in periods of registration was due to a number of reasons. The implementation of the approach in Jeddah is very recent, having been introduced in 1988. Some of the registered respondents indicated periods of time dating back before the approach was implemented in Jeddah, because they used to go to the same health centre before it was converted into a PHC centre. Those who gave shorter periods of time, such as four months, were indirectly forced by the new regulations to register in order to utilise the public health services.

8.4.3 Difficulties:

Registration with and utilisation of the PHC centres involved some difficulties. When registered respondents were asked if they faced any difficulties, 89.6 % of the registered respondents indicated that they did. Those difficulties are summarised by frequency and percentage in Table 8 - 24.

Table 8 - 24 Distribution of Respondents by Type of Difficulty.

Type of Difficulty	Frequency	%
Long waiting queue	216.00	74.70
Receptionists were not helpful	153.00	52.90
No waiting room for men	82.00	28.30
No waiting room for women	51.00	17.60
No available car park	158.00	54.60
Communication difficulties	116.00	40.10
Provision of the service is very slow	233.00	80.60
Physicians ignore patients' feelings	97.00	33.50
Others	119.00	41.10
Total respondents = 289 Multiple Responses		

Table 8 - 24 reveals that 80.6 % or 233 of the respondents complained about the slow delivery of the health services. Closely related to this, 74.7 % complained about the long waiting at the centre before being seen by the doctor. 54.6 % faced problems with car parking. This problem, in fact, is partly a result of the above factors, as the slowness in delivery of the health service leads to overcrowding in some health centres. Thus, even if a car parking area is available, its limited capacity may not be enough to accommodate the number of cars, particularly during vaccination periods or the afternoon shifts. In some health centres there is no car park at all, as mentioned previously.

Problems in relations with the health personnel were a common cause of complaint. 52.9 % of the respondents stated that receptionists were unhelpful. 40.1% expressed difficulties with communication with the health personnel, because in some health centres members of the staff do not speak Arabic; some respondents indicated that because of miscommunication between them and the physician at the health centres, the doctors tended to prescribed pain killers, to relieve them from pain, but did not get to the root of any underlying disease. Sebai (1984) discussed language difficulties. He found that in his study in Al - Qasim region, 44 % of the nursing staff and 33 % of the technician assistants were from the Philippines; this was in a very conservative Bedouin region

where some people had difficulty understanding the dialect of people from other regions of Saudi Arabia, let alone people who were not native Arabic speakers. A further 33.5 % indicated that they thought physicians ignored patients' feelings.

28.3 % and 17.6 % of the respondents complained about the lack of availability of men's waiting rooms and women's waiting rooms respectively. Similar findings were found in other studies carried out in different parts of Saudi Arabia, Sebai (1983, 1984, 1988), Al - Ghamdi (1981), Al - Saania (1983), Al - Osimy (1991), Al - Baz (1992).

Finally 41.1% of the sample experienced difficulties other than those listed. The physical environment did not escape complaint. About 20 % of the utilisers complained about the low standard of cleanliness of the health centres. Some said there was a shortage of seats in both men's and women's waiting rooms and that some of the available seats were not comfortable. Almost 25 % complained about organisation of people; no one noted their time of arrival at the centre, leaving patients to guess and negotiate for themselves, whose turn it was to see the doctor.

Some 25 % of the "other" difficulties indicated, related to the shortages of some medical practitioners and facilities, such as dentistry, obstetricians, paediatrics, X - ray departments and laboratories. Furthermore, some stated that in some health centres, there is only one GP available and he has to carry out all the activities, contributing to slow delivery of service and to crowding at the health centre. 20 % of the respondents complained of the lack of female obstetricians at the health centre, causing them to go to the private sector. Further complaints related to shortages of equipment, medicines and health personnel such as nurses.

Related to the complaint of shortages of some specialities, were difficulties with the referral system. When registered subjects were asked about the referral system, 34 % of them stated that it was very easy, while 48 % indicated that it was complicated. There were also complaints of abuse, which result from the inconsistent behaviour of doctors. Some physicians misused the referral system in two ways, either by refusing to refer, other by referring any patient, regardless whether or not the service in question was available at the centre.

All these difficulties and complaints were the result of misunderstanding and confusion. The referral system is one example of this, for in addition to the confusion caused by variation in doctors'

practice, utilisers generally have unrealistic expectation, preferring whenever possible, to be treated at a higher level. Professionals as well as utilisers misunderstand the main philosophy and policy of the PHC approach. In interviews with many of medical personnel, most mentioned that their perception of what the PHC centre is supposed to be, is that it should be run by specialists or consultants rather than general practitioners only, and they should provide a wider range of medical services if not parallel to what used to be delivered at the out - patient clinics. Also they mentioned the shortage of many facilities at the PHC centres; on the other hand, the utilisers of the PHC centres tend to compare the health services available at the PHC centres either with the private health centres, where the services are mostly delivered by specialists or consultants, or with the general hospitals, thus degrading the services delivered at the PHC centres. These factors all contributed to the misunderstanding and confusion. Many utilisers of the health centre services presumed that the health centre should have all the needed specialities. Some of the respondents indicated that going to health centres which lacked these facilities was a waste of time and money.

Most of these difficulties stemmed from a misunderstanding of the main aims of the approach. Other studies found similar problems with the services at the health centres, particularly Sebai (1983, 1984, 1988), Banoub (1984), Al - Osimy (1991) and Al - Baz (1992).

An attempt was made to find out whether there was any relationship between difficulties faced by respondents and their socio - economic characteristics or attitudes and behaviour questions. A significant difference was found only in relation to gender, where females and males experienced different types of problems.

Table 8 - 25 Type of Difficulty Faced at the Health Centre by Gender.

Type of Difficulty	Gender %		Total	
	Male	Female	No.	%
Long waiting queue	58.10	72.90	216.00	74.70
No waiting room for men	27.10	7.10	82.00	28.30
No waiting room for women	8.10	40.00	51.00	17.60
No car park	49.30	25.70	158.00	54.60
Provision of the services is very slow	62.70	78.60	233.00	80.60
Physicians ignore patients' feelings	26.80	30.00	97.00	33.50
Total No.	227.00	62.00	289.00	-
%	80.20	19.80	-	100.00

Table 8 - 25 reveals that the type of difficulties that faced respondents were different in relation to gender. For example, females complained about the unavailability of a women's waiting room and very few men mentioned it, while males were more concerned with the lack of men's waiting rooms. Both were significant at .00039 and .0000 levels respectively for males and females and chi - square test results were 12.58303 and 46.347753 with D. F. = 1. The long waiting queue was a greater problem for women than men (.02335 level of significance, and chi - square 5.14250). Lack of parking facilities was mentioned by both men and women but, due to the fact that females do not drive in Saudi Arabia, the concern was greater among men. The only factor which did not show any significant difference between women and men was that the physician ignores patients' feeling.

8.5 Satisfaction with the Health Services:

A significant relationship was found between registration with the health centre and satisfaction with the health services at the health centre, in that those who expressed dissatisfaction were more likely to be unregistered. This suggests that dissatisfaction could be a major reason for non-registration. The dissatisfaction of the non - registered with the health centre could be attributed either to the low image that is usually attached to the public services, or to previous experience with the public service in general.

Table 8 - 26 Registration with the Health Centre by Satisfaction

Satisfaction	Registration				Total	
	Yes		No		No.	%
	No.	%	No.	%		
Yes	83.00	28.70	3.00	4.60	86.00	24.30
No	206.00	71.30	62.00	95.40	268.00	75.70
Total Number	289.00	100.00	65.00	100.00	354.00	-
%	81.60	-	18.40	-	-	100.00
Chi-square = 16.76377 D. F = 1 Significance = .00004						

It was expected that the socio-demographic characteristics of the sample would have some influence on their satisfaction with the health services at the PHC centres. Indeed, there were significant relationships between some of those characteristics, while others did not show any

significant effect. Those which influenced the respondents' satisfaction were income, marital status and nationality.

Table 8 - 27 Satisfaction with Health Services at PHC by Income

Satisfaction	Income %			Total	
	Low	Middle	High	No.	%
Yes	29.70	15.10	23.10	86.00	24.30
No	70.30	84.90	76.90	268.00	75.70
Total Number	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00
Chi-square = 8.73750 D. F. = 2 Significance = .01267					

Table 8 - 27 reveals that almost 30 % of those with low monthly income were satisfied, but more than two thirds them were dissatisfied. However, 85 % of those with middle income were not satisfied with the health services at the health centre. Surprisingly, 23 % of those with high income were satisfied with the services. However, their actual number in the sample was very small (26), accounting for only 7.3 % of the total sample, so this finding is all the more significant it may reflect a positive choice on their part. However, utilisation of this type of health care occurs in every age group, gender and level of income as well as education..

Satisfaction in relation to marital status disclosed that the married were more likely to be satisfied than the single who, as mentioned previously, might utilise inpatient facilities more than married people, but still their level of satisfaction was not high. For people in both categories, the level of satisfaction with the standards of the health services delivered at the health centres was very low.

Table 8 - 28 Satisfaction with Health Services in PHC Centre by Marital Status.

Satisfaction	Marital Status %		Total	
	Married	Single	No.	%
Yes	26.30	7.70	86.00	24.30
No	73.70	92.30	268.00	75.70
Total No.	315.00	39.00	354.00	-
%	89.00	11.00	-	100.00
Chi-square = 6.56786 D. F. = 1 Significance = .01038				

The study found also that there was a significant relationship between nationality and satisfaction. Non-Saudis were more satisfied than Saudis with the health services at the PHC centre. Table 8 - 29 shows that more than 79 % of Saudis were not satisfied, while for non-Saudis, the figure was less than 63 %. This could be attributed to the fact that non-Saudis came from different backgrounds and some of them came from areas where public health care did not exist, so they would be satisfied with any standard of health care, as they had no standard of comparison. Also, many non-Saudis were of low income; thus, it would be hard for them to go to the private sector and to compare the two sectors. Thus, they were happy with the minimum level of health care. The situation for Saudis was different. In an urban centre, in particular, alternative facilities are available and compete with the public health centres.

Table 8 - 29 Satisfaction with the Health Service by Nationality.

Satisfaction	Nationality %		Total	
	Saudi	Non-Saudi	No.	%
Yes	20.70	37.80	86.00	24.30
No	79.30	62.20	268.00	75.70
Total Number	280.00	74.00	354.00	-
%	79.10	20.90	-	100.00
Chi-square = 9.33141 D. F. = 1 Significance = .00225				

8.6 Transportation

Many studies carried out in Saudi Arabia have shown the importance of transportation in facilitating or impeding visits to health centres. Table 8 - 30 shows that 53.4 % of the registered respondents used private cars to go to the health centre; 17 % walked; 7.3 % used taxis in travelling to the health centre; while 4 %, mostly women, indicated that they went in someone else's car.

The fact that the majority of the utilisers of the health centre services in this study owned cars, suggests that people who do not have transportation may be less likely to use the services. Other studies have reported similar findings. For example, Al - Ghamdi (1981) revealed that 48 % used their own car; 17 % used taxi and 14 % walked to the health centre. Al - Saania (1983), found that 53 % of the respondents used a private car to go to the health services, while 9.4 % used taxi. El - Zahranly (1989), found that 56.4 % of his sample used private cars. This highlights also the

importance of the health centres providing adequate parking space. Many respondents stated that unavailability of parking space caused them some discomfort when visiting the health centres. The majority, 86 %, of the respondents indicated that there was no car park near the health centre, while the few who indicated the availability of a car park, complained about its capacity. Sometimes, particularly in the afternoon shift, the car parks get full, and some visitors have to park their car in relatively remote places. This is a problem when taking a sick child or an elderly person, in the absence of facilities such as a wheel chair, or mobile bed. Such problems were supposed to be avoided when health centres were opened in the new districts but unfortunately, no strict criteria are used in selecting rented buildings for use as health centres.

Table 8 - 30 Distribution of Respondents by Transportation to PHC Centres

Transportation	Frequency	Percentage
Own and Family Car	189.00	65.40
Someone else's Car	14.00	4.80
Taxi	26.00	9.00
Public Bus	0.00	0.00
Walk	60.00	20.80
Total	289.00	100.00

The relationship between gender and type of transportation used to go to health centres was very strongly significant. As mentioned earlier, women by civil law, are not allowed to drive in Saudi Arabia. Therefore, they must rely on someone to drive them to the health centres, either the family's car, someone else's car or taxi.

Table 8 - 31 Transportation Used to the Health Centre by Gender.

Transportation	Gender %		Total	
	Male	Female	No.	%
Own and Family's Car	74.40	32.30	189.00	65.40
Someone else's Car	1.80	16.10	14.00	4.80
Taxi	6.60	17.70	26.00	9.00
Walk	17.20	33.90	60.00	20.80
Total No.	227.00	62.00	289.00	-
%	78.50	21.50	-	100.00
Chi-square = 47.25024 D. F. = 3 Significance = .00000				

other arrangements. The situation now is that many students go to the school health units for routine authorisation only, and otherwise go to the private health services or to the PHC centre. So, by incorporating the school health services within the programme of PHC, huge resources could be saved.

The PHC approach attaches importance to personal relationships between providers and recipients of the health services. The close interaction between patients and doctors should lead to mutual trust. In building such a relationship, how often the patients see the same doctor in visiting the health centre is a very important element.

Table 8 - 33 Distribution of Respondents According to how Frequently they see the same Doctor in PHC Centre

Frequency of Seeing Same Doctor	Frequency	Percentage
Always	15.00	5.20
Most of the times	77.00	26.60
Sometimes	192.00	66.40
Rarely	5.00	1.70
Total	289.00	100.00

Table 8 - 33 reveals that 5.2 % of the registered respondents indicated that they always saw the same doctor; just under 27 % did so most of the time, more than 66 % sometimes and 1.7 % rarely. The grade and size of the PHC centre determines how the health service is delivered (see Chapter Four). Some health centres are run by more than two physicians, and when a patient comes to the centre, he does not necessarily see the same physician. Some physicians work in one health centre in the morning and go to another one in the afternoon. The latter practice in particular does not help to create a relationship between the utilisers and the doctor.

8.8 Referral System:

The Alma - Ata declaration emphasised that PHC forms an integral part of a country's health system. It is the central focus, and the first level of contact of individuals and families. Thus, PHC is designed to work on a referral system. It is the link with other health organisations. Cases needing special treatment or further medication should be referred to a general or specialist hospital. In some countries where CHWs are the first point of contact with the population, they refer any case not within their limited range of health tasks to the health centre and then it is the health centre's

Table 8 - 31 reveals that more than 74 % of male respondents used their own cars to go to the health centres while only 32.3 % of females used the family's car, which was driven by someone else. Also the table shows that women were more likely to use taxi to the health centre, and were more likely to walk.

Distance of the health centre from the respondents' houses plays an important role in the level of utilisation of the health services. Many studies have indicated that people who live farther from the health units are less likely to utilise them. If the distance factor is combined with the absence of public transportation, then utilisation of health services is likely to be low. Because, in Saudi Arabia women do not drive, health centres need to be located within easy reach and accessible by public transportation.

8.7 Arrangements for Visiting the Health Centre

To go to the PHC centres, people sometimes needed to make special arrangements.

Table 8 - 32 Distribution of the Utilisers by Type of Arrangement

Type of Arrangement	Frequency	Percentage
Work excuse	208.00	71.90
Baby-sitter	80.00	27.60
School notify	207.00	71.60
Others	57.00	19.70
Total questioned = 289 Multiple Responses		

Table 8 - 32 shows that more than 71 % or 208 of the registered respondents indicated that they had to take time off work to go to the health centre. If health centre working hours were longer, this problem could be minimised. 27.6 % said they needed to have someone to look after the children. More than 71 % needed to inform the school that their child would be absent. As mentioned in Chapter Five, some governmental organisations provide health services for their employees and dependants. Two of these are the Ministry of Education and the General Directorate of Girls Education. Students and staff of these two organisations need not only notify their work or school but also to go to school health units to authorise any absence or illness leave. 19.7 % had to make

responsibility to treat it or to refer it to higher level of the health institutions. In Saudi Arabia, as well in many other countries, it is the GPs at the health centre who refer cases which can not be treated at the health centre. The main purpose of the referral system is to link the various elements of the health care network together in order to provide different health services at different stages of the health system hierarchy.

However, the referral system is very weak. It is abused by both professionals and patients. Some of GPs at the health centres feel that if they refer cases to the hospital it might be construed as indicating that they are incapable of carrying out their duties and thus they might lose their contract. Other GPs refer any patient who wishes it, without any consideration of the illness and the availability of the health services at the health centres. Regarding the patients' abuse of the referral system, people sometimes by-pass the health centres and go directly to the hospital, even if their illness can be treated at the health centre. If they encounter any difficulty with admission to the hospital, they will go to the emergency department, and probably be admitted. Some patients do not visit the health centres early enough in their illness, but wait until it is beyond the ability of the health centre. Thus, when they go to the health centre and the GP tries to examine them and prescribe medication for them they refuse the treatment and ask for referral. Similarly Al - Mazrou et al. (1991) reported that in areas where the referral system was introduced, the number of patients visiting specialist clinics in hospitals decreased but on the other hand the number of patients seen at the emergency department increased. They concluded that many patients believed that they should be examined in the hospital first, and some tried to avoid overcrowding at the health centres. However, the credibility of the referral system depends on health centre utilisers having a reasonable understanding of the PHC approach, which could be achieved through health education.

Data regarding the referral system were collected. Respondents were asked whether they considered the referral procedures were easy or difficult. 33.6 % of the utilisers indicated it was very easy and almost 48 % stated it was complicated. An attempt was also made to see if there were any relationships between complaints of the referral system and the socio - economic and demographic characteristics of the utilisers. The results of the cross- tabulation revealed no significant difference

except for nationality, where it was found that non- Saudis complained of the procedures more than Saudis.

Although there was no statistically significant relationship between satisfaction and opinion about the referral system, Table 8 - 32 shows that more than 44 % of the satisfied respondents indicated that it was easy, whereas 29.1 % of the non-satisfied did so. Almost 52 % of those dissatisfied stated it was complicated, while the number of those who said referral was neither easy nor complicated was equal for both satisfied and dissatisfied.

Table 8 - 34 Satisfaction with Health Services by Referral System.

Opinion of Referral System	Satisfaction %		Total	
	Yes	No	No.	%
Easy	44.60	29.10	97.00	33.60
Complicated	37.30	51.90	138.00	47.80
Neither easy nor complicated	12.00	12.10	35.00	12.10
Do not Know	6.00	6.80	19.00	6.60
Total Number	83.00	206.00	289.00	-
%	28.70	71.30	-	100.00
Chi-square = 6.90097 D. F. = 3 Significance = .07512				

It could be deduced that one of the reasons why some people were not satisfied with the services delivered by the health centre may be the complicated procedures of the referral system.

8.9 The Use of the Health Centres in Relation to the Type of Ailments

One of the methods used to measure the level of utilisation of the health services is to find which type of disease most frequently prompt people to go to the health centre. To find out about this, a number of common ailments were listed and people were asked to identify which of those listed diseases made them contact the health centre for medical treatment. Because the choice was open to indicate more than one ailment, the calculation of the percentages was based on multiple responses.

Table 8 - 35 Distribution of the Sample in Relation To the Type of Diseases

Type of Ailment	Frequency	Percentage
Coughing lasting for three weeks	170.00	58.80
Sudden feelings of weakness or faintness	201.00	69.60
Frequent headache	141.00	48.80
Repeated pains in or near the heart	216.00	74.70
Diarrhoea for four or five days	208.00	72.00
Pain or swelling in any joints	148.00	51.20
Repeated indigestion or upset stomach	165.00	57.10
Repeated vomiting for day or more	248.00	85.80
Sore throat or running nose with fever	220.00	76.10
Toothache	210.00	72.70
Total questioned = 289 Multiple Responses		

Table 8 - 35 reveals that the largest proportion of respondents (85.8 %) indicated that when they had repeated vomiting for a day or more they would contact the health centre; a sore throat or running nose with fever lasting for at least two days accounted for 76.1 %, while 74.7 % of the respondents indicated if they had pains in or near the heart they went to see a doctor. Diarrhoea for four or five days accounted for 72 % and toothache accounted for 72.7 % . More than 69 % of the respondents indicated that if they experienced sudden feelings of weakness or faintness they immediately contacted the doctor, while just under 60 % of the sample stated that if they had a prolonged cough they contacted a health centre. Problems with stomach and indigestion accounted for 57.1 %; pains or swelling in any joints made 51.2 % or 148 of the respondents contact doctors and more than 48 % of the respondents indicated that when they had frequent headaches they contacted the health centre. Al - Saania (1983) found, in his study in Makkah, lower levels than this of utilising the health centre for general ailments. For example the most frequent use (30.6 %) was made by people had problems with stomach upset, 19. 3 % for coughing; 8 % for sore throat or running nose; 7.3 % for toothache, 5.4 % for injuries, 4.2 % for domestic accidents, 3.8 % for eyes problems, 2.6 % diabetic and 2.6 % heart pain. Al - Ribdi (1989) in Al - Qasim, found that most (19.2 %) of his study respondents used the health centre for indigestion problems, 12.6 % sore throat and running nose, 11.3 % chest diseases, 11.2 % coughing and fever, 7.3 % toothache, 7.1 % for eyes problems, and the rest 31.4 % for others. Both Al - Saania and Al - Ribdi obtain their data

by reviewing medical records. Comparing on international level Hulka et al. (1972) in their study, found that 50.8 % attended for cold, sore throat, 24.8 % for nervousness, worry or depression, 21. % for trouble sleeping, 17.2 % for obesity or overweight. Joint pain and swelling accounted for 16.8 %, severe headache for 14.9, shortness of breath for 14.1 %, sudden weakness or tiredness for 13.7 % and indigestion or upset stomach, vomiting, or diarrhoea for 10.7 % and chest pain for 10.7 %.

Comparison suggests that the health centre or GP in America is used for non - physical disorders, such as nervousness, worry, depression or trouble with sleeping which to great extent relate to psychological disorders, while in Saudi Arabia the health centre is used for physiological pathology. Hulka et al. like the present researcher found high levels of use for cold and sore throat, but much lower rates of attendance than in the present study for vomiting, upset stomach and diarrhoea.

However, the distribution of the respondents in relation to the types of diseases in fact, conveys a message that the people would make insufficient use of the health services available at the health centre in general, and this could be attributed to many reasons: often people underestimate the potential danger of an ailment, and the possible implications of delay in going to consult doctors. Delay in contacting a physician may lead to aggravation of the disease and make eventual treatment more difficult and costly. As mentioned above, people prefer to go hospitals rather than go to the health centre and this could be one of the reasons for low responses to ailments. One manager of a general hospital in Jeddah emphasised that most of the cases which came to the hospital could be treated at the health centre, and often, in cases that needed admission to the hospital, if the patient had gone to the health centre early enough, they could have avoided hospitalisation. This lack of awareness may be related to lack of health education. If people were provided with essential health education, they might change their patterns of health service utilisation, which would increase the level of utilisation of the health services and ultimately, improve health conditions in general.

In the coming section, the relationship between type of diseases and some socio - demographic characteristics will be discussed.

8.9.1 Age and Types of Ailment

To find out about health centre utilisation for various types of disease in relation to age, crosstabulation was used to show the percentage of utilisers in each age category. The result of the crosstabulation is shown in Table 8 - 36. The chi - square statistical tests revealed some strong significant differences between age categories in consulting a doctor for some ailments.

Table 8 - 36 Type of Ailment by Age.

Type of Ailment	Age Group %					Total	
	20 - 30	31 - 40	41- 50	51 - 60	Over 60	No.	%
Cough lasting for three weeks	57.50	60.30	64.40	41.70	60.00	170.00	58.80
Sudden feelings of weakness @ 1	57.50	66.90	76.30	100.00	100.00	201.00	69.60
Frequent headache @ 2	48.80	52.90	55.90	16.70	20.00	141.00	48.80
Pains in or near the heart	67.50	75.20	83.10	70.80	100.00	216.00	74.70
Diarrhoea for four or five days	61.30	74.40	76.30	79.20	100.00	208.00	72.00
Pains or swelling in joints @ 3	47.50	40.50	55.90	100.00	80.00	148.00	51.20
Indigestion or upset stomach @ 4	53.80	53.70	76.30	41.70	40.00	165.00	57.10
Repeated vomiting	85.00	82.60	91.50	87.50	100.00	248.00	85.80
Sore throat or running nose with fever @ 5	75.00	80.20	84.70	45.80	40.00	220.00	76.10
Toothache @ 6	82.50	70.20	74.60	58.30	20.00	210.00	72.70
Total	80.00	121.00	59.00	24.00	5.00	289.00	-
Percentage	27.70	41.90	20.40	8.30	1.70	-	100.00

- @ 1 Chi - square = 19.82881 D. F = 4 Significance = .00054
- @ 2 Chi-square = 13.59056 D. F = 4 Significance = .00872
- @ 3 Chi-square = 31.05108 D. F. = 4 Significance = .00000
- @ 4 Chi-square = 12.71350 D. F. = 4 Significance = .01276
- @ 5 Chi-square = 19.26172 D. F. = 4 Significance = .00070
- @ 6 Chi-square = 13.82358 D. F. = 4 Significance = .00788

Some of the ailments are particularly associated with age, such as pains or swelling in any joints, sudden feelings of weaknesses or faint, pains in or near the heart, diarrhoea for four or five days and repeated vomiting. In contrast, toothache, vomiting, and sore throat were more likely to make utilisers of age group 20 - 30 go to the health centre. Age group 31 - 40 indicated that if they had vomiting for a day or more, sore throat with fever, pains in or near the heart, diarrhoea for four days and toothache, they would go to the health centres to seek medical treatment. As age increases, the number of symptoms that make utilisers go to seek medical care increases. The age group 41 - 50

indicated that seven of the listed ailments would be likely to make them go to the health centre. These are, in descending order, vomiting, sore throat or running nose, pains in or near the heart, diarrhoea, sudden feelings of weakness or faintness, problem with indigestion and upset stomach, and toothache. Age group 51 - 60 would use the health centre for ailment such as sudden feeling of weakness, pains or swelling in joints, vomiting and diarrhoea for four days or five, while those in age group over 61 years old indicated that the ailments most likely to force them to seek medical treatment were sudden feeling of weakness, pains in or near the heart, diarrhoea for four or five days, repeated vomiting and pains or swelling in joints.

It is understandable that young people might seek medical treatment more frequently than older ones for some types of symptoms, for many reasons; for the elderly to travel to the health centre is not so easy as for the young, who might have their own transportation, while the elderly might need someone to drive them to the health centre; the elderly might opt to use a home remedy rather than to go to the health centre; also, some aged people often underestimate the effect of some types of diseases. Another reason for the younger age groups to use the health centre when they have some ailments may be that, because they work outside, they are more likely to catch infectious ailments, than the aged who stay at home more. Younger people may also seek prompt medical attention in order to avoid having time off work for illness.

Regarding the relationship between age and utilisation of the health centre for dentistry care, significant differences were found between the age groups of the utilisers at level of significance of .00788, where the young made more utilisation of this service than the older groups.

Utilisers of the health centres were asked how they would respond if they had pains or swelling in any joints during the day. The study found a significant difference at a level of 0.00000, between the age groups in favour of older people, i. e. the higher the age, the more likely they were to go to seek medical treatment or advice. The complaint of joint pain can in part be attributed to age and also to the high humidity in Jeddah, which sometimes reaches 99 %.

Utilisation of the health centre when having a problem with the stomach showed a significant difference at the level of 0.01276, in favour of the middle - aged.

The chi-square test reveals that there were three ailments which were not significantly related with age: cough lasting for three weeks, repeated pains in or near the heart and repeated vomiting for a day or more.

8.9.2 Gender and Types of Ailment

It is unarguable that the sexes differ in their utilisation of the health centre. There are some diseases associated with gender, and the utilisation of the health centre would vary accordingly. Usually, utilisation of the services at the health centres for women can be explained in relation to age. Women of child bearing age attend more frequently for maternity care (antenatal, natal and postnatal) and for other health disorders which are associated with this period of life. This type of special utilisation will be discussed in Chapter Nine. However, Table 8 - 37 shows the distribution of general utilisation of the health centre in accordance with the gender of the utilisers. The chi - square tests did not show any significant difference between males and females in terms of utilising the health centre for the list of ailments discussed previously, because such ailments are not associated with any particular gender. Therefore, it can be concluded that both females and males make the same level of utilisation of the health centres when the ailment is not gender - specific.

Table 8 - 37 Type of Ailments by Gender .

Type of Ailment	Male	Female	Total	%
Coughing lasting for three weeks	58.10	61.30	170.00	58.80
Sudden feelings of weakness or faintness	70.00	67.70	201.00	69.60
Frequent headache	47.60	53.20	141.00	48.80
Repeated pains in or near the heart	75.80	71.00	216.00	74.70
Diarrhoea for four or five days	73.60	66.10	208.00	72.00
Pains or swelling in any joints	52.00	48.40	148.00	51.20
Repeated indigestion or upset stomach	58.60	51.60	165.00	57.10
Repeated vomiting or a day or more	85.00	88.70	248.00	85.80
Sore throat or running nose with fever	74.90	80.60	220.00	76.10
Toothache	74.00	67.70	210.00	72.70
Total Respondents	227.00	62.00	289.00	-
Percentage	78.50	21.50	-	100.00

8.9.3 Marital Status and Type of Ailments

The chi - square test shows there were significant differences related to marital status, in seeking medical treatment, for four ailments only. Those ailments are repeated indigestion or upset stomach, sudden feelings of weakness, diarrhoea and repeated pains in or near the heart. The other ailments did not show any significant differences among the two marital categories.

Table 8 - 38 Type of Ailment by Marital Status .

Type of Ailment	Married	Single	No.	%
Coughing lasting for three weeks	59.80	50.00	170.00	58.80
Sudden feelings of weakness or faintness @ 1	73.00	40.00	201.00	69.60
Frequent headache	50.20	36.70	141.00	48.80
Repeated pains in or near the heart @ 2	76.80	56.70	216.00	74.70
Diarrhoea for four or five days @ 3	75.70	40.00	208.00	72.00
Pain or swelling in any joints	51.70	46.70	148.00	51.20
Repeated indigestion or upset stomach @4	59.80	33.30	165.00	57.10
Repeated Vomiting for a day or more	86.50	80.00	248.00	85.80
Sore throat or running nose with fever	76.10	76.70	220.00	76.10
Toothache	71.40	83.30	210.00	72.70
Total Respondents	259.00	30.00	289.00	-
Percentage	89.60	10.40	-	100.00

- @ 1 Chi - square = 13.80246 D. F. = 1 Significance = 0.00020
 @ 2 Chi - square = 5.79213 D. F. = 1 Significance = 0.01610
 @ 3 Chi - square = 16.96348 D. F. = 1 Significance = 0.00004
 @ 4 Chi - square = 7.71446 D. F. = 1 Significance = 0.00548

Table 8 - 38 reveals the percentage of distribution of utilisers of the health centres with types of ailment by their marital status. The general tendency shown is for married people to make more use of the health centre than the single. The table shows that 78 % of the married would visit the health centre when they had pains in or near the heart. Indeed, for almost all the other symptoms, married respondents showed that they would make more use of the health centre than the single in general, the exception being for toothache; here there was no significant difference, but single people appeared more likely to make use of the health centre than married ones.

In general, this pattern of utilisation of the health centre indicates that the married are more likely to make use of the out patient - clinics or health centre.

8.9.4 Income and Type of Ailment

Usually, level of income is associated with level of utilisation of the health services. People with high income are more likely to visit doctors for any diseases, even if minor. On the other hand, because they live in a more comfortable healthy environment and have the means to purchase better quality food, they may be healthier and less vulnerable to disease. People with low income have less money to buy good food and are likely to live in poorer accommodation, so they are more likely to have health problems, and because of shortage of money they are more likely to use the public health services and less likely to go to the private health service. The relationship between income and responses to types of ailments is seen in Table 8 - 39.

The chi-square test shows there were significant difference between income level and response to type of ailments in six ailments. These ailments are stomach problems, frequent headache, sudden feelings of weakness, diarrhoea for more than four days, repeated pain in or near the heart and a prolonged cough. The test did not show any significant relationship between income and health centre use with regard to other types of ailment. However, Table 8 - 39 reveals that there is a general positive relationship between income and seeking health treatment at the health centre. The higher the income, the more likely the respondents are to go for medical treatment at the health centre. This relationship was straightforward with almost all type of ailments, the minor exception being for with pain or swelling in any joints. However, the general pattern is that those with higher income are more likely to make use of the health centre services. Fewer people with high income (53.8%) utilise the health centre in relation to pains in joints, perhaps because most of those who attend for this reason are people over 50 years old, few of whom fell in high income categories.

Table 8 - 39 Type of Ailment by Income.

Type of Ailment	Income %			Total	
	Low	Middle	High	No.	%
Coughing lasting for three weeks @ 1	58.10	55.30	92.30	170.00	58.80
Sudden feelings of weakness or faints @2	63.40	80.00	92.30	201.00	69.60
Frequent headache @ 3	41.90	61.20	69.20	141.00	48.80
Repeated pains in or near the heart @ 4	71.20	78.80	100.00	216.00	74.70
Diarrhoea for four or five days @ 5	65.40	82.40	100.00	208.00	72.00
Pain or swelling in any joints	48.20	57.60	53.80	148.00	51.20
Repeated indigestion or upset stomach @ 6	51.30	64.70	92.30	165.00	57.10
Repeated Vomiting for a day or more	84.80	87.10	92.30	248.00	85.80
Sore throat or running nose with fever	73.30	78.80	100.00	220.00	76.10
Toothache	69.10	78.80	84.60	210.00	72.70
Total Respondents	191.00	85.00	13.00	289.00	-
Percentage	66.10	29.40	4.50	-	100.00

- 1 Chi-square = 6.49429 D. F. = 2 Significance = .03889
 2 Chi-square = 11.02812 D. F. = 2 Significance = .00403
 3 Chi-square = 11.03848 D. F. = 2 Significance = .00401
 4 Chi-square = 6.40929 D. F. = 2 Significance = .04057
 5 Chi-square = 13.63720 D. F. = 2 Significance = .00109
 6 Chi-square = 11.20034 D. F. = 2 Significance = .00370

It might appear surprising that utilisation of the health centre increases with income. Since public health services in Saudi Arabia are delivered free of charge, lack of means need not, in theory, be a barrier to health care access. However, the income factor here means more than the ability of the respondents to purchase health care; it is likely also to be related to ownership of a car, or ability to afford taxis. It also, gives greater freedom of choice, since if the health services were not available at the health centres, those with high income could go to the private sector. Others do not have this choice.

8.9.5 Nationality and Type of Ailment

The utilisation of the health centre in relation to nationality has many implications. It shows the common diseases that prompt Saudi people to go to the health centres, and it reflects how native and non - native population behave in sickness incidents. Furthermore it may give some indications to the health authority as to whether there is any misuse of the public health services in terms of some groups overusing the health centre for very minor ailments. El - Zahrany (1989) reported that the

people who lived in the Northern sector of Makkah city, overutilised the health services compared with other sectors. The majority of the population in the Northern sector were Saudis. Al - Ribdi (1990) found that both Saudis and non - Saudis make frequent visits to the health centre for diseases such as intestinal upset, E.N.T problems, chest and colds. In this study, however, only three ailments showed significant relationships in the pattern of ailments presented at the health centre and nationality. Table 8 - 40 summarises the result of the crosstabulation in relation to nationality, for all the respondents registered with the health centres.

Table 8 - 40 Type of Ailment by Nationality.

Type of Ailment	Saudis %	Non - Saudis %
Coughing lasting for three weeks @ 1	61.50	48.30
Sudden feelings of weakness or faints	71.40	62.10
Frequent headache	49.80	44.80
Repeated pains in or near the heart	76.20	69.00
Diarrhoea for four or five days	70.60	77.60
Pain or swelling in any Joints	51.10	51.70
Repeated indigestion or upset stomach	56.30	60.30
Repeated Vomiting for a day or more @ 2	87.90	77.60
Sore throat or running nose with fever @ 3	79.70	62.10
Toothache	74.00	67.20
Total Respondents	231.00	58.00
Percentage	79.90	20.10

@ 1 Chi - square = 3.33293 D. F. = 1 Significance = . 06791

@ 2 Chi - square = 4.03414 D. F. = 1 Significance = .04459

@ 3 Chi - square = 7.88745 D. F. = 1 Significance = .00498

Table 8 - 40 shows that Saudis would make more use of the health centre services in case of having health problems such as repeated vomiting for a day or more at significant level of 0.044; sore throat or running nose with fever at significant level of .00498; and prolonged cough at significant level of 0.06791. For problems with teeth, sudden feelings of weakness and pains in or near the heart, also, Saudis would use the health centre more than non Saudis. However non - Saudis, as it appears in the table, would seek health treatment from the health centres for health problems such as diarrhoea for four or five days and problem with indigestion or upset stomach. This may be attributed to the fact that many non - Saudi Arabs suffer from diseases such as dysentery and

bilharzia. This is particularly so for Egyptians, Sudanese and some North Yemenis (Al - Ribdi 1990; Al - Walaai 1991; Al - Khalifah et al. 1993). At the same time, it may be that non - Saudis suffer less from certain other diseases than Saudis. These differences may be related to patterns of endemicity, climate, and other environmental factors in different countries. Culture may also play a part.

However, as there was, generally, no great difference between the two categories, it seems that most non - Saudis who were Arab share many common cultural elements and patterns with Saudis regarding the utilisation of the medical care services. If they had been non - Arab, there might have been more significant differences in utilisation of the health service facilities.

8.9.6 Place of Birth and Type of Ailment

As mentioned above, the place of birth is a cultural indicator which might help in finding out if there is any difference between urban and rural people. This study found slight but non-significant differences between people with different types of background. The distribution of people by their place of birth in relation to the pattern of utilisation is summarised in Table 8 - 41.

Table 8 - 41 Type of Ailment by Social Background.

Type of Ailment	Urban %	Rural%
Coughing lasting for three weeks	61.50	50.00
Sudden feelings of weakness or faintness	70.10	67.60
Frequent headache	49.80	45.60
Repeated pains in or near the heart	73.80	77.90
Diarrhoea for four or five days	72.40	70.60
Pain or swelling in any joints	49.80	55.90
Repeated indigestion or upset stomach	53.80	67.60
Repeated vomiting for a day or more	86.00	85.30
Sore throat or running nose with fever	76.50	75.00
Toothache	75.10	64.70
Total Respondents	221.00	68.00
Percentage	76.50	23.50

Table 8 - 41 reveals no significant differences between people with urban or rural background, though people with urban background were more likely to visit the health centres if they had health problems such as toothache, prolonged cough, diarrhoea and sudden feelings of weakness, while the ruralists showed that in cases of having ailments such as repeated pains in or near the heart, problems

with indigestion, and experienced pains or swelling in joints they would go to the health centre. Ailments such as repeated vomiting for one day or more and sore throat or running nose with fever did not show any significant difference between the two groups. Differences between rural and urban people in relation to problems such as indigestion, might be due to a change in diet. However, the differences in pattern of ailments were minor. This may be because many of those with rural background had spent a considerable time in the city, which may have influenced their attitudes towards visiting the health centre for some diseases.

8.10 Conclusion

This chapter has described respondents' attitudes towards PHC approach in general and the general use of the health centre services. The findings reflected people's expectations of PHC, the majority were optimistic about the implementation of the approach, though some expressed reservations relating to bureaucratic constraints, while a few did not believe that the PHC would bring any improvement or improve access to health care. The shortage of facilities at the health centres was one of the factors that influenced people's attitudes and satisfaction with the health services, as has been reported in other studies, for example, Al - Osimy (1991) and Al - Baz (1992). Thus, it was not surprising that due to the shortage of facilities and health personnel few respondents believed that the current situation of the health centres would meet the needs of the ordinary individual.

Many respondents indicated that the introduction of medical records would greatly contribute to the improvement of health conditions, and the test of the introduction of medical records against different socio-demographic variables revealed that the idea in itself was highly appreciated among all the respondents, though there was a suggestion that it may be linked to dissatisfaction with the service in some areas. Those with lower income, and the married, appeared particularly in favour of the record system.

Satisfaction is a very important issue, but measuring satisfaction is difficult and risky, because it is related to expectations and preconceptions, and to personal experience. Some respondents expressed their satisfaction on the basis of past experience. For others, their response was based on their expectation; if their expectation was high it was difficult for the service to live up to the ideal, and people felt dissatisfied. Furthermore, some people are generally cynical, so it is not easy to be

sure of their real attitudes, or the reasons for it. However, in many cases, the dissatisfaction was attributable to specific shortcomings.

This chapter also discussed registration with the health centres. More than 81 % of the sample were registered with the PHC centre. The three main reasons for registration were the expectation of better health services, financial constraints against going to the private sector and, most important, to get access to other public health facilities. However, the majority of the respondents indicated that they were not satisfied with the health service at the health centre. Many had registered with the health centre only to ensure access to the other public health facilities as needed, so registration did not imply satisfaction. The test of satisfaction against different socio-economic and demographic characteristics revealed that married respondents were slightly more satisfied with the health services than single. It has been suggested that married people are more likely to utilise out-patient clinics for medical advice, rather than nursing or in-patient care. Income showed also differences between the three categories. Those with low and middle income were less satisfied, though generally all three categories indicated their dissatisfaction in varying degrees.

The difficulties reported by the registered respondents can be classified into organisational, physical and communication. The organisational matters included delivery of the services, waiting at the health centre, inconvenient opening hours etc. Physical factors related to the location of the health centre, availability of facilities such as waiting rooms and adequate and comfortable seats and lack of parking. The communication factor was mostly related to language barriers, though some respondents also expressed dissatisfaction with interaction with doctors and receptionists. Shortage of some facilities and medicine was complained of by many of the users. Many of the difficulties reported were interrelated.

The accessibility of the health centres has a strong influence on the frequency of utilisation. Accessibility involves the location of the health centre, the physical proximity, how far the health centre is from the utiliser's home, and availability of other facilities such as car parking. Furthermore, the relationship and interaction with the health personnel at the health centres also influences the frequency of visits. The majority of the respondents indicated their strong dissatisfaction with the location of the health centres. The physical location of the health centre plays a role in level of

utilisation of the services at the health centre, which should be looked at in relation to facilities such as the road to the health centre, adequate parking area, waiting rooms and distance from the public transportation. Dissatisfaction with conditions in these areas may reduce utilisation of the health services. Physical location in terms of the accessibility and availability of facilities at the building will convey an important message to the utilisers that they are provided with a decent standard of health care.

Time waiting at the health centre and time consumed in getting to the health centre play an important role in the level of utilisation. Many studies have emphasised the importance of the time spent at the clinics waiting to see GPs (see Chapters Three and Four).

There are many bureaucratic and psychological elements which need to be tackled to attract people to make more use of the public health services. These bureaucratic barriers include working time, appointment system, availability of waiting rooms for both males and females, communication and improvement of the provision of the health services as well as availability of other needed services.

Many respondents believed the current working hours of the health centres need to be increased to give more chance for people to use them, because within the current times it is somewhat difficult for some respondents.

Regarding the need to make special arrangements, there are two main areas. The first is related to the health centre working hours and the absence of an appointment system. These factors necessitate that people make special arrangements, such as taking time off from work or getting someone to look after people at home. The second issue is the lack of co-ordination between the Ministry of Health medical facilities and other governmental medical organisations such as those of the Ministry of Education or the Presidency of Girls Education, which complicates arrangement for children's visits to the health centre. If there was co-ordination, it would be sufficient for the child to obtain a medical report from the health centre and receive medical treatment at the health centre. Incorporating school health services with the health service delivered by the health centre would certainly save financial and human resources, and facilitate delivery of health education through organised visits of health personnel to schools.

Transportation to the health centre was one of the problems faced by utilisers, though the majority of utilisers used their own or a family car. Very few used public transportation (taxi), or walked to the health centre, and these were mostly women, since they are not allowed to drive. This highlights the importance of the location of the health centre, especially to female users.

When asked where they preferred to be treated, many respondents indicated that they would prefer to go to the private sector, because of the standard of health services available at the private sector, better communication and the appointment system which led to reduced waiting time.

A few people can afford the private health services without any financial difficulty, but the majority can not, particularly for major surgical operations. Many people would like to use public health services but due to difficulties of access, they turn to the private sector, where they can have treatment when they like, and from high level providers - consultants or specialists - rather than general physicians.

Saudis and non-Saudis responded differently to the service. Non- Saudis were more satisfied than Saudis with the health services at the health centres. This could be because the majority of non - Saudis came from other Arab countries where the standards of health facilities are far lower than in Saudi Arabia. Moreover, some came from rural or remote areas where health facilities hardly exist. Thus, it was not surprising that non - Saudis were more easily satisfied with the health services, particularly as they were receiving them free of charge.

The government of Saudi Arabia has allocated a considerable amount of money for health care services (see Chapter Four). The health services delivered at the hospital level are considered acceptable and many of the sample would like to make use of them. On the health centre level, people still compare the health centre and the services delivered with the hospital services; thus some prefer to go to the hospital through the referral system than to be treated at the health centre. If this is not possible they go through emergency or they switch to the private sector.

Utilisation of the health centre for ten common ailments was tested and there were few significant differences among those registered with the health centre in seeking medical treatment for those ailments. Gender did not show any significant difference because these ailments were of a general type and associated with either sex. However, given the disproportionate representation of the

sexes in the sample, the validity of this finding may be limited. The same can be said in case of nationality; relatively few non-Saudis were included in the sample. However, other socio-demographic characteristics showed some significant differences. Age, marital status, income and nationality revealed very strong significant difference between the categories in use of the health centre for particular ailments.

On some occasions a comparison between registered and not registered respondents was made, and the non - registered revealed higher positive health awareness and behaviour. However, because they were rather few in comparison with the registered, it would be unwise to make any generalisation based on their behaviour. There is scope for further studies to find the differences between the two groups.

Having discussed general use of the health centre, we now turn to the special use of the centre, as some areas of special care are considered as core elements of the PHC strategy. Thus, the coming chapter will highlight the use of the health centre for maternity and child health care, and dentistry, and try to find if there are any relationships between utilisation of the services and the characteristics of the sample.

9.1 Introduction

This chapter will explore the utilisation of the health centre for special care and particularly for a particular segment of the population, children and mothers through delivery of paediatric and maternity care.

The strategy of the PHC approach emphasises maternal and child health care as well as immunisation against the major infectious diseases. Children and women at child bearing age are the most vulnerable groups of the population. Thus, for health centres to deliver health care for these two groups is a major part of the PHC aims. This chapter will shed light on the extent to which Jeddah's health centre services are fulfilling their role.

Child well-being involves preventive as much as curative care. Therefore, preventive measures should start at an early age, and include educational as well as practical procedures. Thus, information about appropriate methods of feeding the child and the importance of vaccination, are very important aspects of preventive health education, which need to be delivered to children's mothers and fathers. This, too, will be investigated. The other special use of the centre investigated in this chapter is dental care, which is applicable to the whole population.

9.2 The Use of the Health Centre for Paediatric Care.

To find out about the utilisation of the health centre for child care, people were asked about their behaviour if one child got sick and they thought another child had the same symptoms; would they take the second child to the health centre or use the same medicine? Responses to this question will be explored in relation to respondents' backgrounds, education, income, family size and nationality.

Table 9 - 1 summarises the respondents' answers as to how they would behave with the sick child.

Table 9 - 1 Distribution of the Respondents by Utilisation of the Health Centre with Sick Child

Treatment of Sick Child	Frequency	%
Take the child to the health centre	113.00	43.80
Give the child the same medication	145.00	56.20
Total	258.00	100.00

Table 9 - 1 shows that the majority, more than 56 % of the respondents, indicated that they would give the child the same medicine rather than take him to the health centre, while almost 44 % indicated that they would take the sick child to the health centre for treatment. This low level of utilisation of the health centre implies there could be some reasons that might impede people from taking the sick child to the health centre.

Table 9 - 2 Distribution of the Respondents according to the Reasons that Stopped them from taking the Sick Child to the Health Centre

Reasons	Frequency	%
No need to take him to doctor	87.00	60.00
Medicine will not harm him	12.00	8.30
The same medicine will be prescribed	143.00	98.60
PHCs' working hours are inconsistent with my work	61.00	42.10
Fear of overcrowding and long wait	22.00	15.20
Need to make special arrangement	89.00	61.40
Have no one to take him	8.00	5.50
Others	5.00	3.40
Total 145 Multiple Responses		

Table 9 - 2 shows the reasons that impeded registered respondents from taking a sick child to the health centre rather than giving him the same medication. 60 % indicated that they saw no need to take the child to the health centre as long as he / she had the same symptoms. More than 8 % of the respondents stated that the medicine would do no harm to the child; this is a very small group of people who need to be educated in this regard. Further, more than 98 % believed that the doctor at the health centre would prescribe the same medicine for the sick child. This group, like the preceding one, need to be made aware of the danger of using medicine or giving medicine to children without specialist supervision; as this medicine may cause side - effects, even resulting in handicap. But the answer may also indicate a lack of confidence in the health centre. More than 42% of the respondents stated the reason was because the health centres' working hours were inconsistent with their working time. For more than 15 %, the obstacle was fear of overcrowding or long waiting at the health centre, while more than 61 % indicated that they had to make special arrangements, which included taking time off from work, or needing someone to drive to the health centre. More than 5%

indicated that no one was available to take the sick child to the health centre, and 3.4 % indicated other reasons.

Thus, the reasons for not taking a sick child to the health centre, fell into two broad categories: those relating to lack of health education in regard to taking medicine or the help to be gained from the health centre; and those related to practical difficulties, which could to some extent be avoided by an extension of the working hours of the health centre.

9.2.1 Registration and Treatment of Sick Child

The comparison between those registered and not registered with the health centre, in dealing with sick child, revealed significant differences between the two groups. The non-registered who used the private health sector were less likely to give the sick child the same medication that was described for another child rather than to take him / her to the GP, while those registered with the health centre, who enjoy free medical care, were more likely to give the sick child the same medication that was prescribed for another child, rather than to take the sick child to see the GP at the health centre.

Table 9 - 3 Treatment of Sick Child by Registration.

Treatment of Sick Child	Registration Status %				Total	
	Yes		No		No.	%
	No.	%	No.	%		
Take the child to the GP	113.00	43.80	37.00	66.10	150.00	47.80
Give the child the same medication	145.00	56.20	19.00	33.90	164.00	52.20
Total Number	258.00	258.00	56.00	56.00	314.00	-
%		82.20	-	17.80	-	100.00
Chi-square = 9.14869 D. F. = 1 Significance = .00249						

Table 9 - 3 shows that more than 66 % of the non-registered would take the sick child to the GP, while less than 44 % of the registered would do so. As mentioned above, there was more than one reason why the sick child was not taken to the health centre. These reasons influenced the two categories, registered and non-registered, differently, as shown in Table 9 - 4.

Table 9 - 4 Obstacles Stopping Respondents from Taking a child to the GPs by Registration.

Reasons	Registration %		Total	
	Yes	No	No.	%
No need to take him to GP @ 1	30.10	9.20	93.00	26.30
The same medicine will be prescribed @ 2	49.50	27.70	161.00	45.50
Working time @ 3	21.10	0.00	61.00	17.20
Fear of overcrowding and long wait @ 4	7.60	0.00	22.00	6.20
Need to make special arrangement @ 5	30.80	9.20	95.00	26.80

1 Chi-square = 11.93610 D. F. = 1 Significance = .00055

2 Chi-square = 10.15997 D. F. = 1 Significance = .00144

3 Chi-square = 16.57605 D. F. = 1 Significance = .00005

4 Chi-square = 5.27598 D. F. = 1 Significance = .02162

5 Chi-square = 12.56878 D. F. = 1 Significance = .00039

Table 9 - 4 clearly indicates the need for health education for those registered with the health centre, in that more than 30 % among the registered would give a sick child medication prescribed for second child because they believed there was no need to take him. The effect of working hours and overcrowding were also influential on the registered, while the non-registered did not mention these reasons, because at the private health sector where they receive their health care, the appointment system is more effective and there is less crowding than in the public sector. Furthermore, because of limited operating hours of the health centres, people needed to make special arrangements if they wanted to take a child to the health centre (see Chapter Eight).

In the following sub - sections, we examine the influence of some socio - economic characteristics on utilisation of the health centre with a sick child.

9.2.2 Place of Birth and Treatment of a Sick Child

Examination of the effect of respondents' social backgrounds on utilising the health centre shows that there was only a very small, non - significant difference between urban and rural people in relation to whether they would take the sick child to the health centre or give him the same medication.

Table 9 - 5 Treatment of Sick Child by Social Background.

Treatment of Sick Child	Social Backgrounds %		Total	
	Urban	Rural	No	%
Take him to Health Centre	44.10	42.90	113.00	43.80
Give him Same medicine	55.90	57.10	145.00	56.20
No.	195.00	63.00	258.00	-
Percentage	75.60	24.40	-	100.00

It seems, then, that the majority of those of urban and rural origins either similar perspectives towards the idea that those was no need to visit the health centre or suffered similar obstacles that stopped them.

9.2.3 Income and Treatment of Sick Child

Regarding the relationship between income and utilising the health centre for a sick child, it was found that in the low and moderate income categories, more respondents tended to use the same prescribed medicine than to go to the health centre, while those with high income were more likely to take the child to the health centre rather than to use the same prescribed medication. Although the differences between the three categories were not statistically significant, the distribution reveals the expected patterns of behaviour in relation to income. However, low income is not a direct deterrent, because health services are delivered free of charge for all the population in the public sector. Thus, the role of income here might be associated with other factors such as the ability to go to the private sector, availability of transportation or ability to buy medicine.

Table 9 - 6 Treatment of Sick Child by Level of Income.

Treatment of Sick Child	Monthly Income %			Total	
	Low	Middle	High	No	%
Go to the health centre	42.10	45.70	53.80	113.00	43.80
Give the same medicine	57.90	54.30	46.20	145.00	56.20
Total	164.00	81.00	13.00	258.00	
%	63.60	31.40	5.00	-	100.00

It may also be that level of income is related to different attitudes (for example those in high income groups might be, on the whole, better educated).

9.2.4 Parents' Level of Education and Treatment of Sick Child

Usually, education is associated with a higher level of utilisation of the health services as this reflects a higher level of health awareness. This assumption is borne out by the findings of this study although the difference is not statistically significant as Table 9 - 7 shows.

Table 9 - 7 Treatment of Sick Child by Level of Education.

Treatment of Sick Child	Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Take him to the health centre	33.90	44.30	41.50	59.60	113.00	43.80
Give him the same medication	66.10	55.70	58.50	40.40	19.00	56.20
Total	56.00	61.00	94.00	47.00	258.00	-
%	21.70	23.60	36.40	18.20	-	100.00

The crosstabulation of parents' levels of education with visiting the health centre for treatment for a sick child shows that the higher the education, the more likely people are to visit the health centre for medical treatment for the children. Although it can be seen that there were no significant differences between the levels of education in relation to taking the infected child to the health centre or using the same medicine, the pattern of these groups give some indications of a need for more health education, particularly among those with less general education.

9.2.5 Family Size and Treatment of Sick Child

Regarding the family size and utilisation of the health centre for children, it was expected that the larger the family, the more likely it was to use the health centre's services. However, responses to this question showed that those with smaller families were more likely to go to the health centre. Table 9 - 8 reveals that more than 60 % of family size 2 - 4 would take the sick child to the health centre when sick rather than give him / her the same medicine, while those with 5 - 7 or 8 - 10 members were less likely to take the child to the health centre. This is probably because travel to the health centre for a large family can be difficult unless there is someone to stay at home with the other children. Also, there are other reasons such as the ideology of limiting the number of children in order to provide them with a better upbringing. This ideology is probably to great extent established itself among people with official education, as indicated by Table 9 - 7 which shows the relationship between level of education and utilisation of the health centre for treatment for sick child. Another factor which

may help to explain the tendency of small families to use the health centre more is that the small families are more likely to be young couples who have benefited from the spread of education in Saudi Arabia and have reasonable health awareness and education so that they have become more aware of the importance of sought medical treatment rather than given him same medicine. Furthermore, working mothers tend to have small families because of the job burden and responsibility. On the other hand, it could be said that where there are fewer children, the family may pay more attention to the children, or be less confident and experienced in dealing with children's ailments. Through their long experience with children's sickness, larger families may become, to some extent, familiar with some conditions and feel less need to utilise the health centre than those with smaller families. Altogether, using the health centre for sick child by family size reflects many other factors such as level of education, women's working status and age of parents.

Table 9 - 8 Treatment of Sick Child by Family Size.

Treatment of Sick Child	Family Size %					Total	
	2 - 4	5 - 7	8 - 10	11 - 13	More than 13	No.	%
Take Him to Health Centre	61.00	40.30	39.40	44.40	50.00	113.00	43.80
Give Him Same Medicine	39.00	59.70	60.60	55.60	50.00	145.00	56.20
Total	41.00	129.00	66.00	18.00	4.00	258.00	-
%	15.90	50.00	22.50	7.00	1.60	-	100.00

Regarding those with 11 - 13 and more than 13 members, a high proportion of them indicated that they would take the sick child to the health centre rather than give medicine. There are two interpretations for the surprising finding that going to the health centre increases again with the largest families. As the family contains more members, an adult may be available to stay at home with the children. Another factor is that, their number in the sample was relatively small, compared to the other categories, so the findings may not be representative.

9.2.6 Nationality and Treatment for Sick Child

Regarding the relationship between nationality and utilisation of the health centre in relation to a sick child, no significant difference was found between Saudis and non - Saudis.

Table 9 - 9 Treatment of Sick Child by Nationality.

Treatment of Sick Child	Nationality %		Total	
	Saudi	Non - Saudi	No	%
Take the Child to Health Centre	42.60	48.20	113.00	43.80
Give the Child the Same Medicine	57.40	51.80	145.00	56.20
Total	202.00	56.00	257.00	-
%	78.30	21.70	-	100.00

Table 9 - 9 indicates that both Saudis and non - Saudis were more likely to use the same medicine, in general, than to take the sick child to the health centre. However, non - Saudis were more likely than Saudis to use the health centre, and less likely than Saudis in use the same medication.

None of the relationships between socio - economic characteristics and the attitude towards taking the sick child to the health centre or giving him / her medicine were statistically significant. However, they were outlined above to show the expected behaviour in relation to socio-demographic characteristics.

9.3 Patterns of Behaviour with the Sick Child.

In many cases if a child does not recover, his / her parents tend to take him / her to another doctor, because they think the first doctor's treatment did not work; they may even lose confidence in the first doctor, and refuse to visit him again. This could mean that such parents would not seek any further treatment at the health centre, as far the mistrusted doctor is concerned. However, to find out about this attitude, data were collected. Table 9 - 10 summarises the result.

Table 9 -10 Distribution of the Health Centre Utilisers in Relation To Choice of Doctor.

Choice of Doctor	Frequency	%
Same Doctor	79.00	29.70
Another Doctor	187.00	70.30
Total	266.00	100.00

Table 9 - 10 shows that slightly more than 29 % indicated they would go back to the same GP at the health centre, but the majority, over 70 %, indicated that they would go to see another doctor rather than to go back to the GP at the health centre. So, there was a general trend among all the

health centre utilisers to choose to go to another doctor, if they were unhappy with the medical treatment they had received at the health centre.

9.3.1 Satisfaction and Choice of Doctor

To find if there was any relationship between satisfaction with the service at the health centre and the choice of the doctor, data showed that there was a significant relationship between the choice to go back to the same doctor or to go to another one.

Table 9 - 11 Choice of Doctor by Satisfaction with Health Services.

Choice of Doctor	Satisfaction %		Total	
	Yes	No	No.	%
Same GP	40.70	24.90	79.00	29.70
Another GP	59.30	75.10	187.00	70.30
Total Number	81.00	185.00	266.00	-
%	30.50	69.50	-	100.00
Chi-square = 6.77500 D. F. = 1 Significance = .00911				

Table 9 - 11 shows that almost 41 % of the satisfied respondents would go back to the same GP at the health centre, while less than 25 % of dissatisfied would do so. Over 75 % of those who were dissatisfied would go to another GP rather than to go back to the same GP at the health centre.

9.3.2 Education and the Choice of Doctor

The study did not find any significant relationship between respondents' socio - economic characteristics and the choice of the GP, except with level of education. Table 9 - 12 summarises the findings.

Table 9 - 12 Choice of Doctor by Education of Utilisers

Choice of Doctor	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Same GP	28.10	18.20	33.30	40.40	79.00	29.70
Another GP	71.90	81.80	66.70	59.60	187.00	70.30
Total No.	57.00	66.00	96.00	47.00	266.00	-
%	21.40	24.80	36.10	17.70	-	100.00
Chi-square = 7.46287 D. F. = 3 Significance = .05852						

It appears from Table 9 - 12 that education has some influence on the behaviour in dealing with the sick child. Those with secondary and high levels of official education were more likely to stick with the same GPs they had already seen the first time, while respondents with low or intermediate education were more likely to go to another GP.

9.3.3 Registration and the Choice of Doctor

When comparison is made between registered and non-registered in relation to choice, it seems that the registered were more likely than the non-registered to opt for another doctor.

Table 9 - 13 Choice of Doctor by Registration.

Choice of Doctor	Registration %		Total	
	Yes	No	No.	%
Same GP	29.70	83.30	129.00	39.60
Another GP	70.30	16.70	197.00	60.40
Total No.	266.00	60.00	326.00	-
%	81.60	18.40	-	100.00
Chi-square = 58.89471 D. F. = 1 Significance = .0000				

Table 9 - 13 reveals that more than 83 % of non-registered would go back to see the same GP, in contrast with less than 30 % of the registered. This may be because many of those who receive free health care still hold a negative image about the health service in the public sector.

9.4 Preferred Place for Sick Child to be Treated

When parents were asked to state where they would like to go in order to visit another doctor, they responded as shown in Table 9 - 14.

Table 9 - 14 Distribution of Parents' Preferences Where to Treat their Child

Place to be treated	Frequency	%
Public Hospital	50.00	26.70
Private Hospital	132.00	70.60
Ask Relative's Advice	5.00	2.70
Total	187.00	100.00

Table 9 - 14 reveals that less than 27 % of the parents would take their sick child to a public hospital, while more than 70 % of them indicated that they would take him to a private hospital. A

very few, less than 3 %, indicated that they would ask for a relative's advice. It seems that the private sector may be more trusted than the public hospital.

9.4.1 Socio - economic Status and Choice of Place for Treatment

Two socio-demographic factors showed significant differences for the choice of where to take the child to be treated, if it did not recover: level of education and social background. Those with low or secondary education were more likely to go to use the public hospital, through the emergency department, than those with intermediate and high levels of formal education. Table 9 - 15 summarises their answers.

Table 9 -15 Preferred Source of Alternative Medical Treatment by Level of Education.

Place to be treated	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Public Hospital	31.70	18.50	37.50	10.70	50.00	26.70
Private Hospital	65.90	75.90	60.90	89.30	132.00	70.60
Relative Advice	2.40	5.60	1.60	0.00	5.00	2.70
Total No.	41.00	54.00	64.00	28.00	187.00	-
%	21.90	28.90	34.20	15.00	-	100.00
Chi-square = 12.51340 D. F. = 6 Significance = .05145						

As Table 9 - 15 reveals, those with a high level of formal education were more likely to take the sick child to private hospital and they did not indicate that they would listen to a relatives advice. The other category which showed a low tendency to use the public service were those with an intermediate level of education but at the same time they were the group most likely to act according to a relative's advice. However, the higher the education, the more likely the client is to seek treatment in the private sector. A similar result was found by Al -Khalifah et al. (1993).

Significant differences were found between those with urban and rural background. The rural were more likely to go to the public hospital through the emergency department, while the urban showed a greater preference for private hospitals (Table 9 - 16).

Table 9 - 16 Preferred Source of Alternative Medical Treatment by Social Background.

Place to be treated	Social Background %		Total	
	Urban	Rural	No.	%
Public Hospital	22.40	40.90	50.00	26.70
Private Hospital	74.80	56.80	132.00	70.60
Relative's Advice	2.80	2.30	5.00	2.70
Total No.	143.00	44.00	187.00	-
%	76.50	23.50	-	100.00
Chi-square = 5.90175 D. F. = 2 Significance = .05229				

Table 9 - 16 shows that almost 75 % of those with urban background would prefer to be treated at a private hospital while 57 % of the rural said so. Regarding relative's advice, there was no significant difference between the two categories. The urban people may prefer the private health sector because of their long experience with the two systems. A high proportion of rural people may prefer the public sector for a number of reasons: first they came from rural areas where the health service did not exist, or if it did exist, it was in the form of a small health centre; secondly they still judge the hospital by its size, and usually, government hospitals are huge in contrast with the majority of the private hospitals; thirdly most people of rural background have a lower monthly income, so it would be hard for them to afford to go to the private sector. Finally, they hold a strong belief that the government knows best and employs the best doctors and pays high salaries.

9.5 Parents' Involvement in Decision - Making For Treatment Choice

Although the percentage of those who indicated that they would ask for a relative's advice was very low, the study attempted to investigate whether there is any involvement of parents' parents in the decision - making as to where to take a child for medication. Most respondents indicated that their parents sometimes gave advice, while a very small number indicated that they were not involved.

Table 9 - 17 Distribution of the Respondents by Receiving Advice from Parents on where to Take a Child for Medical Treatment

Parents' Parents Provide Advice	Frequency	%
Yes	119.00	86.20
No	19.00	13.80
Total	138.00	100.00

Such influence is likely to be particularly strong where parents live in the same house, but it may also happen that parents' advice is received during the course of general conversation.

Table 9 - 18 shows to what extent respondents followed the advice given by their parents.

Table 9 - 18 Distribution of the Respondents by Frequency of Accepting Parents' Advice

Frequency of Compliance	Frequency	%
Always	33.00	27.70
Sometimes	66.00	55.50
Rarely	19.00	16.00
Never	1.00	0.80
Total	119.00	100.00

It appears from the table that almost 28 % always accepted and acted on their parents' advice, and more than 55 % did so sometimes. 16 % did so rarely and only one person never accepted parents' advice in seeking medical treatment for a sick child. Thus, the influence from the older generation is still relatively strong.

An attempt was made to find out whether there was any influence of socio - demographic characteristics or attitudes (such as satisfaction) on the acceptance of parents' advice. The tests of significance did not reveal any significant relationships between the sample's characteristics and acceptance of the advice. However, the general trend was for the acceptance of parental advice to be greater among female than male respondents. There is an inverse relationship between acceptance of advice and levels of education. Regarding social background, urban respondents were more likely to accept advice from their parents than rural ones, perhaps because the parent lived in the same house, or at least nearby, while rural respondents' parents might still live in their villages, far from the city, or if they have come to the city, may be too new to it to be able to provide advice as to where to go for treatment.

To find out who usually accompanies the child to the health centre, and to whom the doctor gives instructions and explanations, some data were collected in this regard.

Table 9 - 19 Distribution of Respondents by Person Accompanying the Sick Child to the Health Centre

Person Accompanying the Child	Frequency	Percentage
Father	75.00	28.80
Mother	55.00	21.20
Both Father and Mother	125.00	48.10
Eldest Brother	5.00	1.90
Total	260.00	100.00

Table 9 - 19 shows that almost 29 % of the respondents indicated that the father usually goes with the sick child to the health centre, and more than 21 % indicated the mother. More than 48 % stated that the father and mother both go and less than 2 % said the eldest brother goes with the sick child to the health centre. This reflects the fact that Saudi society is patriarchal, and family outside activities are normally carried out by the man. It is more likely that both parents will go to the health centre than the mother alone, because of the constraints on transportation for unaccompanied women, referred to earlier.

From the above, it is to be expected that the doctor usually gives his instruction and explanations to the father or both father and mother, if they both accompanied the child. This study found that 28 % indicated that the doctor usually gives the instructions to the father, 22 % to the mother and 50 % to both father and mother.

9.5.1 Person Who Gives Medicine to Child

When the sample were asked to identify who usually gives the child the medicine, the majority (more than 68 %) indicated the mother, while the father accounted for less than 2 %. Both father and mother accounted for 27.4 %. In a few cases, medicine was given by the eldest sister or a housemaid.

Table 9 - 20 Distribution the Sample in terms of Who Gives the Medicine to the Sick Child.

Who gives the medicine	Frequency	Percentage
Father	4.00	1.50
Mother	178.00	68.70
Both Father and Mother	71.00	27.40
Eldest Sister	3.00	1.20
Housemaid	3.00	1.20
Total	259.00	100.00

Table 9 - 20 reveals the strong role that women play in looking after the family health. The man alone administered medication in less than 2 % of cases, but women alone did so in more than 68 % of cases, and in combination with the man for a further 27 %. Thus, health education programmes should be particularly oriented toward women and provide them with all the necessary basic health information.

9.6 Immunisation

Children's immunisation against the major preventable communicable diseases of infancy and childhood is one of the core matters of the PHC approach. The rate of child immunisation coverage through the health centres gives an indication of the improvement in the health conditions of children, and indeed, the whole society. Immunisation protects children from preventable communicable diseases and saves considerable human as well as financial resources for the country.

In Saudi Arabia, each child at birth is issued with a card. When a child is vaccinated, the data is entered on the card, with the type of vaccinations. This card is supposed to be accurate and kept up-to-date.

A very influential factor for the high rate of immunisation in Saudi Arabia is that the government has decreed that no birth certificate is issued unless a child has all the necessary immunisation. This means parents would not be able to register their child with the department of nationality, and they would be fined if they did not register within the approved time. Furthermore, a child can not be admitted to school without a birth certificate. These regulations have helped to increase the number of vaccinated children.

In this study, parents were asked if their children had been vaccinated. If the answer was yes, then other related questions were asked, such as where was the child immunised, was it at the suggested times, and did parents think immunisation is very important.

9.6.1 Immunisation and Social Background

In this study the vast majority, 89.1 %, of the health centre utilisers indicated that their children were vaccinated, though a difference was noticed between people of urban and rural background. 91.3 % of the urban indicated that their children had been vaccinated compared with 82.5 % for rural (see Table 9 - 21). Comparing with recent studies, Nur (1989) found vaccination rate was 83

% for urban, 73 % for rural and 58 % for nomadic areas. Al - Mazrou and Farid (1991) found that 95 % of the urban children had been vaccinated and 85 % of rural.

Table 9 - 21 Child's Vaccination by Background.

Vaccination Status	Social Background %		Total	
	Urban	Rural	No.	%
Yes	91.30	82.50	230.00	89.10
No	8.70	17.50	28.00	10.90
Total No.	195.00	63.00	258.00	-
Percentage	75.60	24.40	-	100.00
Chi-square = 3.76155 D. F. = 1 Significance = .05244				

9.6.2 Parents' Level of Education and Child Immunisation

Another differential factor was the parents' level of education. The higher the parents' level of education, the more likely the children were to be vaccinated. Although the difference between some levels were not statistically significant, they generally reveal some influence of education as Table 9 - 22 shows.

Table 9 - 22 Child's Vaccination By Parents' Level of Education

Vaccination Status	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Yes	84.20	90.00	89.40	93.60	230.00	89.10
No	15.80	10.00	10.60	6.40	28.00	10.90
Total No.	57.00	60.00	94.00	47.00	258.00	-
%	22.10	23.30	36.40	18.20	-	100.00

Other studies have also reported on this relationship. Al - Mazrou and Farid (1991) found that the mother's level of education is more influential than that of the father. Nur (1989) found that the vaccination rate was 91 % for children whose mother had some kind of education, while it was 64 % for mothers with no education.

9.6.3 Scepticism of Modern Medicine and Child Vaccination

It was thought that there might be a significant relationship between scepticism of modern medicine and child vaccination. However, the cross-tabulation did not show any significant differences between those who believed and disbelieved in modern medicine, (see Table 9 - 23) though there was a slight general trend for those who strongly believed in modern medicine to be

more likely to have their children vaccinated. The lack of significant difference probably arises because, as stated above, vaccination is compulsory and reinforced by government decrees. Thus, the socio-demographic and economic features of the sample would not give any significant relationship, as it is not a voluntary act.

Table 9 - 23 Child's Vaccination by Scepticism of Modern Medicine.

Level of Agreement with Modern Medicine	Vaccination %		Total	
	Yes	No	No.	%
Strongly Agree	16.50	14.30	42.00	16.30
Agree	31.70	32.10	82.00	31.80
Disagree	30.40	25.00	77.00	29.80
Strongly Disagree	15.20	28.60	43.00	16.70
Do Not Know	6.10	0.00	14.00	5.40
Total No.	230.00	28.00	258.00	-
%	89.10	10.90	-	100.00

9.6.4 Relationship between Vaccination and frequency of visiting Maternity care

Another factor which it was thought might have some influence on child vaccination, is the frequency of women's visits to the obstetrician during pregnancy, in other words, that those who made frequent visits to the health centre may have been more likely to have their children vaccinated than others who made fewer visits or never visited the obstetrician at all. In fact, perhaps because of the compulsory act of vaccination, this factor did not have a strong influence. More than 91 % of those who made frequent visits to maternity care had their children vaccinated, while almost 93 % of those who rarely visited the maternity care at the health centre had their children vaccinated (Table 9 - 24).

Table 9 - 24 Child's Vaccination by the Use of Maternity Care.

Vaccination Status	Always	Sometimes	Rarely	Never	No.	%
Yes	91.30	85.90	92.90	50.00	228.00	89.10
No	8.70	14.10	7.10	50.00	28.00	10.90
Total No.	127.00	99.00	28.00	2.00	256.00	-
%	49.60	38.70	10.90	0.80	-	100.00

However, among those who indicated that they had never been for the maternity care, 50 % had vaccinated their children and 50 % had not. It is possible that if both the maternity care clinics

and well child care units were situated in one health centre, this might increase the rate of vaccination, as might the combining of maternity care and child care appointments, if an appointment system were introduced.

9.6.5 Relationship Between Vaccination and Compliance with GP's Instructions

Regarding whether compliance with doctor's instructions had any influence on vaccination, the findings showed there was no significant difference among the respondents (Table 9 - 25).

Table 9 - 25 Child's Vaccination by Complying with Doctors' instructions.

Vaccination Status	Level of Complying %			Total	
	Always	Sometimes	Rarely	No.	%
Yes	91.50	87.10	89.50	229.00	89.10
No	8.50	12.90	10.50	28.00	10.90
Total No.	106.00	132.00	19.00	257.00	-
%	41.20	51.40	7.40	-	100.00

Table 9 - 25 reveals that more than 91 % of those who always followed doctors' instructions indicated that their children had been vaccinated. Although those who rarely or sometimes complied were less likely to have their children vaccinated, the difference was not large.

9.6.6 Organisational Effect on Rate of Vaccination

We also investigated whether any organisational factors impeded respondents from achieving 100 % vaccination. The findings revealed that those who had faced some difficulties had a lower rate of vaccination. Though the difference was not statistically significant, (Table 9 - 26) it may be that bureaucratic and organisational obstacles had some effect on the behaviour of the utilisers of the health services in this respect.

Table 9 - 26 Child's Vaccination by Difficulties.

Vaccination Status	Difficulties %		Total	
	Yes	No	No.	%
Yes	88.80	92.00	230.00	89.10
No	11.20	8.00	28.00	10.90
Total No.	233.00	25.00	258.00	-
%	90.30	9.70	-	100.00

9.6.7 Compliance with Suggested Times for Vaccination

Children are supposed to be immunised at a suggested time for each type of vaccination. Some parents sometimes skip these suggested times, for one reason or another, even if they recognise the importance of vaccination. Table 9 - 27 shows the percentage of respondents' children that had been vaccinated at the suggested times.

Table 9 - 27 Distribution of Children's Vaccinations at the Suggested Times.

Vaccinations Taken at the Suggested times	Frequency	%
All of Them	45.00	17.40
Most of Them	112.00	43.40
Some of Them	48.00	18.60
None of Them	53.00	20.50
Total	258.00	100.00

Table 9 - 27 illustrates that a little more than 17 % of respondents said that their children had all the essential vaccines at the suggested times, though more than 43 % said they had most of them at the suggested times. 18.6 % said their children had had some of them, while more than 20 % of the children had none of the necessary vaccines at the suggested times. The majority of parents acknowledged the importance of vaccinating the children, and would like their children to be protected from preventable diseases, but in practice, the majority of the parents did not comply with the suggested times for having their children vaccinated. However, of those who indicated that their children did not have any of the vaccination at the suggest times (20 %), the majority of them gave the reason that at the time of vaccination their child had an allergy.

Compliance with the suggested times for vaccination showed a significant relationship with level of education and with difficulties facing the utilisers of the health centre while other socio-demographic characteristics did not reveal any significant differences. Regarding the level of education, those with a high level of formal education were more likely to have had their children given all of the necessary vaccines at the suggested times, while only 10.5 % of those with a low level of education had done so (Table 9 - 28).

Table 9 - 28 Vaccination at the Suggested Times by Level of Education.

Vaccination Taken	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
All of Them	10.50	14.80	17.20	29.80	45.00	17.40
Most of Them	43.90	32.80	49.50	44.70	112.00	43.40
Some of Them	24.60	21.30	14.00	17.00	48.00	18.60
None of Them	21.10	31.10	19.40	8.50	53.00	20.50
Total	57.00	61.00	93.00	47.00	258.00	-
%	22.10	23.60	36.00	18.20	-	100.00
Chi-square = 177.49943 D. F. = 9 Significance = .04145						

The second factor which had an impact on taking vaccination at the suggested time was organisation - related. Those who had faced some kind of difficulties were less likely to have all the vaccinations at the suggested time. Table 9 - 29 summarises the findings.

Table 9 - 29 Vaccination at the Suggested Times by Facing Difficulties.

Vaccination Taken	Facing Difficulties %		Total	
	Yes	No	No.	%
All of Them	15.90	32.00	45.00	17.40
Most of Them	42.50	52.00	112.00	43.40
Some of Them	19.70	8.00	48.00	18.60
None of Them	21.90	8.00	53.00	20.50
Total No.	233.00	25.00	258.00	-
%	90.30	9.70	-	100.00
Chi-square = 7.62744 D. F. = 3 Significance = .05437				

It appears from Table 9 - 29 that the difficulties facing many utilisers had influenced them in one way or another. Less than 16 % of those who had faced some difficulties had their children vaccinated at the suggested times, whereas it was 32 % for those did not report any difficulties. Conversely, 22 % of those who had difficulties said that their children did not have any vaccination at the suggested times, compared to only 8 % for those who did not face difficulties.

Places where children were usually vaccinated were calculated on a multiple response basis, because the child might have been vaccinated in more than one institute. The results in Table 10 -30 show that PHC centres accounted for the highest percentage of vaccination, almost 54 %; public

health centres accounted for more than 43 %, private health centres for almost 28 % , private hospitals more than 26 %, and public hospitals only 8.1 %. The maternity hospital vaccinated less than 13 % and others, 11.2 %.

Table 9 - 30 Distribution of the Sample According to the Institutes where Children had been Vaccinated.

Institutes Where Child Vaccinated	Frequency	%
Maternity Hospital	32.00	12.40
General Hospital	21.00	8.10
Private Hospital	66.00	25.60
PHC Centres	139.00	53.90
Private Health Centres	72.00	27.90
Public Health Centres *	112.00	43.40
Others	29.00	11.20
Total questioned = 258 Multiple Responses		

* Public Health centres are the General Health Centres and Health Post before they were converted into PHC centres.

Vaccination sometimes took place at the maternity hospital because all children born at this hospital had their growth monitored by the hospital, so the opportunity of vaccination was taken on these visits. However, since the introduction of PHC centres, most children's vaccinations have been carried out at the health centres. Public health centres, before being converted into PHC centres, used to provide a limited range of child vaccinations. Their functions are now carried out by the PHC centre.

The private sector, both hospitals and health centres, had been the source of vaccination in almost 53.5 % of cases. This may be because of the inconvenient working hours of the public health centres in the past and the PHC centre now, as mentioned above.

Immunisation is very important to protect children against many preventable illnesses. Many children every day , on the global level, die of diseases which can be immunised against. Although child vaccination in Saudi Arabia, as mentioned previously, is obligatory, discussion revealed that a few respondents (10.2 %) indicated their children had not yet been vaccinated, and not all had a valid reason (e. g. allergy, or child still too young) for this. This ratio of non - vaccinated children,

persisting despite legal requirements, might suggest to the health planners and administrators that there is a group of the population which needs to be targeted to educate them about the significance of child vaccination. With this in mind, this study attempted to survey all the population characteristics to find whether it was possible to identify such a group, as in a country like Saudi Arabia, even though extensive efforts have been made to improve health conditions, it is expected that some of the population may still not vaccinate their children for cultural reasons, such as fear that vaccination causes illness. In fact, those who said their children had not been vaccinated were found in almost every segment of the population, to varying degrees. They were represented in all levels of income, although the majority were among those with low income (16 %). Non - vaccinators constituted 16 % of those with a low level of education. There were more among age groups over 41 years (21 %) and, in terms of social background, those who failed to take up vaccination were more prevalent among rural (17.5 %) than urban (8.7 %) population. If these groups were to receive special attention and health education it seems likely that the rate of child immunisation in Saudi Arabia could be considerably increased in a very short time.

Regarding whether immunisation was taken at the suggested time, it was indicated above that few (17.40 %) always vaccinated their children at the suggested times, while more than 20 % had none of the vaccinations at the suggested times. Discussion revealed significant relationships between education and difficulties facing the utilisers, and their behaviour with regard to timing of vaccination. This implies two different issues, one concerned with organisational factors and the other with health awareness. Thus, to improve the situation, it will be necessary both to address the problem of conditions at the health centres, and related matters, and to increase people's awareness of preventive care, through health education.

9.7 Utilising the Health Centre for Maternity Care.

Maternity and child health care services are delivered at the maternity hospital and through PHC centres. The maternity hospital was formerly the main source of maternal and child care, but since the introduction of the PHC approach, only delivery takes place at the maternity hospital, while all the health care for the pregnant woman should take place at the health centre.

As a cornerstone of the PHC programme, maternal care aims to promote and protect the health of women of childbearing age. Maternal care services are basically in the form of ante-natal care, delivery care, postnatal care and family health. Data were collected concerning a number of issues related to visiting the health centre for maternity care, frequency and types of these visits, health education for expectant mothers and institutes where delivery usually takes place.

Regarding use of the health centres for maternity services, it was found that the vast majority of the respondents indicated that the pregnant women in their family at some time visited the obstetrician. The answers of the respondents are seen in Table 9 - 31

Table 9 - 31 Distribution of the Health Centre Utilisers by Frequency of Visits made by the Pregnant Women in the Family

Visit Obstetrician	Frequency	%
Always	138.00	49.60
Sometimes	107.00	38.50
Rarely	31.00	11.20
Never	2.00	0.70
Total	278.00	100.00

Table 9 - 31 reveals that less than 50 % of the respondents indicated that the pregnant women in their family always visited the obstetrics clinics at the health centre. More than 38 % said they did so sometimes, 11.2 % rarely and less than one per cent indicated no visits at all.

This can be attributed to the fact that older respondents reflected the time when pregnant women would not see obstetricians because no females were practising. As a result, the rate of maternity mortality was very high. Some women still consider delivery at hospital is unacceptable; they prefer delivery at home with the assistance of a midwife.

It is recommended that pregnant women attend for antenatal care every month during the first and second trimesters, once every two weeks during the following eight weeks (28th to 36th) and once every week until delivery, if everything progresses normally. This was not practised by every pregnant women in the respondents' families. Therefore, the health team at the PHC centre need to encourage pregnant women to utilise this service and to provide them with the necessary health

education. If this period of time is exploited and the pregnancy supervised, many complications could be avoided and maternal mortality would be reduced.

9.7.1 Level of Education and Maternity Care

Cross - tabulation revealed that the number of visits made by the pregnant women increased with the level of education, as shown in Table 9 - 32. Many other studies have also found that there is a relationship between women's education and the take - up of antenatal care. Al - Mazrou and Farid (1991) found that 83 % of literate pregnant women had pregnancy check - ups, compared to 62 % of illiterate women. However, the utilisation of maternity health care services in general is expanding among Saudi women, due to the spread of female formal education, which started just twenty years ago.

Table 9 - 32 Visits made by Pregnant Women to the Health Centres by Level of Education

Visit Obstetrician	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	35.00	50.00	53.40	59.60	138.00	49.60
Sometimes	45.00	35.30	39.80	31.60	107.00	38.50
Rarely	18.30	13.20	6.80	8.50	31.00	11.20
Never	1.70	1.50	0.00	0.00	2.00	0.70
Total	60.00	68.00	103.00	47.00	278.00	-
%	21.60	24.50	37.10	16.90	-	100.00

Chi-square = 12.68215 D. F. = 9 Significance = .17752

9.7.2 Place of Birth and Maternity Care

Urban pregnant women were found to be more likely to have pregnancy check ups than rural women, a difference which was statistically significant.

Table 9 - 33 Visits made by Pregnant Women to the Health Centre by Background.

Visit Obstetrician	Backgrounds %		Total	
	Urban	Rural	No.	%
Always	56.90	26.90	138.00	49.60
Sometimes	31.80	59.70	107.00	38.50
Rarely	10.40	13.40	31.00	11.20
Never	0.90	0.00	2.00	0.70
Total	211.00	67.00	278.00	-
%	75.90	24.10	-	100.00

Chi - square = 20.59076 D. F. = 3 Significance = .00013

However, the two respondents who said women in their families never visited for maternity care were both urban. Comparing with other studies, Nur (1989) found that 73 % of urban women made use of maternity care, 62 % of rural women did so and 56 % of nomadic women. Al - Mazrou and Farid (1991) reported that 76 % of urban women visited the obstetrician during pregnancy and 56 % of rural ones did so. A large proportion of women believed that there is no need to visit the obstetrician periodically during pregnancy, as long as the pregnant woman's health is normal, she feels no pain and there are no complications with the pregnancy.

9.7.3 Nationality and Maternity Care

Table 9 - 34 reveals there was a noticeable but not statistically significant difference in the use of maternity care between Saudis and non - Saudis; non - Saudi pregnant women more frequently visited for maternity care than did Saudi women. Almost 58 % of non - Saudis indicated that the pregnant women in their family frequently visited the obstetrician, compared with 47.5 % for Saudis. More than 40 % of Saudis stated that sometimes pregnant women utilised the obstetrician services at the health centre whereas the percentage for non - Saudis was 30 %. Among those who rarely visited the obstetrician, the proportions were statistically identical at 11 % for Saudis and a little over 12 % for non - Saudis.

Table 9 - 34 Visits made by Pregnant Women to the Health Centre by Nationality.

Visit Obstetrician	Nationality %		Total	
	Saudi	Non - Saudi	No.	%
Always	47.50	57.90	138.00	49.60
Sometimes	40.70	29.80	107.00	38.50
Rarely	10.90	12.30	31.00	11.20
Never	0.90	0.00	2.00	0.70
Total	221.00	57.00	278.00	-
%	79.50	20.50	-	100.00

9.7.4 Other Factors and Maternity Care.

Some other factors had an influence on the utilisation of maternity care at the health centre. Satisfaction with the health services delivered at the health centre revealed a significant relationship. Those who were satisfied were more likely to make frequent visits to the health centre than the

non-satisfied. The dissatisfied were more likely to use the maternity clinic sometimes or rarely (see Table 9 - 35).

Table 9 - 35 Visits made by Pregnant Women to the Health Centre by Satisfaction.

Visit Obstetrician	Satisfaction %		Total	
	Yes	No	No.	%
Always	57.50	46.40	138.00	49.60
Sometimes	30.50	41.80	107.00	38.50
Rarely	9.80	11.70	31.00	11.20
Never	2.40	0.00	2.00	0.70
Total No.	82.00	196.00	278.00	-
%	29.50	70.50	-	100.00
Chi-square = 8.29886 D. F. = 3 Significance = .04022				

Also, compliance with the doctor's instructions showed a significant relationship (Table 9 - 36). Those who always complied with the doctor's instructions made the highest rate of use of the maternity clinic, while over 42 % of those who indicated they sometimes complied with the doctor's instructions made frequent visits, and those who rarely complied with the doctor's instructions were less likely to make regular ante-natal visits.

Table 9 - 36 Visits made by Pregnant Women to the Health Centre by Complying with Doctor's Instructions.

Visit Obstetrician	Level of Complying with The Doctor's instructions			Total	
	Always	Sometimes	Rarely	No.	%
Always	62.00	42.50	28.60	130.00	49.40
Sometimes	26.90	43.30	66.70	101.00	38.40
Rarely	10.20	13.40	4.80	30.00	11.40
Never	0.90	0.70	0.00	2.00	0.80
Total No.	108.00	134.00	21.00	263.00	-
%	41.10	51.00	8.00	-	100.00
Chi-square = 17.19617 D. F. = 6 Significance = .00859					

Finally, a significant relationship was found between the working status of women and frequency of utilising the maternity clinic (Table 9 - 37). More than 65 % of the working women always made use of the clinic, compared with 45.4 % for non-working women. More than 40 % of

non-working women sometimes made use of the clinic, in contrast with less than 32 % of working women. Working women, because of contact with their work mates, might learn the importance of seeing the obstetrician regularly and also exchange information about good obstetricians. Also, women with a career may be more educated (especially as in Saudi culture, acceptable careers for women are in health and education) . Another factor is that working women are used to going out, and either the availability of transportation or the habit of going out may make it easier for them to visits the obstetrician. Non-working women may be impeded by obstacles such as lack of transportation.

Table 9 - 37 Visits made by Pregnant Women to the Health Centre by Women's Working Status.

Visit Obstetrician	Women's Working Status %		Total	
	Yes	No	No.	%
Always	65.20	45.40	131.00	50.400
Sometimes	31.80	40.20	99.00	38.10
Rarely	3.00	13.40	28.00	10.80
Never	0.00	1.00	2.00	0.80
Total No.	66.00	194.00	260.00	-
%	25.40	74.60	-	100.00
Chi-square = 10.33778 D. F. = 3 Significance = .01590				

Arrangements for having a pregnancy check - up were categorised into three categories as seen in Table 9 - 38. More than 40 % of pregnant women paid a visit every month during the pregnancy, 56.5 % did so only when they had pain, while less than 3 % visited the obstetrician at delivery only (those actually go to the maternity hospital or general hospital).

Table 9 - 38 Distribution of the Health Centre Utilisers in Relation to Pregnant Women's Visits to Obstetrician at the Health Centre

Visit Arrangement	Frequency	Percentage
Once a month	113.00	40.60
When she feels pain	157.00	56.50
Only at delivery	8.00	2.90
Total	278.00	100.00

The first group followed up the whole procedure of infant development and whenever any unexpected complication happened they would be in touch with their obstetrician. The importance of

this is that pregnancy check - ups can help to reduce maternity mortality and also to monitor infant health.

The foregoing discussion on using the maternity care clinic revealed that there was a small proportion of the respondents who rarely or never used the maternity clinic. The issue has two different aspects: philosophical and cultural. On the one hand, many people view pregnancy as an illness and believe that women at this stage need much care and attention, while others believe that pregnancy is a natural event for women, and there is no need for special care or surveillance. Most of those who indicated they rarely or never used the maternity clinics held the latter perception of pregnancy. Although this is true to some extent, pregnancy also involves some risk, that needs to be dealt with through health education and awareness. It is important to change people's perceptions and behaviour. This takes time, but some progress has already been made. Sebai (1984) in his study, found few women were willing to go to the maternity clinic, whereas the situation now in Saudi Arabia is far better. Nevertheless, it would be desirable to target those who made less use of the maternity clinics, particularly those with a low level of education, and those of rural background, and to give them health education to increase their health awareness and encourage them to make use of the available health services.

9.7.5 Maternal Preventive Health Education

To reduce infant and child as well as maternal mortality rates, preventive health education is essential. Potentially, one of the most effective health interventions for the prevention of maternal mortality and morbidity is prenatal care (Royston and Armstrong 1989), particularly in places where the general health condition of women is very poor. Health education during prenatal care could be given individually and informally or more systematically in groups. It may cover topics related to pregnancy and women's health, such as nutrition and self - care. Advances in communications technology have provided many tools at the disposal of health educators to convey their message by films and videos which can be taken to villages or in urban communities, if necessary, rather than waiting for people to come to the health centre. Newly expectant mothers need to be informed about changes taking place during pregnancy and what should they do in such circumstances.

However, when health centre utilisers were asked if the health centre provided systematic programmes of health education for groups of pregnant women, to inform and educate them about personal hygiene and appropriate methods to feed the new-born baby, only 8.7 % said the health centre personnel gave such kinds of health education, while more than 69 % said no. Also, almost 77 % of the health centre utilisers indicated that the health centre did not run any health education programmes for expectant mothers who have not yet had any experience with pregnancy, delivery or maternity. These new mothers have to rely on traditional knowledge from their mothers, relatives or friends. The PHC approach strategy is supposed to be based on preventive measures more than curative care. Preventive measures should include health education given at places where people work or live, or at the health centre. It seems that the centres attended by the respondents were failing in this regard.

9.7.6 Pregnant Women and Diet during Pregnancy

The nutritional status of the mother not only affects her own health but is also a crucial and decisive factor in foetal nutrition, growth and health. Malnutrition leads to delivery of underweight babies and to a high incidence of infant and maternal morbidity and mortality. Thus, pregnant women need adequate nutrition to meet their own bodily needs and those of the foetus and infant during pregnancy and lactation. So, the PHC centre has a task to perform here, through health education, to emphasise the importance of adequate nutrition for pregnant women.

Variables such as income, education, place of birth and nationality are believed to have, to some extent, some influence on whether the pregnant women follow a special diet during the pregnancy period. Thus, these factors will be considered in relation to the pregnant woman's diet.

9.7.6.1 Income and Pregnant Women's Diets

It might be expected that a positive relationship would exist between income and following a special diet for pregnant women. However, the crosstabulation of income by special diet revealed no significant difference between the income categories in this respect. If anything, there appears to be a negative relationship. Those with high income were less likely to indicate that the pregnant women followed a special diet, while low and medium income categories, were more likely to do so (Table 9 - 39). This is probably due to the fact that people with low and medium income are more likely to have a lower general standard of

nutrition, and might suffer from a shortage of vitamins, minerals and protein. Therefore, pregnant women need to follow a particular diet. On the other hand, people with high medium and high income may already be having a well - balanced diet and be less likely to suffer from a shortage of vitamins, minerals and protein. Therefore, pregnant women can meet their needs without special treatment in normal circumstances.

Table 9 - 39 Following a Special Diet in Pregnancy by Income.

Follow Special Diet	Income %			Total	
	Low	Middle	High	No.	%
Yes	48.70	59.00	46.20	146.00	51.60
No	48.10	41.00	53.80	131.00	46.30
Do Not Know	3.20	0.00	0.00	6.00	2.10
Total No.	187.00	83.00	13.00	283.00	-
%	66.10	29.30	4.60	-	100.00

9.7.6.2 Level of Education and Pregnant Women's Diets

Education and health awareness generally, and awareness of nutrition in particular, are expected to be associated, i. e. the higher the level of education, the more likely the women is to be aware of the importance of healthy nutrition in general and for the pregnant women in particular. To a great extent, this view was borne out by our findings. The result of the crosstabulation appears in Table 9 - 40.

Table 9 - 40 Following a Special Diet in Pregnancy by Level of Education.

Follows Special Diet	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Yes	43.50	49.30	55.20	57.40	146.00	51.60
No	51.60	49.30	42.90	42.60	131.00	46.30
Do Not Know	4.80	1.40	1.90	0.00	6.00	2.10
Total	62.00	69.00	105.00	47.00	283.00	-
%	21.90	24.40	37.10	16.60	-	100.00

More than 43 % of the utilisers with low levels of education - illiterate, read and write and primary school- indicated that the pregnant women in their families followed a special type of diet during pregnancy period, while among people with intermediate education more

than 49 % indicated that the pregnant women in their families followed a special diet. This increase in the likelihood of special diet increased with the other levels of education. This pattern suggests that with some efforts from the health team at the health centre, people could be better educated as to the importance of a nourishing diet.

9.7.6.3 Place of Birth and Pregnant Women's Special Diet

It was thought that cultural differences between rural and urban people might be reflected in their diets as well as other related issues to pregnancy and childbirth. In this study, only a weak relationship was found between people with rural or urban backgrounds; however, the crosstabulations in Table 9 - 41 show that the rural respondents seemed to play slightly less attention to following a special diet. Probably this is because, as we saw before, few of the people with rural backgrounds indicated that the pregnant women always visited the obstetrician at the health centre, so less utilisation of maternity care during pregnancy resulted in less knowledge about the importance of a nourishing diet for pregnant women. Sebai (1983) reported that, in three studied communities, women followed a special diet after delivery but it was at the advice of older women, and based on customs, culture and experience, rather than knowledge of nutrition.

Table 9 - 41 Following a Special Diet in Pregnancy by Social Background.

Follows Special Diet	Backgrounds %		Total	Percentage
	Urban	Rural		
Yes	52.80	47.80	146.00	51.60
No	44.40	52.20	131.00	46.30
Do Not Know	2.80	0.00	6.00	2.10
Total No.	216.00	67.00	283.00	-
Percentage	76.30	23.70	-	100.00

9.7.6.4 Nationality and Pregnant Women's Special Diet

Table 9 - 42 shows that almost 60 % of non - Saudi pregnant women among the health centre utilisers followed a special diet during pregnancy, whereas just under 50 % of Saudi pregnant women did so. Although non - Saudi women have to a great extent a similar

culture, they made more visits to the health centre during the pregnancy period and so may have been instructed that women need to follow a special diet.

Table 9 - 42 Following a Special Diet in Pregnancy by Nationality.

Follows Special Diet	Nationality %		Total	
	Saudi	Non - Saudi	No.	%
Yes	49.60	59.60	146.00	51.60
No	48.20	38.60	131.00	46.30
Do Not Know	2.20	1.80	6.00	2.10
Total No.	226.00	57.00	283.00	-
Percentage	79.90	20.10	-	100.00

The findings might also reflect differences in culture, custom and practices among people of various nationality backgrounds.

9.7.6.5 Who Advised Pregnant Women to Follow a Special Diet ?

Some data were collected to see who usually gives advice on sickness, pregnancy and other health related matters. People were asked on whose advice the women in their families followed a special diet during pregnancy. In many cases, there was more than one source of advice. Thus, the responses were based on multiple responses and their results as are shown in Table 9 - 43.

Table 9 - 43 Source of Dietary Advice to Pregnant Women.

According to Whose Advice	Frequency	%
Obstetrician	113.00	77.40
Mother	79.00	54.10
Relatives	23.00	15.80
Friends	11.00	7.50
Neighbour	3.00	2.10
Midwife	5.00	3.40
Total = 146 Multiple Responses		

From Table 9 - 43, it appears that 77.4 % or 113 of the respondents reported that the pregnant women followed a special diet according to the obstetrician's advice, and 54.1 % did so according to mother's advice. Just over 15 % did so according to relatives' advice, friends' advice accounted for less than 8 %, neighbours for 2.1 % and the (daya) midwife for

3.4 %. This type of distribution shows the vast majority of pregnant women followed a special diet on the advice of their obstetrician, who might emphasise the need for the pregnant to take more fresh fruit and vegetables as well as some tablets for shortage in iron, vitamins and other minerals. However, the mother's influence was also strong. The mother's advice to eat or avoid certain foods might be based on traditional practice rather than scientifically approved knowledge. The same would be true of advice given by relatives, friends and neighbours. The Daya had little influence, because her role comes at the delivery rather than in the pregnancy period. However, some women have had a long and good relationship with the midwife, so might contact her for advice on diet in case of any type of health problem during pregnancy. On the other hand, the daya nowadays is less likely to be involved, even in delivery. Most of the new generation now prefer to go to hospital for delivery rather than to opt for the daya.

9.7.6.6 Places Where Women Gave Birth.

The policy in Saudi Arabia is to encourage pregnant women to have the delivery at a medical institution rather than at home. If there is no complication birth may take place at home or in the PHC centre, but if the delivery involves any kind of difficulties or complications, then it must be at one of the health institutions, through the referral system. If home delivery is preferred and no complications exist, the PHC centre staff attend or supervise the delivery, ensuring that all needed equipment and facilities are provided and a trained midwife should attend, with a well - equipped delivery kit. If there is any sign of complication, the midwife should immediately report it to the health centre, which will instantly make arrangements to refer the case to other health institutions.

Table 9 - 44 Distribution of Health Centre Utilisers By Place of Delivery

Place of Delivery	Frequency	Percentage
Home under midwife's supervision	63.00	22.80
Home in the presence of obstetrician	27.00	9.80
Home with relatives	17.00	6.20
At General Hospital	73.00	26.40
At Maternity Hospital	83.00	30.10
At Private Hospital	141.00	71.40
Somewhere else	25.00	9.10
Total questioned = 276 Multiple Responses		

Table 9 - 44 displays the places where delivery usually occurred. The calculation is based on multiple responses, because utilisers with more than one child indicated different places for deliveries. However, from the table it appears that the majority of respondents tended towards institutional delivery rather than home delivery. This may be because a high percentage of the sample were among younger age groups, who prefer to go to hospital rather than to stay at home. In the past, people did not like to go to hospital because they associated death with hospitals. There were also some cultural barriers, since at one time no female obstetricians were available and women did not like to be seen by strange men, although religion permits it in cases of necessity and emergency. However, the new generation are losing these fears and they do not want to go through the same hardship suffered by their mothers and grandmothers.

There is a preference for private hospitals which may be attributed to factors mentioned previously, such as a better relationship with the staff, unrestricted visiting time, facilities available in the room, single rooms, etc.

The existence of facilities for maternal care does not necessarily mean that they will be used - even by women who have been expressly advised to use them. In some cases the underutilisation of the facilities can be explained by simple and obvious reasons: the health centre or hospital is too far from the woman's home and she lacks the time, transportation, or possibly the money to go there. However, in general the change towards delivery taking place in hospital shows the influence of socio - economic changes taking places in Saudi

Arabia, even though it is a very conservative society. Also, the increased number of Saudis with formal education helps to some extent to encourage people to change some attitudes towards delivery at hospitals.

9.7.7 Feeding the New-born Baby

There are two ways to feed newborn babies: breast - feeding and bottle or artificial feeding. Breast - feeding plays an important role in child nutrition, health and growth. An infant who is breast fed acquires the needed immunity against common communicable diseases as well as essential nutrients which sustain it through the first few crucial months of life. Mother's milk has been described as the true biologically wholesome food, very suitable for the infant, as human milk looks different, has a different composition and its various nutrients are digested with greater ease when compared with the milk of other mammals (Al - Mazrou and Farid 1991). Breast feeding may help to create a closer relationship between the mother and her infant. Moreover, many studies have reported that infant mortality among infants who are bottle fed is more than double that for those who are breast - fed. This may be due to incorrect make - up of formula feeds, contaminated bottle, unclean water, and unsterile utensils, especially in rural areas where there may be no clean water available, or no electricity to keep the bottle in the refrigerator. So, all of these factors contribute to cause infant mortality and morbidity.

At one time, bottle feeding was considered as a symbol of modernisation (Sebai 1984), therefore it was widely practised, but in the light of increasing awareness of the importance of breast feeding, the new trend, to a large extent, is towards breast - feeding. However, because there are some difficulties facing working - mothers, most working mothers tend to use bottle feeding or combine both breast and bottle feeding. Table 9 - 45 shows that there was no significant difference in the number of mothers breast - feeding and bottle -feeding. However, mixed feeding was the most popular approach, accounting for more than 44 % of the respondents. Some of these may have been working mothers. In other cases, mothers may have practised breast -feeding in the early months but been unable to sustain it, for various reasons, such as lack of mother's milk, the child refusing the breast, mother's illness, nipple problems or pain, the mother being on medication, or becoming pregnant again. Many people nowadays, however, argue that with proper education and support,

most breast - feeding problems can be overcome and there need be no switch to bottle - feeding. Such advice and education could be an important role of the PHC centre.

Table 9 - 45 Distribution of Sample by Type of Feeding of New-born Babies.

Methods of Feeding Infant	Frequency	Percentage
Breast Feeding	98.00	28.80
Bottle Feeding	91.00	26.80
Both Methods used	151.00	44.40
Total	340.00	100.00

Looking at the findings of recent studies, Valerie et al. (1989) found that in Indonesia, the percentage of mothers who fully breast - feed their children up to at least three months of age ranged from 46 % to 79 % in urban areas. Within each urban area, the percentage is generally lower among the more educated, and those who work outside the home. Al - Mazrou and Farid (1991) found in their survey that 34 % used breast feeding, 10 % bottle feeding and 56 % both methods. Chua et al. (1989) argued that urbanisation and industrialisation historically have been associated with the decline in breast - feeding in many countries and still are in many developing countries, but the proportion of mothers returning to breastfeeding in industrialised countries such as Sweden and the United States is increasing. Furthermore, they attributed the breastfeeding decline in Singapore to the increasing affluence and modernisation of the population and they found that the Chinese favoured breastfeeding less while Malays favoured it most. This is believed to be due to the influence of cultural differences and beliefs among the ethnic groups towards breastfeeding.

9.8 Utilising Health Centre for Dental Care

Another example of special use of the health centre is dentistry care. Dental care is (theoretically) delivered through all health centres in Saudi Arabia. However, not all the health centres do in fact provide dentistry services, though some health centres in Jeddah provide dental care services. Healthy teeth are good indicators of the overall health condition of a person. One of the crucial factors causing teeth problems in Saudi Arabia is the shortage of fluorides in drinking water. Saudi Arabia faces a huge shortage of drinking water because there is no stable source of fresh water. Thus, the country to a large extent relies on distilled sea water. This type of water has a lower quantity of natural fluorides. Therefore many people, particularly children, suffer from tooth decay.

The coming discussion will review the utilisation of dentistry services in relation to general characteristics of the health centre utilisers.

9.8.1 Age and Utilising Dental Care

The relationship between age and visiting dentists is a positive one. Younger people are more likely to make use of the dentistry services, as this stage is associated with problems in teeth more than in later ages, when many people have lost their own teeth and have false teeth.

Table 9 - 46 Utilising Dental Care by Age.

Use Dental Care	Age %					Total	
	20 - 30	31 - 40	41 - 50	51 - 60	Over 60	No	%
Yes	86.30	76.90	72.90	50.00	20.00	218.00	75.40
No	13.80	23.10	27.10	50.00	80.00	71.00	24.60
Total No.	80.00	121.00	59.00	24.00	5.00	289.00	-
Percentage	27.70	41.90	20.40	8.30	1.70	-	100.00

Table 9 - 46 shows the result of crosstabulation of age and utilisation of dental health care. The result indicated that there are significant differences between the age categories; the higher the age, the less likely the use of dental care. From the table we see that more than 86 % of the 20 - 30 age group indicated that they visited the dentist, 77 % of the 31 - 40 year old did so, 73 % of the age 41 - 50, then the percentage declined to 50 % for age group 51 - 60 years old and down to 20 % of people over 60 years old. This type of utilisation of the dental services emphasises the importance of making this service available at all the health centres. The majority of the population are young, so the overall need for dental care is likely to be high.

9.8.2 Gender and Dental Care

This study found a strong significant difference between males and females in use of dentistry services, with women more likely to use them than men. Findings in Table 9 - 47 show that more than 87 % of females used the service in contrast to 72.2 % of the males.

Table 9 - 47 Utilising Dental Care by Gender.

Use Dental Care	Gender %		Total	
	Male	Female	No.	%
Yes	72.20	87.10	218.00	75.40
No	27.80	12.90	71.00	24.60
Total No.	227.00	62.00	289.00	-
%	78.50	21.50	-	100.00
Chi-square = 5.79506 D. F. = 1 Significance = .01607				

One reason for this may be that in pregnancy, women need to be seen by a dentist because in the sixth week of pregnancy, the foetus's teeth start to form and at the end of the fourth month the teeth have formed and calcium is taken from the mother. So, women at this period need much dental care, although there is a mistaken idea that the pregnant woman's dentist can not do anything to help her with any dentistry problems and she has to bear all the toothache and gum pain until she gives birth. In reality, she needs much care for herself and for the foetus.

9.8.3 Level of Education and Usage of Dental Care

Utilisation of dental services available at the health centre varied significantly with education, as shown in Table 9 - 48. The utilisation of the dental care services generally increases with the rise in the level of education from low until high level, although those with a high level of formal education showed a slightly lower level than those with secondary education.

Table 9 - 48 Utilising Dental Care by Education.

Use Dental Care	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Yes	58.10	75.40	82.70	81.30	218.00	75.40
No	41.90	24.60	17.30	18.80	71.00	24.60
Total No.	62.00	69.00	110.00	48.00	289.00	-
%	21.50	23.90	38.10	16.60	-	100.00
Chi-square = 14.12725 D. F. = 3 Significance = .00274						

Those with high level of education accounted for more than 81 %. This level of utilisation of dental care services in relation to education implies that, although the water shortage has caused

dental problems, people have become more aware of the need for dental care. Thus, as mentioned above, this service should be available at all PHC centres.

9.8.4 Income and Utilising Health Centre for Dental Care

Dental care, like other services, is provided free at the health centre, so looking at income in relation to utilisation could be seen as unhelpful, but if the services were not available free at the PHC centre, people with a low income may be unable to afford care, as the cost of private care is high.

Table 9 - 49 Utilising Dental Care by Income.

Use Dental Care	Level of Income %			Total	
	Low	Middle	High	No.	%
Yes	73.30	77.60	92.30	218.00	75.40
No	26.70	22.40	7.70	71.00	24.60
Total No.	191.00	85.00	13.00	289.00	-
%	66.10	29.40	4.50	-	100.00

Table 9 - 49 shows that more than 73 % of the utilisers with low monthly income indicated that they utilised dental care, more than 77 % of the people with middle income of and more than 92 % of the high monthly income used dental care services at the health centre. The relationship between income and utilisation of dental care services is positive, but as indicated above, people with high income, if the services were not available in the public sector, would resort to the private sector without any problem, but for the people with low income it would be a serious problem unless the health authority were to establish a dental clinic in each health centre, run by both female and male dentists to make it accessible to both male and female utilisers.

9.8.5 Place of Birth and Utilisation of Dental Care

Utilisation of dental care services varied significantly between people with urban and rural backgrounds. Table 9 - 50 shows that 78 % of the urban respondents made use of dental care compared with 66 % of than the rural. People with a rural background may make less use of dental care because they might give less attention to dental problems, or because they came from places where the water resources were higher in fluorides, so they had fewer teeth problems, or because their diet was less refined, again leading to less tooth decay.

Table 9 - 50 Utilising Dental Care by Social Background.

Use Dental Care	Background %		Total	
	Urban	Rural	No.	%
Yes	78.30	66.20	218.00	75.40
No	21.77	33.80	71.00	24.60
Total No.	221.00	68.00	289.00	-
%	76.50	23.50	-	100.00
Chi - square = 4.11100 D. F. = 1 significance = .04261				

9.8.6 Nationality and Utilising Dental Care

Table 9 - 51 reveals that there was no significant difference between Saudis and non - Saudis in relation to utilising dental care. The similarity may be because most non - Saudis had spent a considerable period of time in Jeddah, and thus might have similar tooth problems to local people, as related to drinking water and lifestyle.

Table 9 - 51 Utilising Dental Care by Nationality.

Use Dental Care	Nationality %		Total	
	Saudi	Non - Saudi	No.	%
Yes	75.30	75.90	218.00	75.40
No	24.70	24.10	71.00	24.60
Total No.	231.00	58.00	289.00	-
%	79.90	20.10	-	100.00

9.8.7 Marital Status and Utilisation of Dental Care

The relationship between marital status and utilising of dental care showed a significant relationship. More than 77 % of the married respondents indicated that they used the dental clinic, in contrast with 60 % of single. Table 9 - 52 shows the relationship.

Table 9 - 52 Utilising Dental Care by Marital Status.

Use Dental Care	Marital Status %		Total	
	Married	Single	No.	%
Yes	77.20	60.00	218.00	75.40
No	22.80	40.00	71.00	24.60
Total No.	259.00	30.00	289.00	-
%	89.60	10.40	-	100.00
Chi-square = 4.30204 D. F. = 1 Significance = .03807				

The relationship between utilising dental care and making regular visit to the maternity care was significant. Those who indicated that the pregnant women regularly visited the maternity clinic were also more likely to use the dental care clinic.

Table 9 - 53 Utilising Dental Care by Frequency of Using Maternity Care.

Use of Dental Care	Frequency of Using Maternity Care %				Total	
	Always	Sometimes	Rarely	Never	No.	%
Yes	87.70	66.40	61.30	50.00	212.00	76.30
No	12.30	33.60	38.70	50.00	66.00	23.70
Total No.	138.00	107.00	31.00	2.00	278.00	-
%	49.60	38.50	11.20	0.70	-	100.00
Chi-square = 20.33979 D. F. = 3 Significance = .00014						

9.8.8 Type of Service Used

To find out what services were most demanded, utilisers were asked to indicate what dental services they had used in the last year. Table 10 -54 summarises the services used.

Table 9 - 54 Distribution of Health Centre Utilisers According to the Type of Dental Services Used.

Type of Services Used	Frequency	%
Teeth Examined	89.00	32.50
Teeth Cleaned	108.00	39.40
X - Ray	33.00	12.00
Tooth or Teeth filled	146.00	53.30
Dentures, plates, repaired, replaced or adjusted	77.00	28.10
Gum Treatment	81.00	29.60
Tooth or teeth pulled	123.00	44.90
Total = 274 (Multiple Responses)		

This distribution reveals that fillings and extractions were the services most used. It is evident that most of the services used were curative - less than a third of respondents had attended for examination- , suggesting a need for the health centre to provide education about preventive dental care. This could not only protect people from dental problems but could also save financial resources, e. g. by reducing the need for extractions.

9.8.9 Difficulties Preventing People from Using Dental Care

People sometimes wished to go to or to accompany someone to the dentist but for one reason or another could not do so. Some reasons were bureaucratic procedures, financial problems, or difficulties of making personal arrangements. Table 9 - 55 shows these obstacles.

Table 9 - 55 Distribution of Health Centre Utilisers in Relation to Difficulties Impeding them from Using Dental Care.

Type of Obstacle	Frequency	%
Did not know which dentist to go to	150.00	51.90
Long waiting at the clinic	104.00	35.98
The visit would cost too much	200.00	69.20
Special arrangements	227.00	78.54
Felt I could treat the condition	91.00	31.48
Did not think the condition serious	159.00	55.02
Have fear of dentists	107.00	37.02
Total questioned = 289 Multiple Responses		

Table 9 - 55 reveals that more than 51 % or 150 of the respondents indicated that they did not know what dentist to go to. There are many dental clinics in the private sector, in hospitals, health centres and private surgeries. People did not know who to go to because it was difficult to distinguish who was most expert. 36 % stated that they were afraid of long waiting at the dentist clinic. This may occur if the dentist is working in the health centre and does not follow an appointment system. If an appointment system is used, there should not be too much waiting or long queues.

More than 69 % or 200 of the respondents did not go because of the cost of the services (this was in the case of the private sector). Dentistry services are very expensive. Although the Ministry of Health classifies dentists and fees according to their qualification, still the services are very dear and many people try to be treated at the public service, or otherwise, to go to a cheap dentist.

The need to make special arrangements impeded more than 78 % . Less than 32 % indicated that they thought that they could treat the condition, and more than 55 % stated that the reason was they did not think the situation was serious. Those who indicated that their reasons were they could treat the condition or thought it was not serious needed to be aware of the complications that could result if they did not go to a dentist whenever they had any dental problem. More than 37 % indicated the main reason was they had dentist phobia.

How often these obstacles stopped people from utilising the dental services is seen in Table 9 - 56.

Table 9 - 56 Distribution of the Utilisers of the Health Centre by Degree of Being Impeded by these Barriers

Degree of impediment	Frequency	%
Frequently	80.00	27.70
Sometimes	156.00	54.00
Rarely	51.00	17.60
Never	2.00	0.70
Total	289.00	100.00

Almost 28 % indicated that those obstacles stopped them frequently, while 54 % said sometimes. Rarely accounted for more than 17 % and less than 1 % indicated that those barriers did not stop them.

9.9 Conclusion

This chapter has dealt with the special usage of the PHC centre, i. e. child, maternity and dental care. The level of utilisation and the problems facing the utilisers of the health centre in relation to these fields of medical care, were examined in relation to the socio - economic characteristics of the utilisers. These three areas of health care each received much attention and emphasis in the PHC declaration at Alma - Ata.

The findings showed that more than half the health centre utilisers would give a sick child the same medication which was prescribed for another child rather than to go to the health centre, the main reason being that they believed the GP would prescribe the same medicine. This is a potentially dangerous pattern of behaviour because all medication has side effects and giving or taking it without supervision could result in unpleasant disability. Thus this pattern of behaviour needs to be altered through health education to inform parents of the danger of using medication given to another child. Other misconceptions indicating the need for health education also emerged. Other reasons that stopped parents from taking their child to the health centre were organisational, relating to the health centre's working hours and to the need to make special arrangement, such as taking time off from

work. These two barriers could be eased by increasing working hours of the health centres and / or introducing an appointment system.

Cross - tabulation of respondents' characteristics with the pattern of behaviour when there was a sick child in the family, showed that urban people were more likely to take the sick child to the health centre than rural. Income in general had no direct effects, since all these services are provided free of charge. However, the effect of income may reflect the fact that those with high income have the facilities (e. g. transportation) to go to the health centre at any time. The higher the parents' level of education the more likely they were to go to the health centre for medical treatment for the sick child. The smaller the family, in general, the more likely the parents were to take the sick child to the health centre. There was no significant difference between Saudis and non - Saudis in this regard, though non - Saudis were slightly more likely to visit the health centre with the sick child rather than to give the same medication.

The findings showed that if a child does not recover, more than two thirds of the respondents would go to see another doctor and more than 70 % of them would prefer to go to a private hospital. This behaviour was influenced by level of education, satisfaction with the health service and registration with the health centre. Those not registered showed a higher level of health awareness in general and in this case in particular. Regarding satisfaction with the service, more than two thirds of the non - satisfied would go to another doctor rather than go back to the previous one at the health centre. Because of these shortcomings at the health centres the majority of the sample respondents preferred to go to the private hospitals rather than to go to even a public hospital, for medical treatment. This to great extent is because at the private health service, all the specialities are available, working hours are greatly extended (sometimes around the clock seven days a week), parking areas are available, there are adequate and comfortable separate waiting rooms for males and females, and TV sets in each waiting room. Furthermore, the patient finds someone to listen to him (Al - Nunu 1992 and Al - Khalifah et al. 1993)

The role of the parents' parents was found to be very strong, especially if they lived together in same house. 86.2 % indicated that their parents gave advice about where to seek medical treatment for a sick child and 55.5 % reported they sometimes accepted their parents' advice. More than 90 %

of female respondents indicated that their parents gave them advice, confirming the traditional role of information passed from mother to daughter. This emphasises the importance of the women's role in health care, as do the findings regarding who gives medications. Therefore, health awareness and health education should be orientated towards women and focus on their roles in the health affairs of the family.

The study found that the importance of child immunisation was recognised by all the respondents. However, there was a significant difference between urban and rural respondents and this is supported by other studies carried out in Saudi Arabia. The increase in children's immunisation in Saudi Arabia in part can be attributed in part to the government's regulations, as mentioned above (see 9.4). Some groups of the respondents showed a positive attitude toward immunisation, including those with higher level of education, those who always make use of maternity care and those who comply with the GP's instructions. Few respondents, 17.4 %, indicated their children had all the essential vaccinations at the suggested times, but 45.4 % said they had most of them on time. Thus, the health centre has a role to fulfil in encouraging more parents to be aware of the importance of having their children immunised at the suggested times. Also, it was found that some respondents were impeded by some difficulties that stopped them from complying with the suggested times for vaccination.

Regarding use of the health centre for maternity care, the findings showed there is increasing improvement in females' attitudes towards visiting the obstetrician during pregnancy. Almost 50 % of the respondents indicated that the pregnant women in their families always visited the obstetrician. Some groups of the respondents used the maternity care more than the others. Related factors were level of education, social background, nationality, satisfaction with health services, complying with the doctor's instructions and women's working status. Those with higher formal education made use of maternity care more than those with lower levels of education; and urban people did so more than rural. Non-Saudis more frequently used maternity care than Saudis, but overall, Saudis made more use of this facility than non-Saudis. Working mothers were more likely than non-working mothers to make use of the maternity care unit.

Regarding the frequency of visits, 40.6 % stated the pregnant women in the family visited the obstetrician once every month, but 56.5 % did so only when they felt pain. One factor which may help in increasing the number of visits to ante - natal clinics is health education; another is increasing the number of female doctors, particularly gynaecologists. Many respondents indicated that the PHC centre did not carry out any maternal health education to educate mothers in groups about maternal care, personal hygiene, new - born infant's care and feeding.

Looking at dental care, there was a significant relationship between age and use of dental care. Level of education, gender, marital status, income and the frequency of utilising the maternity care were significantly related to use of dental care. The higher the level of education, the more likely the respondent was to consult a dentist. Similarly, the higher the income, the more likely people were to visit the dentist. With regard to social background, rural people were found to be less likely to use the dentistry services than the urban. Most of the dental services used were of a curative nature. This implies that there is a role for the health centre to play through health education, to increase people's awareness and knowledge and avoid many tooth problems. Most of the difficulties that stopped respondents from visiting the dentist at the health centre could be overcome with attention to administrative factors.

No socio - demographic variable was a consistent predictor of behaviour at a statistically significant level, although some always pointed in the same direction. However, urban / rural background and levels of satisfaction were the mostly commonly - oriented variables, followed by level of education.

The general trend reveals that there are some groups in the population who need to be targeted by health education to increase their health awareness and to improve their utilisation of the health service. On the other hand, organisational difficulties were the main factor in impeding many utilisers from utilising the health centre services, and these difficulties should be removed or measures to improve the situation should be adopted, such as, introducing an appointment system, increasing the working hours and improving the available facilities such as waiting rooms. Health education could be transmitted through TV at the waiting rooms or by using posters and leaflets.

To comment on whether there is any progress in the increase of health awareness it is necessary either to carry out a follow up study or to compare with findings of other studies with similar aims and objectives. However, due to lack of similar studies of health awareness in Jeddah city in particular and Saudi Arabia in general, comparison is virtually impossible. However, drawing some conclusions from what is available, Al - Abdulatif (1989) reported that there was a general increase in the health awareness, especially reflected in the observation that more Saudi females preferred to give birth at hospital, rather than at home as before. This study tends to reinforce her conclusion and to suggest that the increase of education and access to the mass media, as well as the implementation of the PHC approach, has continued to increase health awareness among the population.

The discussion of health service utilisation is usually associated with health awareness and practice. Thus, it is necessary to examine these issues and to relate them to the socio - economic and demographic characteristics of the sample. This will highlight the issue of health awareness and the means to achieve it in Saudi Arabia. This will be the subject matter of the next chapter.

10.1 Introduction:

The previous three chapters have discussed attitudes to and knowledge about PHC, and general and special use of the health centres. This chapter discusses issues related to health awareness and practices, including the use of traditional medicine. Also, the relationship between health service utilisers and providers is explored through the image that the utilisers hold about the providers of the health services. The discussion in this chapter includes the whole of the study sample, whether registered with the health centre or not.

10.2 Health Awareness

Health awareness covers a wide range of preventive health activities. The term health awareness implies the translation of knowledge and facts related to health and illness into a realistic and appropriate pattern of health behaviour. It is, thus, both an educational and a practical process.

10.2.1 People's Attitude Towards General Check - up

Health awareness covers a wide range of health preventive measures. One of these measures is the general check - up. People's attitudes towards the general check - up show whether they regard it as a preventive or a curative measure. If it is carried out only for reasons resulting from sickness or other some related event, it is curative, but if it is carried out in order to be aware of a person's overall health situation and to avoid any unanticipated circumstances, it becomes a preventive health measure. In order to find out about people's attitudes, a few questions were asked about the general check up, including when and why it is conducted. The frequency with which respondents reported having a general check - up is summarised in Table 10 - 1.

Table 10 - 1 Distribution of Respondents by Frequency of having General Check - up.

Frequency of General Check - up	Frequency	Percentage %
Frequently	35.00	9.90
Sometimes	123.00	34.70
Rarely	182.00	51.40
Never	14.00	4.00
Total	354.00	100.00

It appears from Table 10 - 1 that less than 10 % of the respondents indicated that they frequently had a general check - up, while slightly less than 35 % indicated they sometimes had one. More than 51 % rarely had a general check - up, and 4 % indicated that they never had one. This implies that very few, those who indicated that they frequently had a general check up, did so for preventive reasons. Those who indicated they sometimes or rarely would have a general check - up usually did so for some specific reason (to be discussed below). Thus, there is an indication that most of the respondents viewed having a general check - up as a curative measure and they would not have a check - up if they were not asked to do so.

The above findings concerned the respondents themselves. However, we also asked whether any of their families ever had a general check - up, because in many circumstances, people take more care for their dependants than for themselves. In particular, mothers are quick to seek medical advice on their children's behalf, but slow to do so for themselves (Graham 1984). However, Table 10 - 2 shows that similar attitudes were shown towards general check - up for family members, as for respondents. The vast majority, 87.8 %, of respondents said their family members had a general medical check - up occasionally, when there was some specific reason, but only 9 % indicated that members of their families had a regular medical check - up. Some of those who indicated "sometimes", included pregnant women having a check - up during pregnancy.

The lack of attention to general medical check - ups suggests respondents saw no need for a general check - up if a person is not suffering from any health disorder. However, such check - ups play an important role in health education and preventive care, for example in relation to modern life style diseases, such as blood pressure, diabetes or high cholesterol. The socio - economic changes occurring in Saudi Arabia also expose the population to new types of psychological disorders which could, if not treated, lead to stress - related physical disorders, particularly among the urban population and especially the urban poor.

Table 10 - 2 Frequency of Respondents' Families Members Having General Check - up.

Frequency of General Check - up	Frequency	Percentage
Always	32.00	9.00
Sometimes	123.00	34.70
Rarely	188.00	53.10
Never	11.00	3.10
Total	354.00	100.00

The relationship between respondents' socio-economic characteristics and frequency of having general check-up was explored. However, there were no statistically significant differences between the respondents' characteristics and the frequency of general check-up. Nonetheless, the collected data may help to highlight the general attitudes of the respondents. Thus, the following discussion will review the relationships between some socio-economic characteristics and general check-up.

Regarding gender, females were more somewhat likely to have a general check-up than males, as Table 10 - 3 indicates.

Table 10 - 3 Frequency of General Check - up by Gender.

Frequency of Having General Check-up	Gender %		Total	
	Male	Female	No.	%
Always	9.20	12.90	35.00	9.90
Sometimes	34.20	37.10	123.00	34.70
Rarely	53.50	42.90	182.00	51.40
Never	3.20	7.10	14.00	4.00
Total No.	284.00	70.00	354.00	
%	80.20	19.80	-	100.00

It should not be surprising that female respondents indicated that they would be more likely to have general check-ups than male respondents. Women of child bearing age need health care before and during pregnancy, so it is likely that women will have a general check-up for reassurance about their health or that of the baby. Furthermore, some couples prefer the woman to have a general check-up before conception.

Regarding marital status, single respondents were less likely to have a general check-up than married ones. Indeed, single respondents showed a very low rate of a having frequent general check-up 2.6 %, compared with almost 11 % of the married respondents. Among those who

"sometimes" have a check-up, there was less difference between the two groups, though again, the unmarried response was lower than that of married respondents. Single respondents were more likely than married ones to have a general check-up rarely. Table 10 - 4 summarises the findings.

Table 10 - 4 Frequency of General Check - up by Marital Status

Frequency of General Check-up	Marital Status %		Total	
	Married	Single	No.	%
Always	10.00	2.60	35.00	9.90
Sometimes	34.90	33.30	123.00	34.70
Rarely	49.80	46.10	182.00	51.40
Never	4.40	0.00	14.00	4.00
Total No.	315.00	39.00	354.00	-
%	89.00	11.00	-	100.00

There was also a relationship between the level of monthly income and the frequency of having a general check-up. Those with high monthly income said that they were more likely to have a frequent general check-up than those with low and medium income, who to a great extent had similar attitudes to each other (Table 10 - 5).

Table 10 - 5 Frequency of General check - up by Income.

Frequency of General Check-up	Level of Income %			Total	
	Low	Middle	High	No.	%
Always	9.10	9.20	19.20	35.00	9.90
Sometimes	33.00	37.00	38.50	123.00	34.70
Rarely	53.10	50.40	42.30	182.00	51.40
Never	4.80	3.40	0.00	14.00	4.00
Total	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00

Respondents' social backgrounds also influenced their behaviour. This study found that those with a rural background were less likely to have a general check-up. Table 10 - 6 shows that compared to their urban counterparts, they were less likely to have a general check-up, always or sometimes, and much more likely to have one rarely.

Table 10 - 6 Frequency of General Check - up by Social Background.

Frequency of General Check-up	Social Background %		Total	
	Urban	Rural	No.	%
Always	10.60	7.50	35.00	9.90
Sometimes	36.90	27.50	123.00	34.70
Rarely	47.80	63.80	182.00	51.40
Never	4.70	1.30	14.00	4.00
Total	274.00	80.00	354.00	-
%	77.40	22.60	-	100.00

Finally, the effect of nationality on having frequent general check-ups was examined and the findings revealed that Saudis were more likely to have general check-ups than non-Saudis, although non-Saudis, by regulations, are requested to have general check-ups (to be discussed below).

Table 10 - 7 Frequency of General Check - up by Nationality.

Frequency of Doing General Check-ups	Nationality %		Total	
	Saudi	Non-Saudi	No.	%
Always	11.40	4.10	35.00	9.90
Sometimes	35.40	32.40	123.00	34.70
Rarely	48.60	62.20	182.00	51.40
Never	4.60	1.40	14.00	4.00
Total No.	280.00	74.00	354.00	-
%	79.10	20.90	-	100.00

The comparison between those registered and not registered with the health centre revealed a significant difference (Table 10 - 8). All of those not registered had general check - ups with varying degrees of frequency. Those registered with the health centre, were more likely than the non - registered to have frequent general medical check- ups but if the two categories always and sometimes are combined, it seems that those not registered were more likely to have a check - up.

Table 10 - 8 Frequency of General Check - up by Registration Status.

Frequency of General Check-up	Registration %		Total	
	Yes	No	No.	%
Always	11.40	3.10	35.00	9.90
Sometimes	32.20	46.20	123.00	34.70
Rarely	51.60	50.80	182.00	51.40
Never	4.80	0.00	14.00	4.00
Total	289.00	65.00	354.00	-
%	81.60	18.40	-	100.00
Chi-square = 9.87216 D. F. = 3 Significance = .01968				

Another non socio - economic or demographic factor influenced people's attitudes towards having a medical check - up. Satisfied respondents were more likely to have general check - ups than dissatisfied (Table 10 - 9).

Table 10 - 9 Frequency of General Check - up by Satisfaction with the Health Services.

Frequency of General Check - up	Satisfaction %		Total	
	Yes	No	No.	%
Always	18.60	7.10	35.00	9.90
Sometimes	31.00	35.80	123.00	34.70
Rarely	43.30	53.40	182.00	51.40
Never	4.70	3.70	14.00	4.00
Total No.	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00
Chi - square = 10.05040 D. F. = 3 Significance = .01814				

Table 10 - 9 reveals that the proportion of those who regularly had general check - ups was, among the satisfied more than twice that among the dissatisfied. Although the incidence of having no check - up at all, was slightly higher among the satisfied, this is more than balanced by the greater tendency of the dissatisfied to have check - ups only rarely (53.4 %), compared with 43.3 % for the satisfied.

To find out the reasons for having a general check - up, people were asked to indicate the main reason that impelled them to have such a check. The responses are shown in Table 10 - 10.

Table 10 - 10 Distribution of Respondents by Reasons for having General Medical Check - up.

Main reason for having a general check - up	Frequency	%
Required by PHC centre	36.00	10.60
Joining new job	50.00	14.70
Enrolling in school or university	29.00	8.50
To join a club	25.00	7.30
To obtain residence permit (Iqamah)	35.00	10.30
Health conditions were not good	139.00	40.80
Annual check - up	26.00	7.60
Other	1.00	0.30
Total	341.00	100.00

Table 10 - 10 reveals that the most common reason for having a general check - up, more than 10 % had a check - up because it was required by the PHC centre when opening a new medical record with them; almost 15 % did so as an entry requirement for a new job, more than 8 % were requested to do so by an educational institute, as a condition of enrolment, more than 7 % did so to join a sports club, more than 10 % indicated the main reason was to obtain a residence permit (applies only to non - Saudis). Less than 8 % had an annual examination and only one person indicated another reason, namely, as a precautionary measure before getting married.

These reasons can be classified into three main groups: curative, preventive but officially requested and preventive. The curative category was the biggest (40.8 %). Around one third of respondents said they had a general check - up as a formality required for official reasons (job, education, club membership or as required by the immigration office for a residence permit) i. e. not initiated by the individuals themselves. The last category, preventive, contains three choices: annual examination, for the PHC centre and before getting married. It may be questioned why the general check - up required by the PHC centre is listed here , rather than with check – up carried out because of official requirements. The reason is that the health centre carries out the routine check - up with the aim of screening for conditions for which treatment will be offered, whereas other organisations do not aim to discover health problems in order to treat them, but in order to exclude the candidate from enrolment or residence.

Regarding time of last general check - up, more than 29 % said they had a general check - up less than one year ago, less than 27 % indicated two years, three years accounted for more than 19 % and more than 24 % indicated four years (Table 10 - 11).

Table 10 - 11 Distribution of Respondents by Last Time had General Check - up

Last Time had general Check up	Frequency	Percentage %
Less than one year	99.00	29.20
Two years	91.00	26.80
Three years	67.00	19.80
Four years	82.00	24.20
Total	339.00	100.00

15 cases had not had any general check - up.

10.2.2 People's Attitudes Towards Availability of First - aid Cabinet and Medication Misuse.

Usually a first - aid cabinet contains the necessary simple tools and medicine for initial treatment in an emergency, before reaching the hospital or health centre, and also, to treat any minor home injuries. It will usually contain plasters, aspirins, iodine and so on. As far as the first - aid cabinet and its importance are concerned, 55.1 % indicated that they had a first -aid cabinet at home, while 44.9 % reported they did not, though the importance of having a first - aid cabinet at home was attested by the vast majority, 82.5 %, and only 17.5 % thought it was unimportant to have a first - aid cabinet. Some people did not have a first - aid cabinet at home, but kept some type of medication at home in the refrigerator and considered it as the first - aid kit. However, due to the rise in the number of people with formal education and to the increased usage of modern technology at home in Saudi Arabia, it is expected that more people will pay some attention to such preventive health activities.

The impact of education on the availability of a first aid cabinet at home was explored and it was found that the higher the level of formal education, the more likely were respondents to have a first-aid cabinet.

Table 10 - 12 Possession of First-aid Cabinet by Level of Education.

Possession of First Aid Cabinet	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Yes	42.90	46.30	66.40	55.20	195.00	55.10
No	57.10	53.80	33.60	44.80	159.00	44.90
Total No.	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi-square = 13.87340 D. F. = 3 Significance = .00308						

Table 10 - 12 reveals that there was a significant relationship between level of education and possession of a first-aid cabinet. Furthermore, the higher the education, the more likely the respondents to state that it was very important to have a first-aid cabinet.

Income also was associated with the availability of the first-aid cabinet; the higher the income, the more likely the respondents to have a first-aid cabinet (Table 10 - 13).

Table 10 - 13 Possession of First-aid Cabinet by Income.

Possession of First-aid Cabinet	Level of Income %			Total	
	Low	Middle	High	No.	%
Yes	52.20	58.80	61.50	195.00	55.10
No.	47.80	41.20	38.50	159.00	44.90
Total No.	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00

Regarding registration and attitudes towards having or keeping first - aid cabinet, it was revealed that the non registered were better in this regard than the registered. Although there was no statistically significant difference between the two groups, the attitude indicates that the non - registered were to some extent more health aware. Availability of the first - aid cabinet implies at least some understanding of the significance of quick action in an emergency.

Table 10 - 14 Possession of First - Aid Cabinet by Registration Status.

Possession of First-aid Cabinet	Registration %		Total	
	Yes	No	No.	%
Yes	53.30	63.10	195.00	55.10
No.	46.70	36.90	159.00	44.90
Total No.	289.00	65.00	354.00	-
%	81.60	18.40	-	100.00

Respondents were asked where they usually kept medication. This was to find out if precautions were taken to prevent any misuse or abuse of medicine, particularly by children. Table 10 - 14 shows the answers to this question.

Table 10 - 15 Distribution of Respondents by Places of Keeping Medicine.

Place where medicine was kept	Frequency	%
In the refrigerator	204.00	57.60
Far from children's reach	61.00	17.20
In the first - aid Cabinet	23.00	6.50
Near the patient	31.00	8.80
No particular place	35.00	9.90
Total	354.00	100.00

Table 10 - 15 reveals that more than half the sample, 57.6 %, indicated that they kept medicine in the refrigerator, 17.2 % reported they kept it far from children's reach, less than 7 % said in the first - aid cabinet, almost 9 % reported that they kept it near the patient and almost 10 % of the respondents said there was no particular place. Keeping medicine in the refrigerator is commonly practised, but in some circumstances can be very dangerous, as it is easy for children to reach and to use it. Newspapers and magazines have reported many cases of children poisoned by taking medicine from the refrigerator. Other dangerous locations are near the patient and in no particular place. It is risky to keep medicine next to a sick child's bed, because he might take medicine without supervision from an adult person. Even if the sick person is an adult, care should be taken, as patients can easily become confused as to dosage and timing.

An attempt was made to compare those registered and not registered with the health centre. The cross - tabulation test did not reveal any significant difference between the two groups in this regard.

Respondents were also asked how often they bought medicine without a prescription.

Table 10 - 16 Distribution of Respondents by Frequency of Buying Medicine without Prescription

Buying Medicine	Frequency	Percentage
Frequently	126.00	35.60
Sometimes	174.00	49.20
Rarely	52.00	14.70
Never	2.00	0.60
Total	354.00	100.00

Table 10 - 16 shows that more than 35 % of the sample respondents indicated that they frequently bought medication without a physician's prescription, and 49 % did so sometimes. Less than 15 % did so rarely, and less than 1 % never did so. This reveals that the pharmacy plays a major role in providing medical treatment and it can be considered as one of the health service sources, since so many people buy medication without prescription. Over - the - counter sale of medication is restricted to a very limited range, in theory, but neither pharmacists nor consumers comply with the regulations.

In theory, the pharmacist's role is to dispense medicine according to the prescription and to explain to the patient how to use it, including drawing their attention to any warning message. However, in Saudi Arabia and presumably in many developing countries, the pharmacist considers himself as an alternative to the doctor and provides two services: treating patients and prescribing medication. The type of medication given by the pharmacist is not just for ordinary minor ailments, such as influenza, headache, coughing or joint pain, but covers a wide range of diseases, and medication could include antibiotics or other drug preparations.

Thus, those who indicated they frequently or sometimes buy medication may either go to the pharmacist and ask him to prescribe a medicine for the health condition they have, or may simply just ask for a particular medicine, without prescription. Some may just buy pain killers and suchlike, but

the majority buy any type of medicine. This indicates that regulations are not effective in stopping people from buying medicine without prescription, so health education is needed to alert people to the danger of taking medicine without expert supervision or prescription.

Nevertheless, respondents' socio - demographic characteristics showed some influence in this regard. Education, for example, revealed strong significant differences among the respondents in relation to buying medication without prescription. The lower the level of education, the more likely they were to buy medicine without prescription.

Table 10 - 17 Purchase of Medicine Without Prescription by Level of Education.

Frequency of Buying Medicine	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	48.60	45.00	29.20	23.90	126.00	35.60
Sometimes	37.10	48.80	54.70	50.70	174.00	49.20
Rarely	14.30	6.30	15.30	23.90	52.00	14.70
Never	0.00	0.00	0.70	1.50	2.00	0.60
Total No.	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi-square = 22.13306 D. F. = 9 Significance = .00847						

Table 10 - 17 reveals that more than 48 % of those with low level of education indicated that they always bought medicine from the pharmacy without prescription, while among those with a high level of education, less than 24 % of them indicated they did so. Furthermore, very few in any category, and none in the low and intermediate categories, said they had never bought medication without prescription. Official regulations are evidently not working effectively. People need to be alerted to the danger of taking medication without supervision, through health education.

Gender showed slight but not statistically significant differences in favour of males. Females were found to be more likely to buy medicine without prescription than did males, perhaps because for females it is easier to go to a nearby pharmacy rather than to be driven to the health centre and encounter the overcrowding there.

Table 10 - 18 Purchase of Medicine without Prescription by Gender.

Frequency of Buying Medicine	Gender %		Total	
	Male	Female	No.	%
Always	35.20	37.10	126.00	35.60
Sometimes	50.00	45.70	174.00	49.20
Rarely	14.10	17.10	52.00	14.70
Never	0.70	0.00	2.00	0.60
Total No.	284.00	70.00	354.00	-
%	80.20	19.80	-	100.00

The impact of level of income on purchasing medicine without prescription was examined and the general trend was that people with low income were more likely to buy medicine without prescription than those with medium and high income.

Table 10 - 19 Purchase of Medicine Without Prescription by Income

Frequency of Buying Medicine	Level of Income %			Total	
	Low	Medium	High	No.	%
Always	37.30	35.30	23.10	126.00	35.60
Sometimes	50.70	47.10	46.20	174.00	49.20
Rarely	12.00	16.80	26.90	52.00	14.70
Never	0.00	0.80	3.80	2.00	0.60
Total No.	209.00	119.00	26.00	354.00	-
%	59.00	33.60	3.80	-	100.00

The difference may arise because those with high incomes have easier access to the medical services network than those with low incomes. They can afford transportation, and even go to the private health sector for medical treatment if they prefer. Money means power, to choose and to buy; the more the money, the wider the range of choice.

Regarding social background, the collected data revealed that urban respondents were inclined to buy medication without prescription more frequently than rural ones (Table 10 - 20).

Table 10 - 20 Purchase of Medicine Without Prescription by Social Background.

Frequency of Buying Medicine	Social Background %		Total	
	Urban	Rural	No.	%
Always	37.60	28.80	126.00	35.60
Sometimes	47.80	53.80	174.00	49.20
Rarely	13.90	17.50	52.00	14.70
Never	0.70	0.00	2.00	0.60
Total No.	274.00	80.00	354.00	-
%	77.40	22.60	-	100.00

It is believed that this pattern of behaviour is a matter of cumulated experience in that urban areas normally have more pharmacies than rural areas; indeed, the latter often have no pharmacy except the one in the health unit, if any. The existence and the business-orientation of the pharmacy's owners, dissatisfaction or overcrowding at the public health services, and inability to go to the private medical sector, all encourage urban dwellers to buy medication more than their rural counterparts, for whom these conditions had not existed in their towns or villages.

Satisfaction or dissatisfaction about the available health services may also have influenced on people's behaviour in terms of buying medication without prescription. The findings show that more than 37 % of those who were dissatisfied with the health service indicated that they always bought medicine, while among those who were satisfied only 29.1 % said so (Table 10 - 21). Thus, it seems that dissatisfaction with the health services may influence some people to ignore the health centre and buy over - the - counter remedies.

Table 10 - 21 Purchase of Medicine without Prescription by Satisfaction with Health Service

Frequency of Buying Medicine	Satisfaction %		Total	
	Yes	No	No.	%
Always	29.10	37.70	126.00	35.60
Sometimes	55.80	47.00	174.00	49.20
Rarely	15.10	14.60	52.00	14.70
Never	0.00	0.70	2.00	0.60
Total No.	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00

Nationality was also influential; Saudis were more likely always to buy medicine without prescription than non-Saudis (Table 10 - 22). However, if the two categories always and sometimes were taken together, the overall trend was for non-Saudis in general to be more likely to buy medicine over - the - counter, without prescription.

Table 10 - 22 Purchase of Medicine without Prescription by Nationality

Frequency of Buying Medicine	Nationality %		Total	
	Saudi	Non-Saudi	No.	%
Always	37.10	29.70	126.00	35.60
Sometimes	47.10	56.80	174.00	49.20
Rarely	15.40	12.20	52.00	14.70
Never	0.40	1.40	2.00	0.60
Total No.	280.00	74.00	354.00	-
%	79.10	20.90	-	100.00

As mentioned above, non-Saudis sometimes face difficulties in having access to the public health service, so it would be understandable that they might ask the pharmacist to prescribe them some medicine.

Regarding purchasing medicine without prescription and registration status, the cross - tabulation did not indicate any significant difference between the two groups. However, the general behaviour showed that 29.2 % of the not registered indicated that they always bought medicine without prescription, while 37 % of those registered said so. The general implication of this behaviour reveals that those registered with the health centre are in greater need of health education than the non - registered, although both groups in this regard lack health awareness, judging by the high proportion (more than 74 %) who indicated they always or sometimes bought medicine without prescription. Nonetheless, it is a matter of concern that there were large numbers of people who bought medication without prescription in every segment of the population, regardless of their level of education or gender. The question arises as to why so many people, among different categories, bought medicine without supervision. It is believed many reasons lie behind this behaviour for both registered and not registered. For the former, it could be to avoid overcrowding at the health centre,

problems with working hours, lack of trust in the diagnosis at the health centre because of lack of equipment or physician's behaviour in diagnosing. A general lack of health education is indicated.

Health awareness is also reflected in how individuals co-operate and comply with the physician's instructions regarding taking medication or following some particular diet or regime. People were asked how often they complied with the doctor's instructions in terms of completing the whole course of medicine, taking medicine at the set time, following a particular regime, etc.

Table 10 - 23 Distribution of Respondents by Compliance with Doctor's Instructions

Degree of Compliance	Frequency	Percentage
Always	144.00	43.90
Sometimes	161.00	49.10
Rarely	23.00	7.00
Never	0.00	0.00
Total	328.00	100.00

Table 10 - 23 reveals that less than 44 % indicated they always complied with the doctor's instructions, just over 49 % did so sometimes, while those who said rarely accounted for 7 %. It seems that those who said they always followed the doctor's instructions, are aware of the importance of complying with instructions if they want to recover; those who said they did so sometimes or rarely need to be educated about the importance of following the instruction, e. g. that when taking medication there is a time limit for the medicine to be effective.

An attempt was made to find out whether the respondents' socio-demographic characteristics had any effect on their compliance with their doctors' instructions. Some differences between age groups were found. For example, 60 % of the elderly (over 60) population of the sample indicated that they always complied with the doctors' instructions, while only 31 % of those of age 51-60 years old indicated that they did so. The greatest rate of non- compliance was among the younger age group (20-30 years old).

Table 10 - 24 Compliance with Doctor's Instructions by Age

Degree of Compliance	Age %					Total	
	20-30	31-40	41-50	51-60	Over 60	No.	%
Always	51.40	43.80	40.50	30.80	60.00	144.00	43.90
Sometimes	40.50	49.30	53.20	61.50	40.00	161.00	49.10
Rarely	8.10	6.90	6.30	7.70	0.00	23.00	7.00
Total	74.00	144.00	79.00	26.00	5.00	328.00	-
%	22.60	43.90	24.10	7.90	1.50	-	100.00

Education is a crucial factor in the process of complying with the doctors' instructions. The findings show strong significant differences between different levels of education in this regard. The higher the education, the more likely the respondents are always to comply with instructions (Table 10 - 25).

Table 10 - 25 Compliance with Doctor's Instructions by Education.

Degree of Compliance	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	31.80	40.00	41.00	66.20	144.00	43.90
Sometimes	63.60	48.00	52.50	29.20	161.00	49.10
Rarely	4.50	12.00	6.60	4.60	23.00	7.00
Total	66.00	75.00	122.00	65.00	328.00	-
%	20.10	22.90	37.20	19.80	-	100.00
Chi-square = 22.19289 D. F. = 6 Significance = .00112						

Income also revealed a strong significant relationship; those with high income complied most with the doctor's instructions. It could be that income was related to education. On the other hand, higher income would also make it easier to follow a special diet, take time off work and so on. Thus, it is not unexpected that those with high income show greater compliance. Table 10 - 26 summarises the findings.

Table 10 - 26 Compliance with Doctor's Instructions by Income

Degree of Compliance	Level of Income %			Total	
	Low	Medium	High	No.	%
Always	42.00	41.20	69.20	144.00	43.90
Sometimes	48.90	53.50	30.80	161.00	49.10
Rarely	9.00	5.30	0.00	23.00	7.00
Total No.	188.00	114.00	26.00	328.00	-
%	57.30	34.80	7.90	-	100.00
Chi-square = 9.79452 D. F. = 4 Significance = .04403					

Compliance with the GP's instructions differed but not statistically significantly between Saudis and non-Saudis (Table 10 - 27). More than 51 % of non-Saudis indicated that they always complied with the doctor's instructions, while for Saudis it was less than 42 %. More than 50 % of Saudis sometimes complied, as did almost 45 % of non-Saudis. However, 8 % of Saudis rarely complied, compared with 4.1 % of non-Saudis.

Table 10 - 27 Compliance with Doctor's Instructions by Nationality

Degree of Compliance	Nationality %		Total	
	Saudi	Non-Saudi	No.	%
Always	41.70	51.40	144.00	43.90
Sometimes	50.40	44.60	161.00	49.10
Rarely	7.90	4.10	23.00	7.00
Total	254.00	74.00	328.00	-
%	77.40	22.60	-	100.00

We also investigated whether satisfaction affected people's behaviour in complying with instructions. Satisfaction with the health services revealed no significant effect, though satisfied respondents were slightly more likely than unsatisfied, to comply " always" (Table 10 - 28).

Table 10 - 28 Compliance with Doctor's Instructions by Satisfaction with Health Services

Degree of Compliance	Satisfaction %		Total	
	Yes	No	No.	%
Always	47.60	42.60	144.00	43.90
Sometimes	45.20	50.40	161.00	49.10
Rarely	7.10	7.00	23.00	7.00
Total	84.00	244.00	328.00	-
%	25.60	74.40	-	100.00

The other factor examined was registration with the health centre. Cross-tabulation revealed that there was a significant difference between those registered and non-registered with the health centres.

Table 10 - 29 summarises the findings.

Table 10 - 29 Compliance with Doctor's Instructions by Registration Status

Degree of Compliance	Registration %		Total	
	Yes	No	No.	%
Always	40.70	58.30	144.00	43.90
Sometimes	51.10	40.00	161.00	49.10
Rarely	8.20	1.70	23.00	7.00
Total No.	286.00	60.00	328.00	-
%	81.70	18.30	-	100.00
Chi-square = 7.71054 D. F. = 2 Significance = .02117				

It appears from Table 10 - 29 that those who were not registered with the health centre were more likely to comply always than were the registered, and less likely to comply rarely (1.7 %). It may be that the private facilities used by those not registered command more respect and trust than the public services. However, the highest level of compliance with the doctor's instructions can be attained through close interaction with the patients and by listening to their problems, particularly in the public health sector.

10.2.3 People's Response to Ill - health Conditions

People's perception of illness and health orientates them to follow certain patterns of behaviour during sickness. Respondents were asked how soon they would react when they noticed any symptom or ill - health condition. Those who said they would immediately seek medical treatment accounted for 20.3 %, while those who said they would wait constituted almost 80 % of the sample.

The crosstabulation of socio - demographic characteristics of the sample with the speed of responding to the noticed symptoms revealed a statistically significant difference only for level of education; other variables were not significantly related to speed of response to symptoms. The chi - square test result is shown in Table 10 - 30.

Table 10 - 30 Response to Noticed Symptoms by Level of Education.

Response	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Immediately	12.90	15.00	19.00	37.30	72.00	20.30
Wait	87.10	85.00	81.00	62.70	282.00	79.70
Total	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi-square = 15.89743 D. F. = 3 Significance = .00119						

Table 10 - 30 reveals that people's response to noticing any ill - health condition was inversely related to education; people with lower levels of education were more likely to wait rather than see the doctor. Those with high education were more likely to react quickly than to wait. The difference was significant at the level of 0.00119.

Income revealed some differences between respondents. The higher the income, the more likely the individual was to act quickly and the lower the level of income, the more likely to wait. As mentioned above, the health service is delivered free, but it is believed that other obstacles such as transportation or the like may impede respondents from going to the doctor (see below). Table 10 - 31 summarises the findings.

Table 10 - 31 Responses to any Noticed Symptoms by Income

Responses	Level of Income %			Total	
	Low	Medium	High	No.	%
Immediately	18.70	21.00	30.80	72.00	20.30
Wait	81.30	79.00	69.20	282.00	79.70
Total No.	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00

Almost 31 % of those with high income indicated they would respond immediately, while only 19 % of low and 21 % of medium income said so. This implies the importance of the economic factor, not only for purchasing health care, but also for other dimension of health - related behaviour.

Marital status revealed a difference between married and single respondents. The married were more likely to react immediately, but the percentage who would do so (21.3 %) is still very low. Single respondents may have been less likely to react quickly when they noticed any symptom, because most of the single were young people who generally feel healthy and strong , and recover easily from minor ailments. Table 10 - 32 summarises the findings.

Table 10 - 32 Responses to Noticed Symptoms by Marital Status.

Response	Marital Status %		Total	
	Married	Single	No.	%
Immediately	21.30	12.80	72.00	20.30
Wait	78.70	87.20	282.00	79.70
Total No.	315.00	39.00	354.00	-
%	89.00	11.00	-	100.00

Satisfaction was related to illness behaviour, in that those who were satisfied with the health service, were more likely to react immediately than the dissatisfied (Table 10 - 33). It could be concluded that satisfaction is an important factor in encouraging people to use the health service or discouraging them.

Table 10 - 33 Responses to Noticed Symptoms by Satisfaction with Health Services.

Response	Satisfaction %		Total	
	Yes	No	No.	%
Immediately	24.40	19.00	72.00	20.30
Wait	75.60	81.00	282.00	79.70
Total	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00

Regarding registration with the health centre there was no statistically significant difference between the two groups. In fact their responses were almost identical.

Reasons for waiting rather than going immediately were listed and respondents were asked to choose the reasons which influenced them, and at the end to indicate the main reason if they had more than one. Table 10 - 34 summarises the main reasons for waiting for a while.

Table 10 - 34 Distribution of the Sample in Accordance with the Reasons for Waiting.

Reasons for Waiting	Frequency	%
Do not know what doctor to go to	84.00	23.72
Felt I could treat the condition	134.00	37.85
Believed doctor could not do anything	22.00	6.21
Thought symptoms were not serious enough	247.00	69.77
Thought the visit would cost too much	51.00	14.41
Thought it would take too long or cost too much to go there	67.00	18.92
Thought it would take too long wait at the clinic	70.00	19.77
Have fear of doctor	60.00	16.95
I was afraid to discover other illness	56.00	15.82
Had to make special arrangement	195.00	55.08
Others	137.00	38.70
Total questioned = 354 Multiple Responses		

From the table it appears that 69.77 % or 247 of the respondents indicated that they thought the condition was not serious, , 55.08 % stated that they had to make special arrangements such as time off from work, baby-sitter, or someone to drive them to the health services. More than 38 % indicated "other reasons". Those others reasons included illness which did not last for more than one or two days. More than 37 % indicated that they thought they could treat the ill - health condition themselves. Almost 24% said they did not know where to go for medical treatment. 19.77 % of the respondents stated that they were afraid of a long wait at the clinic, while 18.92 % indicated that they thought it might take too much time and money to get to there. More than 16 % were afraid of doctor. Almost 16 % indicated they were afraid that doctor might discover another illness, more than 18 % stated that the visit might cost too much and almost 8 % thought that the doctor could not do anything.

These reasons can be categorised into four groups: personal judgement of the situation, financial constraints, psychological, and organisational. The personal evaluation of the ill - health condition was the most common factor that impeded respondents from going to seek medical treatment

immediately; however, such personal evaluation might be misjudged and worsen the situation rather than treat it. Organisational reasons were the next most common impediment. These factors, if removed, would increase level of utilisation of the service and encourage respondents to seek immediate care when sick. Financial difficulties are represented by cost of transportation to go to the health service. This is very important, particularly for people with a low income. Psychological factors include doctor phobia and fear of doctor discovering other diseases. This may in some cases have been brought on by bad experiences in the past.

It is believed that through the implementation of PHC approach, many of the above reasons would be removed, because the approach would indicate where to seek medical treatment, save much expense, as the health services are provided free, and with good training for the health personnel and other official employees in the health centre the communication and interaction would create an atmosphere that would eradicate fear of doctors as well as remove all the organisational barriers in order to transform the hopes into reality.

10.3 Practising Health Awareness

Health education is meant to provide an awareness of both health issues and good health practice. Some data were collected to measure to what extent people put health awareness knowledge into practice. Issues related to preventive care are good examples for examining health awareness in practice. However, respondents were also asked questions about other aspects of health awareness, such as how often they washed fruit and vegetables before eating them, whether they checked the validity date of canned food and whether children were taught to practice preventive measures to avoid disease, such as washing hands before and after eating and after using the toilet, and so on.

The responses to the question about washing fruit and vegetables before eating revealed that 76.6 % indicated they always washed fruit and vegetables before eating, and 22.6 % reported that they did so sometimes. Less than 1 % said they rarely did so. It is known that farmers use chemical substances to protect fruits and vegetables from insects and birds, and it is frequently mentioned in health programmes that all fruit and vegetables should be washed thoroughly before eating. However, many respondents indicated that they might eat fruits without washing them and some

argued that they just clean the fruit with tissue and eat it. Probably those people do not believe there would be any long - term ill - effects from the chemical sprays.

Another health awareness practice, is checking the validity date if they used canned food.

Table 10 - 35 Distribution of Respondents in Relation to Frequency of Checking the Validity Date of Canned Food

Frequency of Checking	Frequency	Percentage
Always	80.00	22.60
Sometimes	78.00	22.00
Rarely	123.00	34.70
Never	73.00	20.60
Total	354.00	100.00

Table 10 - 35 shows that more than 22 % indicated they always checked canned food before opening or eating it, 22 % said they did so sometimes, while almost 35 % indicated rarely and more than 20 % reported never. It is expected that the supermarket management or small shop owner will check the validity, thus people relied on them, but newspapers have reported many poisoning cases caused by out - of - date products. Some respondents, when they were asked why they did not check the validity date, indicated that they trusted the Saudi merchants. However, the situation here is not one of trust or distrust, but it concerns health awareness and practice, on the one hand, and individual responsibility on the other. Moreover, some merchants are more concerned with profit than health and there have been reports of products bearing altered production dates, and the Consumers Protection Committee having to order the destruction of kilograms and sometimes tons of canned or frozen food that was out of date, which was discovered by the Committee during its inspection of supermarkets and small shops. So, relying on someone else is not a safe act. Health awareness means to be cautious and practical to prevent any health hazard.

In tracing the effect of socio-demographic characteristics on respondents' patterns of checking the validity of canned food, level of education, income and gender were the only factors that showed they might have a significant influence. Looking first at education, those with a high level of education were more likely always to check the validity date and less likely never to leave it without

checking (Table 10 - 36), while those with a low level of education were more likely to buy canned food without checking the validity dates.

Table 10 - 36 Checking of Validity Date of Canned Food by Level of Education.

Frequency of Checking Validity Date	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	14.30	12.50	25.50	37.30	80.00	22.60
Sometimes	11.40	27.50	21.90	26.90	78.00	22.00
Rarely	32.90	38.80	36.50	28.40	123.00	34.70
Never	41.40	21.30	16.11	7.50	73.00	20.60
Total	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi-square = 41.13547 D. F. = 9 Significance = .00000						

Similarly, income showed a strong significant effect on respondents' behaviour. The higher the income, the more likely the respondents were to be concerned about the validity date.

Table 10 - 37 Checking the Validity Date of Canned Food by Income.

Frequency of Checking	Level of Income %			Total	
	Low	Middle	High	No.	%
Always	15.30	31.10	42.30	80.00	22.60
Sometimes	23.00	18.50	30.80	78.00	22.00
Rarely	38.80	30.30	23.10	123.00	34.70
Never	23.00	20.20	3.80	73.00	20.60
Total No.	209.00	119.00	26.00	354.00	-
%	59.00	33.60	7.30	-	100.00
chi-square = 21.63707 D. F. = 6 Significance = .00141					

Table 10 - 37 revealed that more than 43 % of those with high income stated that they always checked the validity date, while for low income 15.3 % did so and 31.10 % of those with medium income did so. Those who never checked the validity date of canned food were unlikely to be in the high income group. 23 % of those with low income indicated they did not check, while less than 4 % of those with high income did not do so. However, of all the respondents the largest group (34.7 %) was of those who rarely checked and this percentage decreased steadily with income. It may be that

those with low income are concerned simply to get enough food at a price they can afford, and are less concerned with quality, and it may also be that income is related to education.

Gender was found to have a significant influence on the respondents. Females were less likely to check the validity date of canned food. This could be attributed to the level of literacy, which is lower among females than males. However, the frequency of checking is very low in general as it appears in Table 10 - 38.

Table 10 - 38 Checking the Validity Date of Canned Food by Gender.

Frequency of Checking	Gender %		Total	
	Male	Female	No.	%
Always	25.70	10.00	80.00	22.60
Sometimes	22.90	18.60	78.00	22.00
Rarely	32.00	45.70	123.00	34.70
Never	19.40	25.70	73.00	20.60
Total No.	284.00	70.00	354.00	-
%	80.20	19.80	-	100.00
Chi - square = 10.72194 D. F. = 3 Significance = .01333				

Related to health knowledge is nutrition awareness. In Saudi Arabia, the staple food is rice, eaten with meat, particularly in nomadic and rural areas. However, due to the social changes and individual income improvement, new types of food have been introduced. Sebai (1983) reported that vegetables and fruits were available in the market but the Bedouins were not interested in buying them, because they did not like them, or they did not know how to cook them, or most important, they did not attach any nutritional value to them, as they did to meat. However, the situation has to a great extent now changed, particularly with the younger generation. But still, meat with rice is the main daily meal in Saudi Arabia. Due to the shortage of available livestock, the country relies on frozen imported meat from Australia, New Zealand, France, Scotland and Denmark. When respondents were asked whether they bought and ate frozen food - vegetables, meat and fruits - their answers are seen in Table 10 - 39.

Table 10 - 39 Distribution of Respondents by Frequency of Buying Frozen Food.

Frequency of Buying Frozen Food	Frequency	Percentage
Frequently	59.00	16.70
Sometimes	144.00	40.70
Rarely	64.00	18.10
Never	87.00	24.60
Total	354.00	100.00

Because many people attached low values to frozen food, relatively few, 16.7 % of respondents indicated that they frequently bought it. However, just under 41 % reported sometimes buying it. Those who rarely and never did so constituted 18.1 % and 24.6 % respectively. It is true that fresh food is recommended and has high nutritional values. But although frozen food is less nourishing than fresh, it still has good nutritional value. However, when frozen food is mentioned in Saudi Arabia immediately people think of imported frozen meat, and people attach less value to it. When there was a shortage of livestock, many people tried the frozen meat, but as far as frozen vegetables and fruits are concerned, few people buy them.

10.3.1 Children and Health Awareness

There is an Arabic saying " a child grows up as his parents bring him up". It summarises what is called " socialisation" in sociology. If a child is oriented to practice particular patterns of behaviour during his / her childhood, these patterns will be embodied in his / her unconscious and become common sense. Thus, if parents teach the child from the beginning to practise some preventive measures, he / she will grow up doing so. We asked parents if they instructed their children to wash hands before and after eating and after using the toilet. Almost 88 % of the respondents indicated that they had instructed their children to wash hands before and after eating, the remaining 12 % of the sample were those who had no children. Regarding washing hands after using the toilet, 87 % indicated that they had instructed their children. Respondents were asked to indicate their main reasons for these habits. However, because people could give more than one answer, the calculation is based on multiple responses. The answers are shown in Table 10 - 40.

Table 10 - 40 Distribution of Respondents By Reasons for instructing Children to Wash Hands Before and After Eating, and Cleaning Hands After Using Toilet.

The Main Reasons	Washing before & after eating	%	Cleaning after using the toilet	%
To protect them against diseases	253.00	71.46	226.00	63.80
General cleanness	179.00	50.56	198.00	56.00
According to religious teachings	205.00	57.90	199.00	56.20
Habit	58.00	16.38	81.00	22.88
Other	3.00	0.85	1.00	0.28
Total questioned = 354 Multiple Responses				

Table 10 - 40 reveals that more than 71 % made children wash before and after meals and almost 63 % did so after using the toilet, to protect them against diseases. Almost 51 % and 56 % indicated they did so for general cleanliness, while more than 57 % and 56 % stated they did so because of religious teachings. More than 16 % for mealtimes and more than 22 % in the case of washing after using the toilet indicated the main reason was to acquire good habits. The overall pattern indicates that there is a need for health education as Table 10 - 40 reveals that instructing children to wash hands after using toilet is not as widely practised as might be anticipated.

Regarding religious teachings, Islam emphasises personal hygiene in many instances, and it is a basic concept, for adults and children. Ablutions are performed before each of the five daily prayers. A woman, after her monthly period, must bathe before resuming her duties. Furthermore, a married couple after having sexual intercourse should both bathe, before practising their daily prayers. Washing hands before eating and after using the toilet is stressed. Although Islamic teaching emphasis personal hygiene, the data in Table 10 - 40 suggest that the effects of this were not strong. This implies there is a need for greater religious attention to this practice as people may accept this more. However, achieving a high level of health education and health awareness would have to come through various channels such as media and health centres.

10.3.2 Environmental Cleanliness

The cleanness of the physical environment is a crucial factor in improving the health status of individuals, family and community. There are two physical locations, inside the house and outside in the streets and surrounding areas. Shelter (home) is essential for physical protection of the individual and family. Healthy homes mean a healthy community and hence the theme adopted by WHO for

1973 was "Health begins at home". The principles of healthful housing have three aspects: physiological needs, psychological needs and need for protection against diseases and accidents. The physiological aspects concern a comfortable environment, adequate daylight, direct sunlight, good ventilation and protection against excessive noise. Psychological needs are related to adequate privacy, normal family and community life, and facilities for performing household duties without excessive tiredness. Protection against diseases and accidents involves measures to keep away rats, vermin and insects to reduce risk of spreading the diseases. The protective has two dimensions: inside and outside. The inside is the house residents' responsibility while the outside is the community responsibility, including the role of the municipality in keeping streets and surrounding areas clean and tidy, with no rubbish and garbage in streets. In Saudi Arabia, streets in large cities are clean. The garbage collector passes three times a day, in the early morning, at noon and after 7 o'clock every day.

Respondents were asked if they used germicide to keep house free of insects and vermin, and if yes, where did they keep it. Almost 98 % of the respondents indicated that they used germicide to keep the house free of any type of vermin, insects and rats. Places where germicide was kept are shown in Table 10 - 41.

Table 10 - 41 Places where Germicide is Kept.

Places	Frequency	Percentage
In the kitchen	130.00	37.50
Far from children	111.00	32.00
Special cabinet	93.00	26.80
Others	13.00	3.70
Total	347.00	100.00

Table 10 - 41 shows that more than 37 % indicated that they kept germicide in the kitchen, 32 % far from children's reach, almost 27 % in a special cabinet and less than 4 % indicated other places. Germicide contains dangerous chemical substances which might cause harm to health. Thus, it should be kept in a secure place, far from reach of children, and precautions should be taken if it kept in the kitchen as indicated by 37 % of the respondents. It is very risky to keep it in the kitchen

because by mistake it could come in contact with food or kitchenware. Local newspapers have reported several cases of people being admitted to hospital because their food was poisoned by germicide substances.

10.4 Use of Traditional Medicine

The majority of the respondents used traditional medicine in one way or another, but the frequency of using it varied and was influenced by different socio - economic factors. Traditional healers are not considered as competitors with modern medical practitioners, but rather as an alternative health service. However, it is believed that those who opt for traditional medicine usually have special health problems or features and some of them have already tried modern medicine but without success. As long as traditional medicine is practised with all its specialities (see Chapter Two), it must be counted as one source of the provision of health services in Saudi Arabia. Therefore, this study included some questions related to the utilisation of traditional medicine.

The relationship between respondents' socio - economic characteristics and use of traditional medicine was investigated by crosstabulation of these characteristics with frequency of visiting traditional healers and chi - square was used to find out the level of significance. Although some socio - demographic characteristics showed some level of significance, because there were many empty cells, they were excluded, because the result would be unreliable.

A point worth mentioning is that when respondents were asked about visiting traditional healers, the question was open; no specific type of treatment or healer was identified. So the healer could be a herbalist, Qura'nic healer (religious Shaikh), bone-setter, or witch - doctor.

10.4.1 Age and Consulting Traditional Healers

The study found a significant association between the respondents' age and visiting traditional healers.

Table 10 - 42 Consulting Traditional Healers by Age.

Consulting Traditional Healers	Age %					Total	
	20 - 30	31 - 40	41 - 50	51 - 60	Over 60	No.	%
Frequently	6.50	5.90	13.90	3.80	40.00	29.00	8.20
Sometimes	22.80	33.60	27.80	38.50	40.00	106.00	29.90
Rarely	45.70	44.70	41.80	26.90	0.00	150.00	42.40
Never	25.00	15.80	16.50	30.80	20.00	69.00	19.50
Total No.	92.00	152.00	79.00	26.00	5.00	354.00	-
Percentage	26.00	42.90	22.30	7.30	1.40	-	100.00
Chi - square = 22.94133 D. F - 12 Significance = .02823							

Table 10 - 42 reveals how frequently respondents visited traditional healers in relation to their age. It appears from the table that the most frequent visits were made by people over 60 years old, and the same was true among those who visited traditional healers " Sometimes"; the latter category, was selected by a high proportion of those over 51 years old. As previously indicated, elderly people have long been used to traditional medicine, and might go to modern medicine only if they did not succeed with traditional medicine, whereas younger people are more likely to go first to modern medicine and then opt for traditional medicine as a last resort. Many other studies have found similar results (Al - Saaty 1983; Al - Khouly 1984; Maikudi 1988; Al - Mubarak 1989 and Al - Ribdi 1990),

Based on this pattern of utilising traditional medicine in relation to age, a theory could be developed, that the use of traditional medicine is declining with the younger generation. However, it is possible that the reliability of the answers given by the younger respondents, about visiting traditional healers, may be questionable. For various reasons, people who use traditional healers do not always like to admit it. They may fear to appear backward or uneducated, or reluctant to admit that their problem is psychological. This would merit further study.

10.4.2 Gender and Visiting Traditional Healers

Many studies have associated the utilisation of traditional medicine with gender and some indicated that women more frequently visited traditional healers than did males (Al - Saaty 1983, Al - Khouly 1984 and Al - Amri 1993).

Table 10 - 43 Consulting Traditional Healers by Gender

Consulting Traditional Healers	Gender %		Total	
	Male	Female	No.	%
Always	10.20	0.00	29.00	8.20
Sometimes	29.60	31.40	106.00	29.90
Rarely	43.30	38.60	150.00	42.40
Never	16.90	30.00	69.00	19.50
Total	284.00	70.00	354.00	-
Percentage	80.20	19.80	-	100.00
Chi - square = 12.45302		D. F - 3	Significance = .00598	

Table 10 - 43 reveals that males were more likely to consult traditional healers than females and there was a significant difference at a level of 0.00589. However, again the extent to which gender as an individual factor accounted for the utilisation of traditional medicine is difficult to ascertain. It may be the result of other factors. For example, age plays a crucial role in deciding to use traditional medicine; as we have seen, younger respondents showed less interest in consulting traditional healers, and most of the aged respondents in this study were males. A similar comment can be made here that some females may have been reluctant to admit consulting traditional healers. Furthermore, female need to be accompanied by someone to go to visit traditional healer. Therefore, the answers here should be taken within the cultural and religious context. Some respondents may have denied consulting traditional healers because of illegality or fear of stigmatisation.

10.4.3 Nationality and Consulting Traditional Healer

It was found that non Saudis made less use of traditional medicine than Saudis (Table 10 - 44). The chi - square test showed a difference at a significance level of 0.0000. This can also be explained in terms of context of the local culture, on the one hand, and the type of consultation, on the other. Non - Saudis probably have less access to traditional healers and the type of health problems for which they seek help are those less likely to be treated by traditional healers. Saudis who suffer psychological problems believe they can get better treatment from some traditional healers.

Table 10 - 44 Consulting Traditional Healers by Nationality.

Consulting Traditional Healers	Nationality %		Total	
	Saudi	Non - Saudi	No.	%
Always	8.20	8.10	29.00	8.20
Sometimes	33.20	17.60	106.00	29.90
Rarely	45.40	31.10	150.00	42.40
Never	13.20	43.20	69.00	19.50
Total	280.00	74.00	354.00	-
Percentage	79.10	20.90	-	100.00
Chi - square = 34.67986 D F - 3 Significance = .00000				

10.4.4 Education and Consulting Traditional Healers

The effect of level of education upon consultation of traditional healer revealed significant differences among the respondents. The relationship is inverse, e. g. the higher the level of education the less likely to consult traditional healers, and the lower the level of education the more likely to consult traditional healers. Those of intermediate and secondary level of education had generally similar attitudes to each other, but a considerable difference existed between those with high and low levels of education. Table 10 - 45 summarises the findings. The matter must be treated with caution, however, since many of the people with a high level of formal education would be reluctant to admit consulting or visiting a traditional healer because of stigmatisation, or the desire to disassociate themselves from people with low levels of education.

Table 10 - 45 Consulting Traditional Healers by Level of Education

Consulting Traditional Healers	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	11.40	11.30	7.30	3.00	29.00	8.20
Sometimes	45.70	27.50	28.50	19.40	106.00	29.90
Rarely	32.90	42.50	43.80	49.30	150.00	42.40
Never	10.00	18.80	20.40	28.40	69.00	19.50
Total	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi-square = 21.05213 D. F. = 9 Significance = .01242						

No significant relationship was found between consultation of traditional healers and place of birth or registration with the health centre, so these crosstabulations will not be displayed here.

10.4.5 Reasons for Consulting Traditional Healer

Respondents were asked to mention the main reasons that urged them to visit traditional healers. The answers in Table 10 - 46, show that there were two main reasons: personal experiences of traditional medicine and diseases that modern medicine did not, for one reason or another, succeed in curing.

Table 10 - 46 Distribution of Respondents by Main Reasons for Visiting Traditional Healer

The Reasons	Frequency	%
Do not trust modern medicine	2.00	0.90
Had successful experience with traditional healers	74.00	33.30
Traditional healers have cured illness incurable by modern medicine	82.00	36.90
They use natural herbs	41.00	18.50
Others	23.00	10.40
Total	222.00	100.00

Respondents were asked how often they thought that traditional healers would treat them better than modern medicine practitioners. The answers show that less than 5 % said always, more than 60 % indicated sometimes, also more than 22% reported hardly and more than 12 % stated never (see Table 10 - 47).

Table 10 - 47 Distribution of Respondents by Benefiting from Traditional Healers

Benefiting from Traditional Healers	Frequency	Percentage
Always	17.00	4.80
Sometimes	213.00	60.20
Rarely	80.00	22.60
Never	44.00	12.40
Total	354.00	100.00

Most respondents gave conditional answers, saying that in some areas of medicine they would prefer traditional healers to modern practitioners. Most of those answers were concerned with fractures, back - pain, and some psychological disorders. These conditional answers were supported by the answers to the question as to whether there were any diseases that traditional medicine could

treat better than modern medicine; 77 % of the respondents answered that traditional medicine succeeded in treating some diseases that were not cured by modern medicine, while 22 % did not think this was the case. Al - Mubarak (1989) found in his study, that 75 % indicated the success of traditional medicine in treating diseases, while only 15 % did not think traditional medicine could treat diseases not cured by modern medicine. This point is dealt with more fully in section 10.4.6 below.

There are some diseases which people still believe have no cure in modern medicine. Such diseases are associated with spiritual and psychological disorders, such as evil eye or Jinn. Epilepsy is also attributed to such causes. Traditional medicine has succeeded in treating these diseases, because traditional healers combine the psychological with physical aspects of the problem, while in modern medicine the physician usually looks at the physiological side of the disease only.

10.4.6 Attitudes Towards Traditional Remedies

People's attitudes to towards some traditional remedies may give indication of acceptance or rejection of traditional medicine. Respondents were asked whether traditional remedies are more effective in curing some diseases than modern medication. Table 10 - 48 reveals that more than 29 % of the respondents stated that they strongly agreed about the effectiveness of some of the home remedies. Those who agreed accounted for more than 45 %. The few who expressed disagreement and strong disagreement accounted for almost 9 % and less than 7 % respectively, but more than 10 % did not know.

Table 10 - 48 Distribution of Respondents By Opinions Towards Traditional Remedies

Opinion	Frequency	Percentage
Strongly Agree	104.00	29.38
Agree	161.00	45.48
Disagree	31.00	8.76
Strongly Disagree	22.00	6.21
Do not Know	36.00	10.17
Total	354.00	100.00

Although Table 10 - 44 has shown that many respondents indicated they were unlikely to visit traditional healers, Table 10 - 48 reveals a high level of belief that some traditional remedies are still better than modern medicine in curing some diseases. People commonly resort to traditional remedies

for some ailments and many books are being published about using and making some traditional remedies at home (see Chapter Two). Therefore, it was not surprising that more than 45 % agreed about the validity and effectiveness of some traditional remedies.

When respondents were asked if they ever used any traditional remedy without prescription from a traditional healer, 53.7 % indicated they did and 46.3 % indicated they did not. The cross - tabulation of this factor with registration did not reveal any significant difference between both registered or not registered, in this respect. Both registered and non - registered showed identical responses.

10.4.7 Attitudes Towards Modern Medicine

This study found that respondents had mixed views regarding the successfulness of modern medicine in curing all diseases. 15 % of the respondents strongly agreed and almost 33 % of them agreed that modern medicine could cure any disease. However, on the other hand, more than 31 % indicated that they disagreed and 16.1 % strongly disagreed that modern medicine could cure any disease.

Table 10 - 49 Distribution of Respondents by Their Opinion on Ability of the Modern Medicine to Cure all Disease

Attitude to modern medicine	Frequency	Percentage
Strongly Agree	53.00	15.00
Agree	116.00	32.80
Disagree	111.00	31.40
Strongly Disagree	57.00	16.10
Do Not Know	17.00	4.80
Total	354.00	100.00

Table 10 - 49 reveals little overall difference between the proportion of respondents who thought modern medicine can cure any disease and those who disagreed. Those who disagreed, are those who considered other alternatives, such as traditional medicine. Many studies have shown that people usually differentiate between diseases that can be treated by modern medicine and those which can be treated by traditional medicine. For example, Maikudi (1988) found in his study that people who used traditional medicine, indicated that some illness can best be treated by traditional

therapy and they thought that modern medicine has no effective medicine for treatment of illnesses such as jaundice, or psychological problems, though they said that modern medicine is effective for diseases with other origins. It was suggested that mental illness is something to do with evil spirits, which modern medicine can not treat. In many cases, after failing to receive effective modern treatment, people go to the traditional healers for treatment.

Al - Mubarak (1989), found that 60 % of his sample indicated that modern medicine is successful in treating all illness, and 32 % stated that it succeeds in treating most diseases. Those who said it can treat some cases, and those who did not know, accounted for 2.5 % and 5. 8 % respectively. However, when the same respondents were asked about the success of traditional medicine, Al - Mubarak reported that 75 % indicated that traditional medicine was successful in treating diseases and only 15 % said it did not succeed. However, a clearer picture of people's opinions about both medical systems could be obtained if a list of diseases was given to the sample, to indicate which school of medicine in their opinion, would be successful in treating each.

10.5 Patients' and Doctors' Interaction.

The interaction or more precisely the relationship between physician and patient is one of the crucial factors in the improving people's health awareness and increasing their utilisation of the health service facilities. A number of studies have examined the patient - doctor relationship in terms of patient satisfaction with medical care (Korsch, et al. 1968; Francis, et al. 1969; Hulka, et al. 1971; Linn 1975; and Greene 1980). Linn (1975) argued that despite the importance of patient evaluation of the physician's performance and competence, many social scientists and physicians have ignored the validity and significance of such evaluation. The patient's evaluation of the physician is reflected in his attitudes to and satisfaction with health care, and whether or not he follows the doctor's instructions. Francis, et al. (1969) found that patients who were highly satisfied with their last visit to the doctor were more likely to follow doctors' orders than patients who were less satisfied.

To find out respondents' attitudes towards physicians, respondents were asked to what degree they agreed with some statements concerning doctor - patient interaction. Respondents were asked to

express their opinions about the statement: "Doctors always treat their patient with respect". Table 10 - 50 shows the responses to this statement.

Table 10 - 50 Distribution of Respondents To "Doctors Always Treat Their Patients with Respect".

Scale of agreement with the perception	Frequency	Percentage
Strongly Agree	111.00	31.40
Agree	173.00	48.90
Disagree	56.00	15.80
Strongly Disagree	8.00	2.30
Do Not Know	6.00	1.70
Total	354.00	100.00

Table 10 - 50 reveals that more than 80 % of the respondents held a positive attitude towards physicians. More than 31 % of the respondents strongly agreed and almost 49 % agreed that doctors treat their patients with respect. Almost 16 % disagreed and less than 3 % strongly disagreed with the statement and a very few stated they did not know. This attitudes held by the respondents towards doctors would undoubtedly influence the interaction between doctor - patient where there is a mutual trust there will be more satisfaction and patients will co-operate better with doctors in following their instructions.

Regarding relationships between the socio - economic and demographic characteristics, both attitudes and behaviour of respondents and their answers to the questions as to whether the doctor always treats his patients with respect, no significant differences were found except for registration status.

Table 10 - 51 Perception of whether Doctor always Treats his Patients with Respect by Registration Status

Scale of Agreement with the perception	Registration %		Total	
	Yes	No	No.	%
Strongly Agree	33.60	21.50	111.00	31.40
Agree	45.30	64.60	173.00	48.90
Disagree	17.00	10.80	56.00	15.80
Strongly Disagree	2.10	3.10	8.00	2.30
Do Not Know	2.10	0.00	6.00	1.70
Total No.	289.00	65.00	354.00	-
%	81.60	18.40	-	100.00
Chi-square = 9.35463 D. F. = 4 significance = .05282				

Table 10 - 51 reveals that generally, respondents in both categories have positive attitudes toward doctors either at the health centre or in private sector. However, the non - registered were more likely to strongly agree and agree (86.1 %) than the registered (79.2 %). This attitude can be attributed, as mentioned previously, to the relationships that physicians in the private sector try to establish with the clients through listening to their problems and trying to explain their conditions and treatment in full detail, while as mentioned above, public sector utilisers complained that the physician did not examine them thoroughly and listen to their complaints. However, the general indication of positive attitudes could be a means of attracting more people to the public health care.

However, when respondents were also asked to what extent they agreed with the statement that " Sometimes doctors make their patients feel foolish", the answers revealed that more than half the respondents agreed, to varying degrees.

Table 10 - 52 Respondents Attitudes towards the View that Doctors Sometimes Make them Feel Foolish

Scale of Agreement with the perception	Frequency	Percentage
Strongly Agree	72.00	20.30
Agree	138.00	39.00
Disagree	93.00	26.30
Strongly Disagree	29.00	8.20
Do Not Know	22.00	6.20
Total	354.00	100.00

Table 10 - 52 shows that more than 20 % strongly agreed and 39 % agreed that sometimes doctors made their patients feel foolish. Slightly more than 26 % disagreed and 8.2 % strongly disagreed. The difference between those registered with the health centre and those not registered was significant. Among those not registered, less than 14 % strongly agreed about feeling foolish and 35 % agreed, while for the registered it was 22 % and 40 % for strongly agreed and agreed respectively. One reason for the negative attitude among the non - registered is that some doctors in the private sector, especially, ask patients to have many unnecessary tests or x - rays, so patients feel that the doctor is making fun of them and just wants to charge them more money. The negative effect of such behaviour is that sometimes, even when a test or x - ray is necessary, a patient will refuse it and go to another doctor (Alyamamah 1988 and Al - Shuruq 1992).

There was a significant difference in relation to people's level of satisfaction with the health services. Almost 28 % of the satisfied strongly agreed, while less than 18 % of dissatisfied said so. More than 26 % of satisfied agreed, while almost 43 % of not satisfied agreed that sometimes doctors make their patients feel foolish (10 - 53).

Table 10 - 53 Perception of Doctors' Behaviour by Level of Satisfaction.

Scale of Agreement with the perception	Satisfaction %		Total	
	Yes	No	No.	%
Strongly Agree	27.90	17.90	72.00	20.30
Agree	26.70	42.90	138.00	39.00
Disagree	24.40	26.90	93.00	26.30
Strongly Disagree	11.60	7.10	29.00	8.20
Do Not Know	9.30	5.20	22.00	6.20
Total No.	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00
Chi-square = 11.09173 D. F. = 4 Significance = .02555				

The doctor's behaviour with his patients may have a strong influence on their acceptance and compliance with his instructions. In this instance, satisfied respondents also had a positive perception of doctors' behaviour towards them.

Sometimes people complain that doctors do not explain patients' conditions to them. This pattern of behaviour causes some worry to some patients. Respondents were asked whether they agreed that: " Doctors cause people to worry a lot because they do not explain medical problems".

Table 10 - 54 Distribution of Respondents to statement that " Doctors cause Worry to Patient because do not explain Medical Problems".

Scale of Agreement	Frequency	Percentage
Strongly Agree	115.00	32.50
Agree	153.00	43.20
Disagree	57.00	16.10
Strongly Disagree	18.00	5.10
Do not know	11.00	3.10
Total	354.00	100.00

The percentage of the respondents who strongly agreed was more than 32 % and more than 43% agreed. Table 10 - 54 shows that 16.1 % disagreed and 5.1 % strongly disagreed. A substantial majority thus indicated their concern that doctors did not explain medical problems sufficiently

Al - Shuruq (1992) reported that many patients, 80 %, switched from the public to private health sector because they believed that in the private sector, the doctor was more friendly, gave the patient enough time to explain his problem and fully answered the patient's questions. Furthermore, Al - Shuruq (1992) said that some doctors in the private sector contact their patients by telephone to see how they are progressing with their medication. In contrast, in the public sector, the doctor just writes down the prescription before patients have finished explaining their problems. This has also been reported by many other studies (Greene 1980; Sebai 1983, 1984 and 1988; Al - Osimy 1991 and Al - Baz 1992).

To find out whether respondents feel that the doctor always respects their feelings, the statement, "Doctors always respect their patients' feelings" was put to respondents. 21 % strongly agreed and more than 57 % agreed. However, more than 16 % disagreed, and 2 % strongly disagreed (Table 10 - 55). As mentioned in Chapter Nine, regarding the view that the physician ignored his patient's feelings, there was no significant difference in terms of the socio - economic

characteristics of the health centres utilisers but females were slightly more likely than males to complain about this.

Table 10 - 55 Distribution of Respondents by their Opinions of " Doctor Respect Their Patient Feelings".

Scale of Agreement	Frequency	Percentage
Strongly Agree	74.00	20.90
Agree	204.00	57.60
Disagree	58.00	16.40
Strongly Disagree	7.00	2.00
Do no know	11.00	3.10
Total	354.00	100.00

To conclude the topic of the patient - doctor relationship, it can be argued that the patient's satisfaction with health care depends to a great extent on many factors, including care received during visit, waiting time, length of time with the doctor in the clinic and interpersonal interaction with the health personnel. The latter includes respect, interest, friendliness, patience, understanding, and willingness to listen to and advise patients. The interpersonal interaction between patients and professionals is very important to patients, because when they feel that they are treated well and with respect this contributes to their satisfaction and to their acceptance of the medical treatment and encourages them to follow doctors' instructions.

10.6 Health Awareness and the Mass - Media

Mass - media - television, radio, magazines and newspapers - are seen as sources of entertainment, but in reality they play an influential role in everyday life. Media orientate and form people's attitudes. Thus, mass media may have a strong influence on health awareness. As indicated previously, TV played the strongest role in introducing the PHC approach to people. In many societies where relatively few people read, the most effective means of information would be TV.

In Saudi Arabia TV is available in almost every house, and it is seen by a large audience of all ages and levels of education. The TV's contribution to health education is presented in four programmes: The first, called " Health and Life" is prepared and presented by a specialist professor in medicine who is enthusiastic about the PHC approach, as well as preventive health care measures,

Z. Sebai. This programme uses very simple language and tries to speak to both educated people and those with a low level of education; the housewife and the university student. Usually, the programme presents a film every week about any health issue and tries to comment on that issue in relation to the Saudi Arabian culture and society. In the second part of the programme, Sebai tries to answer letters on particular health problems, but he quotes these letters as examples of the predominant health issues in the country. This programme has been running for more than seventeen years.

The second programme, called Salamatak is prepared by a team of specialists and writers. It takes the form of a drama, in which each episode, which lasts for half an hour, presents one issue. This programme is watched in all the six Gulf States and it is prepared by the Gulf Organisation for Common TV Programmes. Therefore, it uses classical Arabic which sometimes appears as overacted. Moreover, because it takes a dramatic form, many viewers lose sight of its aim and objectives, because more attention is given to the drama side than to the health education.

The third programme is prepared and presented by a specialist at King Saud Medical School. Unfortunately, this programme does not address a wide audience. Because of the language and level of discussion used, ordinary people find it difficult to understand. Usually the presenter interviews other specialists from the Faculty of Medicine and they use numerous terms which are not familiar to the housewife or lay person. Although much effort is made in presenting this programme, viewers see it as talking mainly to medical students.

Finally, there are some health education messages conveyed through programmes concerning women and the family. In this type, usually the presenter addresses a question to any specialist and he / she gives the answer to that question as an isolated case.

To find out whether these TV programmes contribute to the health awareness and provide a good source of health education, respondents were asked a few questions about them.

Table 10 - 56 summarises respondents' answers regarding how often they watch TV health programmes, 14.1 % stated always, 35.6 % indicated sometimes, 40.1 % rarely, and less than 10 % said they never watched.

Table 10 - 56 Distribution of Respondents According to the Regularity of Watching Health Programmes on TV.

Regularity of watching TV health programmes	Frequency	%
Always	50.00	14.10
Sometimes	126.00	35.60
Rarely	142.00	40.10
Never	36.00	10.20
Total	354.00	100.00

The distribution shown in Table 10 - 56 indicates that the biggest single group, 40 %, rarely watched medical programmes on TV. This could be because those programmes are broadcast at times when most of the audience are at work, outside the home or relaxing. Thus, those who indicated sometimes, said they watched if they were at home at broadcasting time. The " Health and Life" programme is transmitted at 7.0 p.m.. The second programme " Salamatak ", is only an occasional programme transmitted when there is a gap in the daily schedule, or between 3.00 p.m. and 4.00 p.m., when the majority of people are relaxing after work or having lunch.

The third programme is broadcast on Friday mornings, but most people get up late then because it is a weekend holiday. Those who are not still resting are preparing lunch (in the case of women) or out for Friday prayer (for men). Thus, its message is lost. The fourth type of programme, the women's and families' programmes, are transmitted in the morning during week days. So, if a more suitable time was set for transmission the audience number might increase, as it might if the topics were selected to attract and absorb the viewers.

An attempt was made to correlate the frequency of watching TV's medical programmes with respondents' socio - economic and demographic characteristics and health attitudes and behaviour to find whether watching the TV's medical programmes had influenced attitudes and behaviour. The cross - tabulation tests showed level of education and satisfaction were significantly related to watching or regularity of watching TV programmes.

Table 10 - 57 Regularity of Watching TV Health Programmes by Level of Education .

Regularity of Watching TV Health Programmes	Level of Education %				Total	
	Low	Intermediate	Secondary	High	No.	%
Always	11.40	8.80	18.20	14.90	50.00	14.10
Sometimes	21.40	47.50	35.80	35.80	126.00	35.60
Rarely	55.70	37.50	37.20	32.80	142.00	40.10
Never	11.40	6.30	8.80	16.40	36.00	10.20
Total No.	70.00	80.00	137.00	67.00	354.00	-
%	19.80	22.60	38.70	18.90	-	100.00
Chi - square = 20.52124 D. F. = 9 Significance = .01495						

Table 10 - 57 reveals that those with low and intermediate levels of education were less likely to watch TV medical programmes than those with secondary or higher levels of education. This may imply that they are not interested in these programmes which are supposed to target them, address their health problems and raise their health awareness. However, there could be other reasons that discouraged them or impeded them from watching these programmes. It could be the level of language used, types of health issues addressed and the ways in which these issues are tackled. Also, time of transmission may be inconvenient, or clash with popular dramas.

Satisfaction with the health services also revealed significant differences among respondents. Those who were satisfied with the health services were more likely to watch the TV medical programmes, while the dissatisfied were less likely to do so.

Table 10 - 58 Regularity of Watching TV Health Programmes by Satisfaction.

Regularity of Watching TV Health Programmes	Satisfaction %		Total	
	Yes	No	No.	%
Always	23.30	11.20	50.00	14.10
Sometimes	34.90	35.80	126.00	35.60
Rarely	30.20	43.30	142.00	40.10
Never	11.60	9.70	36.00	10.20
Total No.	86.00	268.00	354.00	-
%	24.30	75.70	-	100.00
Chi - square = 9.72462 D. F. = 3 Significance = .02106				

The satisfied respondents generally hold more positive attitudes towards health matters, and this may make them more interested in watching TV medical programmes.

An attempt was also made to see if there was any relationship between viewing of medical programmes and actual utilisation of the health services. The only relationship found was in regard to dental care.

Table 10 - 59 Regularity of Watching TV Health Programmes by Using Dental Care

Using Dental Care	Regularity of Watching TV %				Total	
	Always	Sometimes	Rarely	Never	No.	%
Yes	84.00	80.20	68.30	75.00	267.00	75.40
No	16.00	19.80	31.70	25.00	87.00	24.60
Total No.	50.00	126.00	142.00	36.00	354.00	-
%	14.10	35.60	40.10	10.20	-	100.00
Chi - square = 7.38832 D. F. = 3 Significance = .06050						

Although Table 10 - 59 reveals that there was a strong but not statistically significant relationship between regularity of watching TV's medical programmes and utilising the dental care clinic, whereby the more frequent TV watchers were more likely to use dental care, surprisingly, those who indicated they never watched TV health programmes used dental care more than those who said they rarely watched TV medical programmes, and not much less than the proportion of these who indicated they always or sometimes watched. Thus, this pattern of attitude suggests that the TV programmes may not have a strong influence on people's attitudes in this regard. This argument is supported by other cross - tabulation tests which did not reveal any significant relationships. For example, the cross - tabulation of regularity of watching TV's programmes and child vaccination revealed that the rate of vaccination was 96 % among those who said that they never watched, 89 % among those who said always, 86 % of those who said sometimes and 91 % of those who said they rarely watched TV medical programmes. This implies that the mass media are not very effective because, as seen above, their influence is not very great. This is probably because of the types of the programmes, time of broadcast and the time of discussing particular topics.

Respondents were asked if they thought those health programmes on radio and TV are useful and helpful in increasing people's health awareness. Despite the findings indicated above, the vast majority, 94.4 %, indicated that these programmes were a helpful and useful means to increase people's health education and awareness. Furthermore, many of the respondents strongly supported the idea of increasing those programmes in terms of number and time allocated and very few opposed it (Table 10 - 60). In view of this strong support for increasing the capacity and scope of health education programmes, this overwhelming support should be reflected in the quality and quantity of these programme.

Table 10 - 60 Distribution of Respondents by Opinion as to Increasing the Health Educational Programmes on TV and Radio.

Whether to Increase Health Programmes	Frequency	Percentage
Strongly Agree	176.00	49.70
Agree	133.00	37.60
Disagree	16.00	4.50
Strongly Disagree	7.00	2.00
Do Not Know	22.00	6.20
Total	354.00	100.00

As mentioned above, presenters of these programmes offer medical advice to persons who write to them. Respondents were asked how they reacted to this advice. Table 10 - 61, shows that more than 33 % of the respondents indicated that they always accepted the advice, somewhat less than 47% reported sometimes, 2.3 % rarely and less than 1 % never. 16.7 % said that their acceptance would depend on the situation.

Table 10 - 61 Distribution of Respondents in Relation to Acceptance of Medical Advice on Radio or TV Programmes

Agreement of Medical Advice	Frequency	Percentage
Always	119.00	33.60
Sometimes	165.00	46.60
Rarely	8.00	2.30
Never	3.00	0.80
Depends on the situation	59.00	16.70
Total	354.00	100.00

Respondents thus showed a strong interest in health and medical programmes; more than two thirds of the sample indicated that if they heard health or medical advice, they would follow it. This indicates that careful preparation and presentation of such programmes would lead to increased health awareness and improve the health conditions of the people. This would obviously include appropriate transmission time and use of easily understood language.

Finally, people were asked what they thought would be the most and effective means to increase and widen people's health awareness. Respondents were able to select more than one method.

Table 10 - 62 Distribution of Respondents by Views on Best Means to Increase People's Health Awareness.

Means to increase people's health awareness	Frequency	Percentage
Intensive TV programmes	318.00	89.80
Orientated Radio programmes	198.00	55.90
Distributing leaflets about health matters	176.00	49.70
Magazines and Newspapers	178.00	50.30
Annual weekly campaigns	233.00	65.80
Health education programmes in school	157.00	44.40
Through mosque preaching	210.00	59.30
Regular home - visit by PHC centre personnel	232.00	65.50
Total questioned = 354 Multiple Responses		

Table 10 - 62 reveals that almost 90 % indicated TV as the best means to increase people's health awareness, 56 % chose radio, less than 50 % suggested distribution of leaflets and brochures, more than 50 % indicated the press - newspapers and magazines, annual week - long campaigns accounted for almost 66 %, more than 44 % suggested health education in schools and educational institutes, preaching in mosques accounted for more than 59 % and regular visits by health personnel to the consumers' homes accounted for more than 65 %.

TV was chosen by the vast majority of the respondents as the best means to increase the people's health awareness, and it is true, that TV can play a major role in mass education generally, if it is appropriately used. In countries where the level of illiteracy is very high, TV is believed to be an

appropriate means, because through TV, messages can be delivered through different approaches, such as using drama, direct interviews, panel discussions, hypothetical cases to be used for illustration, and films. It is most important that health programmes should be broadcast at the right time, for the target groups of people. Many studies have recognised the role of TV in health education. For example, Al - Abdulatif (1989) found that the majority of her sample indicated that TV was the most effective means to help in widening the respondents' health awareness and spread health knowledge. Also, Al - Mubarak (1989) found that more than 73 % of his respondents reported that they got their health information and knowledge through TV.

Radio is another communication medium which attracts a wide audience in many parts of the world. People in remote places in developing countries, where TV services are rarely available, turn to radio for entertainment, news, knowledge and education. However, because this study was carried in an urban area where TV was almost universally available, fewer respondents chose the radio. In Saudi Arabia, radio is used to transmit health programmes, but it is not believed to have such impact as TV.

But although there is overwhelming support to increase the scope and capacity of TV programmes this attitude is, in fact, contradicted by the fact that not many respondents frequently watched these programmes. The problem is probably related to transmission time and the limited number of these programmes, as mentioned above.

Distribution of leaflets and booklets is also an effective means. Some argue that because there is a high rate of illiteracy in developing countries, it is less likely that people will accept this means. There is some truth in this, but if leaflets and booklets were simplified and illustrated with drawings and cartoon characters, they might spread the health education message. Also, written material such as leaflets and brochures in simple language could be used for those who can read and write, and people with some level of official education. There is some criticism about distribution of written materials. Certainly, such materials alone will not lead to healthier patterns of behaviour, if they are filled with technical terms and jargon, understood only by professional health personnel, or if poorly illustrated, written in a long - winded, preaching style, with complicated sentences and printing.

However, they have the advantage of being easily kept for reference, and can remind individuals of a health message that they have already learnt in other ways. They can provide extra information about health problems or health practices.

Magazines and newspapers can play a role in increasing people's health awareness through many avenues, for example reporting the launching of an immunisation campaign, or a speech about health matters made by a well - known official. Also, health information can be printed in newspapers in the form of articles by doctors or specialists using simple language to discuss a certain disease or health practice. Newspapers reach many people very quickly, particularly the young, who are very keen to know about sport news, so this medium can be one of the means to send the health message to them. Al - Khalifah et al. (1993) surveyed three Saudi Arabian newspapers published in three different cities, and found that 171 health - related articles were written in these three newspapers during one year. Unfortunately, however, all those articles were concerned with complaints about the health services; no article was written about health education or health awareness.

In Saudi Arabia, there are many campaigns for health, cleanliness, greening and police. Each campaign lasts for one week and is called, for instance " Health Week", " Tree Week". These weeks are meant to be a means for the community to participate in one way or another, and each week has a different format. For example, the health week involves many segments of the society, while the greening week or cleaning week usually focuses more on school students, Shop owners provide some pamphlets or booklets for distribution while at the same time promoting their company' s or shop's activities. In the health campaign, some private hospitals provide free check-ups, for instance, for children. However, there is little use of health education through seminars, workshops and mass media.

Raising people's health awareness by introducing some health educational programmes in schools or educational institutions, is in fact practised; students in primary and intermediate schools receive some instruction about preventive health education. However, it emphasises the theoretical side and students consider it as a component of study to pass exams, rather than something to

practise; indeed, there is a separation between what they learn about health, and what they actually do.

Some respondents suggested using the mosque as a means to increase people's health awareness. The mosque could be very influential if used appropriately. Religious leaders (Imam) could play a very constructive role in health awareness by emphasising the religious health aspects.

Finally, regular visits made by PHC centre personnel to consumers' homes, as suggested, would help to increase people's health awareness by demonstrating to people at home some aspects of health education, particularly if visits are made during pregnancy. Home visits will enable the health personnel to build up a good relationship with people and families, and encourage them to make more use of the available health service. For the health personnel, it would help them to detect any troublesome situations early, before they become big problems. Table 10 - 62 revealed that one of the highest percentages (65.5%) was for regular home visit by health personnel (health educator), this is in line with the philosophy of PHC approach and should be encouraged, particularly for prevention care.

10.7 Conclusion:

Health awareness is the cornerstone of preventive health care. By health awareness is meant individual, family and community awareness and practise of behaviours likely to prevent disease and promote health. Health education, which is the means to health awareness, could be achieved by communication with people through a variety of means. The aim is to spread the word about what people can do to be healthy. However, words alone are not enough. There are other influential factors that influence people's behaviour. Those factors include places in which people live, culture, income, level of education and other factors, all of which should be taken into consideration.

This study examined various practices of health awareness including having a general check - up, checking the validity date of canned food, purchasing medicine without prescription, instructing children to practice hygienic care such as washing hands and possessing first - aid cabinet, as well as places where medication and germicide were kept. Responses concerning these matters revealed that although good practice is followed by a large number of the respondents, the level of health

awareness still needs to be increased to help prevent diseases, particularly these that proliferate in hot weather.

Health awareness aims to activate people to put their knowledge and skills into practice. Mass - media play an important role in increasing people's health awareness. The TV programmes currently shown are failing in this respect, judging by the lack of impact indicated by the empirical data. Firstly, they do not reach many people who really have interest in increasing their health awareness and knowledge. Moreover, audiences with a low level of education who probably rely most on this medium were less likely to watch the TV programmes. Secondly, many people do not follow the advice they receive. Although many studies have reported on the effect of mass media on people's behaviour this study suggests that if TV is to improve health behaviour, it must be used in the right way. Thus, health programmes and articles written in newspapers or magazines should tackle the predominant health problems and implant new healthy attitudes and behaviours, by using suitable language that can be understood by the majority of the audiences. TV programmes should be transmitted at a suitable time. Those who watch these health programmes vary in their age, level of education, interests and concerns. Thus, the language and issues addressed should be varied to suit every group of population.

Traditional medicine is practised in Saudi Arabia and many of the respondents have used some forms of traditional medicine. Furthermore, some respondents strongly believe that traditional medicine can cure diseases not cured by modern medicine. Some modern medicine practitioners reject the practice of traditional medicine because they think it is based on a non - scientific background; they may also unconsciously consider it is a threat to their practices, school of thinking, and status. However, health authorities should not neglect the social reality of the existence of traditional medicine. Rather, they should investigate the good and the bad sides of it and then integrate the good side (perhaps bonesetting and midwifery, for example) into modern medicine, or at least license and regulate practice. It is clear that many respondents still believe that traditional medicine can cure some diseases which are not cured by modern medicine, and now there is a trend

throughout the world towards renewed interest in alternative medicine. It may be possible for the two types of medicine to work together for the benefit of all, and to learn from each other.

The relationship between health personnel and patients is important in forming people's attitudes towards health care in general and persuading them to accept and comply with doctor's instructions. Many studies have shown that if the patient doctor relationship is not good, this will result in dissatisfaction and switching to another health source, or ignoring the physician's instructions. The general attitudes towards and perception of doctors found here were positive. There were relationships between satisfaction and registration, and attitudes towards doctor. The satisfied were to a great extent more positive than the less dissatisfied. This effect implies that the relationship with the doctor had an influence on utilisers. The findings of this study about attitudes towards doctors did not, by and large, reveal any other significant differences among respondents. There are other factors, however, which might affect the relationship. For instance when the issue of the referral system was discussed (see Chapter Nine) a large proportion of the respondents indicated it was complicated. These people might attribute this to the doctor's unhelpfulness and this affects the doctor - patient relationship, as was clear in regard to satisfaction.

Regarding registration, the empirical study found that those not registered in many respects showed a greater health awareness than the registered. Their behaviour and attitudes in various areas revealed positive attitudes. It might be that they have better health education and awareness because of the relationships they have established with their health providers, based on personal judgement, while in the public sector, patients simply have to take what they can get. Because they are not the people who pay the health professionals, their attitudes may be of less concern to doctors. However, because they were very few in number, it would be very risky to generalise from the non registered in this sample to the wider population of non- registered persons.

This study reported on the preference of the majority of respondents for receiving medical treatment in the private sector, despite the fact there were some complaints. However, the preference is formed largely as a result of good relationship between patients and health personnel because utilisers of the private sector find someone to listen and explain their problem to them in a relaxed

manner, while in the public sector, utilisers do not feel they have a right to voice their complaints. Thus, to increase the level of health awareness and utilisation it is important to establish a relationship of mutual trust between utilisers and providers of the public health services.

This chapter has presented the final part of the analysis and discussion of the empirical data. The coming chapter will conclude the whole study and will suggest some policy recommendations and topics for further research, as well as indicating the limitations of the present study.

This study has attempted to investigate health policy in Saudi Arabia in relation to the strategy laid down by WHO, in the declaration of Alma - Ata, 1978, which urged all WHO member states to adopt the Primary Health Care (PHC) approach as soon as possible and to consider it as the key factor for achieving the WHO's global social goal," Health for All the People by the Year 2000". In order to examine the reason for implementing PHC approach and its objectives (in terms of improving the health conditions and lessening the problems facing member states) it was necessary to review the health conditions and problems in the third world, and to report on the sources, nature and main causes of the miserable and unacceptable health conditions prevailing in most developing countries.

The study emphasised the importance of differentiation between third world or developing countries, on the basis of their level of income, industrialisation and level of literacy and availability of social services including health care. The current health situations in many developing countries impel governmental and non - governmental agencies to intervene to help improve people's health conditions. In so doing, they need to adopt an approach which is feasible and benefits the greatest number of people within the prevailing resource constraints, and which is socially and culturally acceptable.

11.1 PHC Approach:

PHC has emerged as the latest approach for improving health conditions and providing a wide range of health care coverage with low cost (WHO / UNICEF 1978). The PHC concept and the core matter of it are not new. They go back to the 1920s when Lord Dawson introduced the approach. In 1978, the approach was re - introduced by the WHO as the main strategy by which to provide health service coverage for many people, with special emphasis on the rural, peripheral and remote communities, particularly in developing countries. The PHC approach was adopted as a result of many reports and studies which have shown that expansion of the conventional health system has not kept pace with the needs of the people of many developing countries, nor has it reduced mortality and morbidity rates or improved the health conditions of those people (Djukanovic and Mach 1975,

Newell 1975, Gish 1975, Gish 1979, Bennett 1979 and Gesler 1984). On the contrary, developing countries have allocated much of their scarce resources on curative health care for a long time, but this investment has not eradicated their health problems. Thus, many studies have indicated that preventive care is more needed in developing countries than curative services. Some studies have shown that in countries where PHC approach was implemented, significant improvements in health care were achieved (Djukanovic and Mach 1975, Newell 1975 and Gish 1979).

The main features of the approach include health education related to prevailing health problems and ways of preventing and controlling them; promotion of food supply and nutrition; adequate supply of safe water and essential sanitation; maternal and child health care; immunisation against major killing diseases that cause major loss of human life, particularly among children and women; prevention and control of endemic diseases and treatment of common diseases and injuries (WHO / UNICEF 1978). The PHC approach implies a radical change, not only in the health field, but also in the whole socio - political and economic system. The main causes of morbidity and mortality in developing countries are preventable. The industrialised world presents good examples and experiences from which to learn. Many diseases currently widespread in developing countries were predominant in the industrialised world years ago, but through improved living standards (e.g. nutrition and sanitation), better public health services, immunisation and health education, these diseases are now controlled. So developing countries, rather than simply building one or two huge prestigious hospitals in urban areas, which will serve only a minority of the population, should adopt the lesson of protecting people by improving sanitation and health awareness, and immunising children in particular, against preventable diseases.

Thus, health improvement is not to be achieved only by improvements in health service provision, but by a strategy of total change in the overall development process. Health will improve most quickly in countries where improving standards of living are spread throughout the whole population, and where efforts are concentrated on PHC.

Of course, all this costs money, which may be in short supply. Developing countries are striving to increase their rate of economic growth, and to this end seek to invest in economically productive

projects. However, governments in developing countries often consider any allocation of resource to the health sector, as a non - productive sector, as a waste of money. Therefore, the health sector, in many developing countries, does not receive much attention nor get the needed financial allocation.

In fact, this is a mistaken view, as improved health would improve productivity. As we emphasised in Chapter One, disease impedes socio - economic development by causing absence from work, or forcing farmers to abandon lands. It needs to be recognised that a healthy population and workforce assists and reflects economic development, whereas an unhealthy population implies poverty and less development.

Thus, both health and socio - economic development will be enhanced by implementation of PHC strategy. This requires co-ordinated support and increased developmental effort not only from the other health sectors, but also from all other related sectors. Furthermore, it needs political commitment and will, without which the approach will remain no more than a blueprint on paper. Poor developing countries need not wait for donors to design and plan for them a feasible approach, but themselves need to set the framework for implementing a health policy that will provide overall health coverage without any favouritism to members of any particular region, city, sector, tribe or political party.

The capacity to make and implement policy necessitates availability of information and due to lack of information, many developing countries rely on expatriate advisers and on solutions to their problems transplanted from different societies and different social and economic contexts. A study of the kind attempted here may provide some of the information needed to help planners and policy - makers to implement the PHC approach effectively.

11.2 Implementation of the Approach in Saudi Arabia

Since the implementation of the PHC approach in Saudi Arabia at the beginning of the 1980s, the health policy has emphasised that the government's health strategy in adopting PHC is to provide a comprehensive health care service through a network of PHC centres. According to the definition of the PHC approach, the PHC centre is an integral part of the national health system and it becomes the first contact between individuals and families in the community and the health network, and the

entry point to the other health service facilities. The provision of these services in Saudi Arabia is progressing, as shown in the increase in the number of PHC centres in both rural and urban areas (see Chapter Four). The implementation of the PHC approach was undertaken in various stages. At the beginning the health authorities focused on the provision of maternity and child health care through health centres situated in each major city, then these centres were converted into PHC centres, through which maternity and child health care was delivered alongside general medical care. The MOH embarked on a policy of gradual extension of the approach to various cities. The declared health policy is to provide comprehensive health care through these PHC centres, combining primary health care by GPs or family doctors as in UK, and special care delivered by specialists such as obstetricians, genealogists, paediatrics and dentists. However, not all health centres surveyed had all these facilities, although in theory they are supposed to deliver comprehensive health care, so in practice what is provided is not the comprehensive approach to the health care which government policy proclaims.

Bryant (1988) pointed out that PHC is not primary medical care; it is not only the first contact with medical or health services; it is not only health services for all; it is intended to reach everybody, particularly those in great need; it is intended to reach to the home and family level, and not be limited to health facilities; it is intended to promote health education as a measure for preventing diseases and increasing people's health awareness, as well as promoting healthy patterns of behaviour (WHO / UNICEF 1978).

The implementation in many developing countries including Saudi Arabia, however, has taken another direction, which emphasises delivering curative primary medical care (Sebai 1988). In Saudi Arabia, PHC is primarily a gate to other health service facilities (Alyamamah 1992). This direction of implementation emphasises the gap between the PHC approach's theory and practice. Many countries still follow the conventional style of delivery of health care. Bahrain state and Saudi Arabia presented typical examples of this practice. Many of components of the approach are not practised, as this and other studies have reported.

Developing countries do not all have the same opportunities of developing and implementing the PHC approach. Every individual country has its own facilities and obstacles, as well as its own socio-economic, cultural and political ideology. Thus, the implementation of the programme will differ from one country to another. Therefore, it is the duty of the health planners and administrators to take into consideration the special characteristics of each country or region within the country, in the implementation of the approach. Failure to do so may result in underutilisation of the facilities and waste of financial resources.

Many studies have reported on the shortage of financial and human resources in many developing countries, where the ratio of health personnel to the population is very low, especially in Africa and some of the South Asian countries. Due to the lack of financial and human resources, there is a very unsatisfactory relationship between the available medical facilities and the people these facilities were designed to serve. Hospitals are usually located in large cities, serving only a small proportion of the population, and focus on curative care rather than preventive, which is not cost-effective. Regarding the problem of shortage of health personnel, the PHC approach suggests that health assistants or health workers (CHW) can be used to deliver some types of health care, particularly to remote or rural areas. After training courses, such people can be upgraded to a higher level. Complicated health problems can be referred to the health centres or district hospitals. This policy provides trained health personnel at low cost and makes it possible to deliver health services to areas not easily reached by highly qualified health professionals who might not like to work in rural or remote areas. Programmes for training and education of CHWs will decide their success or failure. With a well-planned programme and refresher courses, CHWs could save considerable financial resources and could deliver an acceptable level of health services within their capacities and limits. They should be supported by other health professionals and linked to other health services. The Chinese experience with "barefoot doctors" is a clear example. However, in the case of Saudi Arabia, it was noticeable that although there is an acute shortage of professional health personnel, the health policy overwhelmingly relies for the provision of health services on highly-qualified doctors. Nurses usually assist the doctor in minor tasks. CHWs or health assistants do not form part of the

Saudi Arabian health service. Instead, the shortfall in indigenous personnel is to some extent made up by the employment of expatriates, a policy made possible by the country's favourable economic situation. This is not a satisfactory long-term solution to the problem of the shortage of health personnel, and adds to the problem of communication. However, there are four faculties of medicine and a number of secondary health institutions in the country, and these could increase the number of native qualified doctors, which should be a major priority of health policy through co-operation between the Ministry of Health and Ministry of Higher Education, the former in determining future needs of health personnel, and the latter in determining criteria for acceptance of students for medical training. Paramedical personnel who graduate from the secondary health institutions would also be beneficial as they may be able to communicate more easily with people, than can doctors, who even if indigenous and speaking the same language as patients, tend to be distanced from them by social background and education. Moreover, the use of paramedical personnel would be a cost-effective way of providing many of the more basic medical services.

11.3 The Objectives of the Study

This study aimed to explore, analyse and evaluate the policy adopted for PHC, the utilisation of PHC centres in Saudi Arabia and the effect of the socio - demographic and economic characteristics of utilisers on their level of utilisation, as well as on their satisfaction with the health services delivered at the PHC centre in an urban centre (Jeddah), where both public and private health sectors work side by side.

This was done with two main objectives in mind: first, it was hoped that this study will contribute in one way or another to the field of sociology of medicine in general and to highlight the Saudi Arabian experience in implementing PHC approach. Second, it was hoped to fill the gap in knowledge about utilisation of the health services at PHC centre in Saudi Arabia. It should be noted that prior to this study no research has been done on acceptance and use of the PHC approach since implementation in Jeddah. There is consequently a gap in the literature on this aspect which this study tries to bridge in some degree.

Most of the available literature on PHC approach emphasised the importance of the approach for delivering acceptable and sound health care to rural and peripheral areas (WHO / UNICEF 1978), thus there is a gap in the literature concerned with the delivery of health care in urban areas and particularly with the implementation of the PHC approach in rural areas (Ebrahim 1985; Harpham et al. 1988; Tabibzadeh. et al. 1989). In Saudi Arabia there is another problem, that both public and private sectors exist and compete with each other in most of the urban areas, but in rural areas only the public sector exists. So, the question arises, does the existence of the private sector and its competition with the public give room for PHC to succeed in urban centres such as Jeddah?

Research on utilisation of health services, health policy and implementation of PHC in Saudi Arabia is very scarce (see Chapters Four and Five) and little has been done from a sociological perspective. Most of the available studies were carried out by medical professionals or those from other disciplines such as geography or management. So, their focus is different. Moreover, most studies of the utilisation of the health services in Saudi Arabia have been based on household surveying, in which the researchers asked respondents about utilising the health facilities, for example, during the previous year, or during the period of the study. This means that their findings were dependent on the respondents' memory, which may be unreliable. Thus, it becomes risky to make generalisations from them. This approach was adopted by El - Zahrany (1989) and Al - Baz (1992). Al - Saania's (1983) study was a general one, concerned with both hospitals and health centres and was undertaken before the implementation of the PHC approach in Makkah city. Similarly El - Zahrany 's (1989) study of health centres was carried out before the implementation of the PHC approach in Makkah city which began in 1990.

Another problem is that in some studies, researchers went to the field with pre - established conceptions or hypotheses, so their studies limited themselves to particular areas accordingly. For example Al - Baz (1992) hypothesised relationships between satisfaction and several variables, so when he went to the field his main concern was to establish these relationships rather than to measure satisfaction. Patient participation has been included in various studies (Al - Mazrou 1986, Al - Mubarak 1989, Al - Mazrou and Al - Shammari 1991 and Al - Baz 1992), but by participation,

they tended to mean little more than co-operation between patient and doctor. This is not the sense in which the term participation is used by WHO and other commentators and critics. No studies on utilisation of the health services or the use of PHC used types of diseases or ailments, either from records or listed, except Al - Saania (1983) and Al - Ribdi (1990).

Some studies on utilisation of the health services have been conducted by geographers (Al - Ghamdi 1981, Al - Saania 1983, El - Zahrary 1989; Al - Ribdi 1990), who traditionally investigate the importance of the health facilities, the effect of distance on the utilisers and travelling times to the health centres. However, none of these studies tried to establish relationships between distance and other related factors and tried to see if distance had a significant impact on utilisation. Travel times to the health facilities in Jeddah were studied in 1981 by Al - Ghamdi, but due to the rapid expansion of the city his study's findings will no longer be applicable. Furthermore, Al - Ghamdi (1981) carried out his study at a time when there were only seven health centres delivering primary medical care, and the PHC approach was not yet adopted. No one has so far studied the acceptance, attitudes and use of these facilities since implementation. Therefore, this study will fill a gap in the literature on PHC as carried out in an urban area, and on health research on Saudi Arabia in general.

The findings may give rise to suggestions and recommendations which may be of value to the health policy - makers and administrators in Saudi Arabia in the future. In other words, the objective was not only to criticise and analyse the present situation of PHC in Saudi Arabia, but also to shed light on how best the effectiveness and quality of the available services can be improved and the available resources most effectively used. Although the empirical study was carried out in Jeddah, it is hoped that its findings will highlight issues which are also applicable to other parts of Saudi Arabia.

Empirical data collected from 354 respondents, the majority registered with PHC centres, were analysed with a view to shedding light on the current state of health utilisation and awareness since adoption of the PHC approach in Saudi Arabia. The socio - demographic and economic characteristics of the sample were outlined in Chapter Seven. Data analysis and presentation was divided into four parts. The first described the respondents' attitudes towards and knowledge of the PHC approach, and their expectation of the implementation of the programme. The second part

discussed factors influencing registration with the health centre, and the general use of health centre services, in relation to some demographic and socio - economic characteristics of utilisers. The third part discussed the use of the health centre for special kinds of treatment: child care, maternity and dentistry care. Fourthly, we looked at health awareness and practices, including the utilisation of traditional medicine, the patient - doctor relationship and the result of this interaction, peoples' attitudes towards modern medicine and finally, the role of the media in increasing peoples' awareness and spreading health education.

Key themes and issues emerging from the empirical data are discussed below.

11.4 Organisation and Provision of PHC

11.4.1 Organisational Shortcomings

Many studies have reported on the impact of organisational factors and their effect on the accessibility and utilisation of health services. Some studies found that the manner of the health system's organisation affected people's attitudes to and satisfaction with the health services, which would in turn affect their utilisation of them. Other related factors which have an impact on the utilisers' pattern of utilisation behaviour are distance, working hours, location, travelling times, waiting times, and regularity of the health services. This study found that a variety of organisational or bureaucratic factors have influenced people's satisfaction with and utilisation of the PHC centre.

Many respondents complained that the location of many health centres was inappropriate and inaccessible, and the physical environment of the health centres was not suitable to accommodate a health organisation. This study found that almost all the health centres are situated in rented buildings which were not built to accommodate a health organisation, thus making delivery of the health services less easy, particularly for those who need special care, such as the elderly, pregnant and disabled people.

Distance from the health centre was reported by some of the respondents as one of the difficulties, which is understandable, especially where this is associated with lack of public transportation. The problem is particularly severe for women, who are not allowed to drive, and do not travel unaccompanied. The distance of the PHC centres from utilisers' homes necessitates use of private transportation, such as the patient's own car or someone else's car or taxi. The majority in this

study used their own car or the family's car. This in turn highlights another important problem, the availability of parking near the health centre. Most respondents complained about shortage or absence of such facilities. Similar findings were reported by Sebai (1981); Al - Ghamdi (1981); Sebai (1984, 1987, 1988); Banoub (1984); Al - Osimy (1991); Al - Baz (1992).

Working hours were found to have some impact on the utilisation of the health centre. Many respondents indicated that they had to make special arrangements, such as taking time off from work, if they wanted to go to the health centre, because the working hours were inconsistent with their working hours. Almost two thirds of the sample wished the current working hours would be changed. Some asked for an increase in working hours.

Another organisational factor which had an impact on satisfaction and utilisation of the health centre is waiting time before seeing the physician. Almost half the utilisers indicated they waited at the health centre for about 60 minutes before seeing the GP. This is unacceptable, and it caused discomfort and dissatisfaction with the health services, consistent with findings reported in other studies (Al - Torky and Harastani 1984; Al - Saania 1984; Al - Osimy 1991 and El - Zahrany, 1989).

Some organisational difficulties were linked to each other. For example, the slow delivery of the health services led to complaints about overcrowding. This slowness stemmed from shortage of health personnel in some health centres, as it was stated by many people that in some health centres there was only one physician and he was supposed to carry out all the activities: check - up, injection, vaccination of children and attending emergency cases.

Another managerial factor reported as one of the difficulties was the receptionists' poor co-operation with the users of the health centre. The receptionists usually stick to bureaucratic restrictions and sometimes they can alienate people and make them switch to the private sector. Often, receptionists make little attempt to interact with patients and make them feel comfortable, but confine themselves to the minimum response. Sometimes they ask for official documents for registration, which many people resented. They reported that, if they gave only their ID card or children's birth certificate, some receptionists asked for further, unnecessary, documents. This could impede many people from benefiting from the services.

Another complaint was of the shortage of equipment and other related facilities, as well as of staff and medicine, consistent with what has been reported by Sebai (1981, 1984, 1985,1988); Banoub (1984); Al - Mukadam (1987); Al - Osimy (1991) and Al - Baz (1992). This shortage of facilities affected consumers' satisfaction with the services delivered through the health centres. This study found that although the majority of the respondents were not satisfied with the standards of the medical services, this was particularly so for non-registration, income, marital status and nationality, which were all significantly related with dissatisfaction with the standards of the services. Since the non-registered were less satisfied, this might be one reason for their choosing to seek medical treatment in the private sector.

Now that each district has a health centre, this should lead to an increase in the level of utilisation of the health services, provided that the facilities in the health centre and personnel are increased and supported from other health levels. However, in some cases there is considerable distance between public hospitals and consumers' residences. So, in an emergency, cases either have to travel a long distance or go to private hospital. Private hospitals admit emergency cases but do not provide free services. If there was an increase in the number of facilities and availability of different specialities at the health centre, with reasonable working hours and night shift or on call services, many negative attitudes and doubts towards the PHC programmes and its ability to provide easy access and adequate health care coverage for all the population would change and more people might register with the health centre.

Although the PHC programme was welcomed, the data showed that there were some negative attitudes and dissatisfaction on the part of some respondents. The negative attitudes could arise from the discomfort consumers felt when they sought medical advice or treatment at public health institutes, and then this image may be extended to any other public health organisation. This discomfort stems from disorganisation, and poor interaction with the health providers. The organisational difficulties could be minimised. Many respondents complained about overcrowding and the slow delivery of the service. In fact, both of these complaints and other related ones, such as the working hours, are results of disorganisation and underfunding. An increase in number of doctors

and other medical personnel would reduce overcrowding. Moreover, the findings of this study revealed that no appointment system was applied in health centres and this leads to overcrowding in many health centres, which have a high case-load. Introducing an appointment system would help to resolve many complaints, because with an appointment system, every patient would come to the health centre at the suggested time, and this to a great extent would reduce the overcrowding.

11.4.1.1 Referral system

As an integral part of the country's health system, PHC is the central and main focus, and the first level of contact of individuals and families. It works on a referral system, with links to other health organisations; e. g., cases needing special treatment should be referred to the general hospital or a specialist hospital. In some countries where CHWs deliver health care, if a case needs treatment which is not within their limited scope, they immediately refer the case to the health centre and then it is the health centre's responsibility to treat the case or to refer it to other health institutions. In Saudi Arabia, the GPs at the health centre refer cases whose medical needs cannot be met at the health centre. Regarding satisfaction with the health services in relation to the referral system, the study found that more than half the respondents dissatisfied with the system (and most respondents were dissatisfied) complained of the complexity of the referral system and almost half the utilisers felt that the referral system was difficult. However, the empirical study also revealed complaints of abuse of the referral system, which originate from misunderstanding of the actual function of the system. Some GPs were very reluctant to refer any patient to general hospital because they were afraid that the consultants or specialists at the hospitals would consider them unable to carry out their duties and this might result in cancellation of their contract. However, on the other hand, some patients go directly to the general hospital; if not through the reception, then through the emergency department. The finding of a recent study, that since the introduction of the referral system the number of cases referred to hospitals was reduced, but the number of cases admitted to hospital through the emergency department had increased (Al - Mazrou et al. 1991), supports our findings regarding problems with the referral system and the abuse of the system. Patients' expectation of the referral

system is that when they are in need of medical treatment they can use the PHC centre to refer them to hospital rather than to be treated at the PHC centre.

11.4.1.2 Medical Records

The implementation of the PHC approach in Saudi Arabia was associated with medical records. Thus, many individuals think of the PHC programme as a means of having a medical record. The idea in principle was much appreciated and the study found positive attitudes towards having medical records which indirectly means health coverage or health insurance. Respondents believed that having a medical record would be beneficial for all. Different reasons were expressed for the benefits of the medical records for all. The main reasons suggested were to facilitate the follow - up of any sickness and to provide the GPs with all the necessary information about the patient at the needed time. On the other hand there were those who had negative attitudes toward medical records, because they had negative attitudes toward the public services in general. Indeed, although medical records were highly appreciated by many respondents, the practice indicates that these are still far from adequate, with insufficient medical and personal information. There is also still considerable duplication of effort in filling forms for or by the patients.

Examination of the relationship between socio-demographic characteristics and the medical record revealed that married respondents welcomed the practice more than the single and those with low level of income too accepted the idea more than those with high and medium levels of income. Those of low income probably felt that having a medical record means guaranteed access to the medical network and fewer problems with health personnel. Those satisfied with the service as a whole were also more strongly appreciative of the practice of introducing the medical record.

11.4.2 Patient - Doctor Relationship

Meetings between doctors and patients are frequent and regular occurrences. The success or failure of these medical encounters is often influenced by the nature of the relationship between doctor and patient (Morgan 1992). This relationship is based on interaction between two individuals with different interests, perceptions, levels of power, culture, resources and knowledge. Arce and Long (1987) use the term, "interface" to denote this relationship, involving and resulting from interaction between the two individuals. To understand the interaction between doctor and patient it is

necessary to consider the interfaces between the two within a wider perspective, and the effect of other factors, such as organisational and personal factors.

Although there were some complaints against health professionals, attitudes towards their relationship and dealings with patients were generally positive. However, two thirds of the sample were worried that doctors did not explain medical problems to patients. A worrying proportion of the respondents complained that some doctors make patients feel foolish, because they sometimes do not listen to them or just provide them with a prescription, without proper examination. Other studies have reported that many patients turned to the private sector because doctors there were more willing to listen to patients and give them information. Although many patients prefer the private health sector for this and other reasons sometimes they feel that they are persuaded by its doctors to have unnecessary tests or x-rays. Overall, the patient's satisfaction with health care is to a great extent based on the relationship with the doctors. Furthermore, compliance with the doctor's instructions is strongly influenced by the doctor - patient relationship.

The data collected revealed that many utilisers of the PHC centre expressed problems of communication with the health personnel. Indeed, this was reported as one of the major difficulties. It is very important for the utilisers of the health centre to understand instructions and to be able to express themselves and explain their health problems. Due to the shortage of Saudi health professionals, many non - Saudi health personnel work in the health centres, as well as in other health organisations. In hospitals, these professionals may have someone to translate for them, but in health centres, no translators are available, so people use broken Arabic language. Some respondents highlighted the communication issue and to them it represented a major problem. The doctor's verbal communication skills are especially important when a significant proportion of the population are illiterate or have relatively little formal education.

11.4.3 Preventive or Curative Care:

Some components of the PHC approach have not yet been implemented, judging by the findings of this study. We found that the health services delivered by the health centres are mainly curative rather than preventive, although the strategy of the approach is based on promotive, preventive, curative and rehabilitative health care. The main problem is in the misunderstanding and

interpretation of the philosophy of the approach. Many staff of the health authorities believe the PHC role is to deliver curative health care. As Sebai (1985) stated, this perception of PHC is deeply rooted in the nature of medical training and its curriculum. The findings of the present study regarding utilisation of dentistry care also illustrate the focus on cure, rather than prevention. Most of the dental care services that utilisers used were curative in nature (e. g. fillings, extractions), and many perhaps could be avoided with more preventive check - ups and dental health education. Thus, it seems that in many respects, the health centres still practice the delivery of the health service in the conventional style, which prevailed before PHC. Furthermore, although the health authorities claimed that the strategy is to adopt comprehensive PHC, in fact it was noticed during the field study and from the official documents that not all the needed health services were available at the health centres. For example, paediatric, maternity and dentistry care were not available at all the health centres. The same was true for some other facilities and equipment, and there were complaints of shortages in these respects.

11.5 Attitudes and Behaviour of Respondents:

11.5.1 Characteristics of Sample

The socio - demographic characteristics of the sample reflect to some extent the general socio - demographic features of Saudi Arabian society, which need to be taken into account by health planners. The age structure is one common in the developing world, with a high proportion in the younger age group. These age groups have particular needs for health services and education, so financial allocations should be directed to meeting their needs. The gender of the sample did not reflect the actual ratio of males to females in the country. This does not mean that females, who were less represented, do not use the health facilities, or are reluctant to participate in research. It is in fact, due to religious and cultural considerations. There were few women in this study because it is not acceptable for them to be interviewed by a non - related male. The level of literacy among females may also have affected their participation.

Most of the sample were married, and this in fact reflects a religious and cultural influence, that early marriage is preferred in Saudi Arabia. Also, in relation to utilising the health centre, married people are more likely than single ones to visit out - patient clinics. Few respondents were divorced,

reflecting the very low divorce rate in Saudi Arabia, because of religious and cultural considerations. In this respect, our findings are consistent with those of other studies conducted in different parts of the country, for example, Al - Saania (1983); Nur (1989) and El - Zahrany (1989). The average family size was 5 - 7 members, mainly the parents and their offspring. Many recent studies found similar findings, for example Nur (1989); El - Zahrany (1989) and Al - Ribdi (1990). Although social changes have occurred in Saudi Arabia, the extended family institution still exists. Many of the respondents indicated that they lived with their parents and the effects on their decision - making were clear; in case of a sick child, the grandfathers or mothers sometimes suggested where to seek medical treatment.

The study found that the overwhelming majority, 66%, of the sample were of low - income, most employed in the public sector. The public sector does not provide any health care for its employees; they have to seek medical treatment in the public health sector. So, it is not surprising that the majority of utilisers of the health centres were public sector employees.

The relatively high level of education was surprising because the level of illiteracy in Saudi Arabia is supposed to be high, especially among females. Al - Osimy (1991) found that 46 % of her sample had a low level of education, because 80 % of her sample were females. Nur (1989) reported that the rate of illiteracy among females was 44 %, compared to 24 % for males. However, the findings of the present study can be explained in three ways: the rapid growth in socio - economic development has offered good opportunities for many young Saudis to attend school and to pursue a higher level of education, to obtain better jobs. Girls' education started in the early 1960s but the number of girls joining school is very sharply increasing. The second interpretation is that those who utilise the health services are those who have some kind of official education, which is in line with de Kadt (1983). Finally, the study was carried out in an urban centre and people in cities often enjoy a better level of education because of the greater availability of these facilities. Other urban studies carried out in Saudi Arabia, for example Al - Saania (1983), obtained similar findings regarding educational levels.

The study found that the services in the health centres are not only confined to those who registered with them, but that some people who were not registered with the health centres used the services occasionally. This pattern of utilisation highlights the problem of record - keeping and the difficulty of keeping up - to - date information regarding utilisation and type of services most demanded at the health centre.

11.5.2 Attitudes

The study found that people in Jeddah welcomed the implementation of the PHC approach. The vast majority of the people showed positive attitudes towards the programme and they were very optimistic about its component elements. However, because of their previous experiences with public health services, and the shortage of facilities, remedies and medical professionals at health centres, there was some doubt as to the ability of the health centres to meet their health needs. Also, people tended to compare hospital facilities with those of the small health centre, to the detriment of the latter, which again cast some doubt on the efficacy of the PHC programme. PHC is still generally perceived as a transit station on the way to the hospital. This drawback was explicitly pointed out to the Minister of Health (Alyamamah 1992).

Regarding reasons why people register with the PHC centre, the majority did so in order to be able to use other public health facilities, because since the introduction of PHC approach, all general hospitals were instructed not to admit any person unless he or she was referred to the hospital from his / her PHC centre. So, to obtain access to the other health services consumers should be registered with the health centre in their districts. Thus, registration with the health centre does not necessarily imply satisfaction with PHC or conviction as to its value.

The second reason for registration is economic. Most of the utilisers of the health centres were of relatively low income. They registered with the health centre because they could not afford to purchase medical care from the private sector, which is very expensive. This finding is consistent with other studies on the effect of income on the utilisation of the health services (Bice, et al. 1973, Bice 1973, Enterline et al. 1973a, 1973b, Andersen and Newman 1973, Purola 1973; Nyman and Kalimo 1974, Aday 1975, Al - Ghamdi 1981, Al - Saania 1984, El - Zahrany 1989, Al - Osimy 1991).

Almost all those not registered with the health centre expressed dissatisfaction with the service, suggesting that the reason that stopped them from registering was their dissatisfaction more than any other reason (see Chapter Eight). The private sector, they believed, gave them better provision in various ways: the type of services, relationships with providers, appointment system; no long waiting or overcrowding and the interaction with the practitioners. The public sector, from their point of view, was deficient in these respects.

Attitudes towards the PHC approach and acceptance of it are influenced by many organisational factors in the case of registered respondents. Many respondents reported that they faced some kinds of difficulties with the PHC and these difficulties will influence their attitudes towards the PHC approach in general. Complaints included slowness in the provision of services, long waiting before seeing the doctor, the unhelpfulness of receptionists, problems with communication, the feeling that many doctors ignored patient's feelings and the shortage of the equipment at the PHC centres.

The PHC philosophy emphasises that the delivery of the programme should be by socially accepted methods. This means that the delivery of the health services should be within the cultural, social and religious context of the community served. The study reported some discontent from many respondents because of the unavailability of female practitioners, especially obstetricians and gynaecologists, in most health centres. In this respect, social, religious and cultural factors appear to have been neglected in implementation of the approach in Jeddah. This in turn has influenced people's utilisation of the health service. For example, some respondents reported that because of the unavailability of female gynaecologists or obstetricians, they opted for the private sector, where such services are available. Moreover, some respondents with ambivalent attitudes towards the PHC approach were actually criticising the way the health service is delivered, and some of its bureaucratic aspects.

11.5.3 Behaviour

Utilisation of the health centres, as indicated above, was for two types of services: general and special, the latter referring to child, maternity and dentist care. Here we will look at the utilisation of these types.

When we looked at the general use of the health centre in relation to socio - economic characteristics, it was found that there were strong relationships between utilising the health centre for particular ailments and some socio - economic variables. Age, for example, revealed strong significant differences among the utilisers in consulting a physician at the health centre. In the case of some ailments, the age factor plays a role in influencing the individual to seek medical treatment. For example, in this study, chest pains, joint pains and prolonged diarrhoea were particularly likely to make elderly people visit the health centre, while toothache, vomiting and sore throat were more common causes of visits by the 21 - 30 years age group. Gender did not show any significant difference in consulting the doctor in relation to the types of ailments investigated. That is because those ailments were common to both genders. However, many studies, generally, have shown that females are more likely to utilise the health services than males. Females, particularly at child bearing age are more likely to need special care (antenatal, natal and postnatal).

Regarding the effect of marital status, most of the health centre utilisers were married with children. This is consistent with McKinlay (1973) and Calnan (1983), who found that married people tend to use the out - patient clinics more than single ones, who would use the in - patient clinics more. This may be because married spouses get psychological and social support from their partners, and there is someone to take care of them or nurse them, while single people lack such support. However, married people's needs for health care are greater than those of the single, because married women might need other services that would not be used by the single, such as antenatal and obstetric services. This study found statistically significant differences between married and non - married people in utilising the health services for particular ailments. Married people were more likely to seek medical advice than the single in general for diseases associated with the heart, weakness, indigestion and diarrhoea.

A significant relationship was found between level of income and using the health centre for some type of ailments. Although the health service is provided free of charge, it was found that the higher the level of income, the more likely in general the utilisation of the service. People with a low level of income were less frequent utilisers of the health centre in relation to the listed ailments. Those

with a high level of income may enjoy better living standards than those with low or medium income, as they are likely to be able to afford better accommodation and better nutrition. They may therefore be less likely to become ill. On the other hand, when ill, they are more able to afford time off work and transportation to go to the health centre.

No statistically significant relationships were found between level of education, social background of the respondents and using the PHC centre for some types of ailments. Although there were some differences in pattern of use, they were not statistically significant.

Although the PHC approach emphasises the provision of comprehensive health care for all the people, it pays particular attention to those expected to be at risk, such as children and women. The approach recognises that women play a crucial role in health, both as health personnel and as family members (WHO 1981). Much attention is given to child health care and maternity care, emphasising the importance of the provision of care for the two categories of population most at risk. Health indicators reveal that infant mortality rate in developing countries is very high in general and that there are differences between rural and urban areas, as well as among the urban dwellers, where the highest rates are usually among the slum populations.

The rate of maternal mortality, too is very high in developing countries and the reported figures may be far lower than those actually occurring. Therefore, it is unsurprising that the PHC programme gives particular attention to these categories of the population.

The Saudi government is making a considerable effort to improve the health condition of children and women through such measures as including maternity and child clinics within the health centre policy, and the issue of a Royal decree making immunisation compulsory for all children. However, the empirical data found differences in children's immunisation in relation to individual social background and parents' level of education. The rate of immunisation was higher among those of urban than rural background. This result has also been found by other researchers, e.g. Nur (1989) and Al - Mazrou and Farid (1991). Also, the parents' level of education was found to have a strong influence on vaccination. The higher the parents' level of education, the more likely the child to be vaccinated. Furthermore, the study reported that those who were less satisfied with the abilities of

modern medicine were less likely to have had their children vaccinated; and those who said they complied with the GP's instructions, were more likely to vaccinate their children. Moreover, the utilisation of maternity clinics was associated with level of children's vaccination; women who regularly or sometimes used the maternity clinic were more likely to have their children vaccinated.

Few parents always had their children vaccinated at the suggested times. The majority either had most or some of the vaccination at the suggested times. The PHC centre accounted for more than half of all vaccinations reported by the sample. This emphasises the preventive role that the PHC programme can play in the community in relation to child care. In general, the immunisation levels in Saudi Arabia appear to be high, reflecting the effectiveness of official regulations in this regard. Some of the organisational difficulties that faced utilisers played a role in the low level of vaccination, e. g. many of those who indicated their children had not been vaccinated or did not have the vaccination at the suggested times, were prevented by some of the bureaucratic barriers or difficulties when they visited the health centre.

The study did not find any statistically significant relationship between the socio - demographic and economic characteristics of the health centre's utilisers and the patterns of use of the health centre for paediatric care. However, characteristics such as income, parent's level of education, family size, place of birth and nationality were found to have influenced some utilisers in their pattern of behaviour with the sick child. Although it was found that the majority of the utilisers tended to use the same medication as had already been prescribed for another child, which is unwise behaviour, the level of parent's education, income, nationality, social background, family size and registration revealed some effects on the utilisers' behaviour. For example, those with more education, and those with a high income, were more likely to take the sick child to the doctor rather than to give him / her the same medication as a sibling. Those not registered with the health centre were more likely to go to the doctor rather than to give the medicine. However, the study did not find any difference between those with urban and rural backgrounds in this respect.

Both registered and non-registered indicated that some external factors stopped them from taking the sick child to the GP, and there were strong significant relationships between registration

and these barriers. Those registered complained about working hours; overcrowding, the need to make special arrangements and the belief that the doctor would prescribe the same medicine, moreover, some said there was no need to take the second child to the GP (see Chapter Nine). Those not registered only complained about the same medication and a few indicated that they saw no need for a visit. The majority of those who complained were among the health centre' utilisers, and their attitudes disclose the need for health education which is the duty of the health centre personnel.

The study reported on behaviour if the child did not recover, and relationships were found between some socio-demographic and organisational factors, and behaviour. For example, taking the child to another doctor was common among people with lower levels of education, while those who had a higher level of education were more likely to continue with the same doctor. Other factors affecting this behaviour were satisfaction and registration. Those satisfied with the services were less likely to change their doctor while the converse was true of those dissatisfied, who were more likely to change the doctor and take the sick child to another doctor. Also, those not registered tended to go back to the doctor rather than to change him. The private sector was the most common choice for taking the unrecovered child for further treatment.

Regarding the relationship between utilising the health centre for maternity care and socio - economic and demographic characteristics of the sample, a positive relationship was found between level of education and the frequency of pregnant women visiting the obstetrics clinic. This is consistent with the findings of Al - Mazrou and Farid (1991). There were also differences between urban and rural people in the frequency of visits. The urban were more likely to use maternity care than the rural. Nationality was also significantly related to maternity clinic utilisation, in that non - Saudis made more frequent visits to the clinic than Saudis. Also, the more satisfied the utilisers, the more they made use of the maternity clinic. Furthermore, the relationship with the doctor and compliance with his instructions were significantly related to maternity care. Those who always complied with the doctor's instructions were more likely to make frequent visits to the maternity clinic and those who were less likely to comply with the GP's instructions were less frequent utilisers of the

maternity clinic. Working women were more likely to utilise the maternity clinic than non- working women.

These findings in relation to child and maternity care imply that there is a need for more effort to encourage people to make use of the available health services and there is a need to improve the current service. This would include considering the social, cultural and religious aspects, by delivering these types of service through female doctors as much as possible. Also, observation and official documents revealed that not all health centres can offer the services of maternity and child care specialists such as paediatricians, obstetricians and gynaecologists. Availability of such personnel would increase the confidence of clients, and might increase their utilisation of the health centre services.

The data analysis showed a relationship between levels of education, income, place of birth and nationality, and special diet for pregnant women. Low - income women were more likely than others to be instructed to follow a special diet during pregnancy, while those of higher income were less likely to follow a special diet. For level of education, the opposite was true: the higher the level of education, the more likely the pregnant women was to follow a special diet. Place of birth showed a difference between urban and rural women in favour of the urban. Non - Saudis were more likely than Saudis to follow a special diet.

The study found a huge change in places where pregnant women gave birth. Most births took place in health institutes: general hospitals, maternity hospitals and private hospitals. Few deliveries took place in homes. Al - Abdulatif (1989) similarly found more birth delivery taking places in health organisations than at home. This reflects the socio - economic changes in Saudi Arabia. The increase in numbers of girls with formal education, and the availability of female obstetricians would increase the number of deliveries at medical institutions rather than at home.

The study found that over 44 per cent of new-born babies were fed by both breast and bottle. Breast - feeding alone accounted for less than 29 per cent. There are several reasons why women opt for bottle feeding. In many cases, the mother practised breast - feeding but due to some circumstances, she could not sustain it. Most working mothers use the two methods, because during

the morning it would be difficult to breast feed as they are at work and the child is at home. Several studies have shown that there is a gradual change in attitude toward feeding the newborn baby, from bottle toward breast - feeding, but this trend was not strongly reflected in the behaviour of our sample.

Women face conflicting pressure. Their involvement in the workforce creates difficulties in caring for children. The government should try to assist working women to deal with these conflicts by providing facilities that help them perform their work duties properly, and at the same time feel secure about their children. Some privileges are already given to working women, in that every working woman can apply to have a housemaid to help with housework, but child rearing can not be left to housemaids, who have different cultural attitudes and may not even speak the same language. Thus, another solution would be for every workplace to provide a nursery with specialists to look after the children during working hours, and if a child is breast fed, his mother should be able to feed the child at certain times. Many Saudi women give up working because they can not co-ordinate their family duties and work. Tension within the family, which in some cases leads to divorce, often arises because of the imbalance between duties of the home and work.

Another specific area of medical care that was studied was dental care. The data concerning utilisation of dental care revealed statistically significant differences between some socio - economic and demographic characteristics of the utilisers. Age, gender, level of education, income and social background all showed significant difference between utilisers. Nationality and marital status revealed no significant differences. A relationship was found between gender and use of dental care; females used this service more than males. Moreover, pregnant women who made use of maternity care were more likely also to utilise the dentistry clinic. Regarding income, the higher the income, the more likely the patient was to use dentistry care. The study found that there were some obstacles impeding people from utilising dental care. These obstacles were financial, bureaucratic and personal. With delivery of the services in every PHC centre, some of these barriers would vanish.

At present, the dentistry service is not available at every health centre. The service is available at only 36 % of all the health centres in Jeddah (MOH 1991). Some health centres co - operate with

others where the services are available and refer their patients. Probably this factor has to some extent affected the result of this study. However, now the number of health centres with dentistry care is increasing, future research may find different results.

The study also found as mentioned above, that most of the dentistry services used were curative rather than preventive. Such services need not only to be provided by all PHC centres but the importance of preventive care should be emphasised through health education.

Generally, it appeared that attitudes and behaviour of respondents were influenced by their satisfaction with the health services at the PHC centre and this in turn would have its impact on their attendance at the health centre. The data collected showed some organisational obstacles that affected recourse to treatment of various kinds. The study also revealed that in cases of serious illness many respondents would prefer to go to the private sector rather than attend the PHC centres. Satisfaction is very crucial factor that affects both the attitudes and behaviour of utilisers.

11.5.4 Health Awareness

The analysis of the collected data revealed that the majority of respondents, 87 per cent, indicated that no home visit was ever made by any of the health centre personnel. This implies that outreach services, theoretically an important part of the approach, are not carried out in practice. A related implication is that opportunities to provide information and education, about health issues generally, and about the PHC approach, may be missed. And as mentioned above, most of the activities at the health centres were of a curative nature.

The empirical study showed that no health education activities were carried out at the health centres. At the same time, the study revealed the great need for such health education. One example of the need for health education was the reported behaviour with a sick child. More than half the respondents stated they would give the sick child the same medicine as that prescribed for his or her brother or sisters, rather than take him to the health centre. This pattern of behaviour needs to be changed and the change will not happen just by instruction or ordering but through education, which will take time. Another issue to be addressed by health education is that of "shopping" from one doctor to another, particularly because the stereotypical view of the health centre still needs to be improved. When people did not recover, they thought that going to the private health sector would

get them better care. However, this pattern of behaviour needs to be changed; people need to be educated about the danger of switching from one doctor to another. Another education issue is raised by the finding that most utilisers did not comply with the suggested time for children's vaccination, although immunisation needs to be undertaken at the set time to maximise effectiveness. All those examples, and others, provide evidence of a need for health education.

In theory, according to the Saudi health policy, health education is provided at the health centres for women, especially pregnant woman and new mothers, but unfortunately the evidence of this study suggests that in practice, this is not the case. Although at the beginning the PHC centre would face some difficulties, by using an appropriate approach and attractive means, the goal could be achieved. The women's charity organisations have been playing a productive role in this regard, although much remains to be done. Health education for pregnant women, in particular, is essential. Other agencies can share the responsibility for health education, e. g. the media, Ministry of Education, Agricultural Ministry and municipalities. All of these organisations need to co-operate and co-ordinate their efforts with the Ministry of Health in delivering health education.

The data on general check - up, also showed an inadequate level of health awareness. That this is a widespread problem is suggested by the lack of statistically significant relationships between socio - demographic characteristics and the frequency of having a general check - up. However, women were more likely to have a general check-up than men, and people with high income had more general check-ups than those of low and medium income. Saudis were more regular than non-Saudis in having general check-ups. However, the main reason for having a general check - ups was curative rather than preventive. In other words, the general check - up was associated with illness and curative measures.

The importance of keeping a first aid cabinet at home was acknowledged by the majority, but only half of them had one at home. Other indicators of the absence of health awareness were the tendency to buy medication without a prescription, and poor compliance with the doctor's instructions. These areas need to be emphasised in health education through PHC centres, mass media and schools, especially among people with a low level of education, as the empirical data

revealed a clear association between these two patterns of behaviour and education. Lower levels of income and satisfaction also were associated with lower compliance with the doctor's instructions, and the tendency to buy medication without a prescription. This pattern of behaviour indicates lack of knowledge about the danger of medication and low standards of health services at the health centres.

Lack of health education was manifested in reactions to noticing any symptom. Some people made a personal judgement about the severity of the illness, and more than two thirds of respondents did not consult a GP, because they felt their condition was not serious, or they could treat it themselves. Another area in which lack of health education was indicated, was the finding that many respondents paid no attention to the validity date of canned food, trusting to the suppliers. As a result of such carelessness, newspapers report many cases of food poisoning.

However, there was evidence of concern to bring up children with good and healthy concepts. For example, many respondents tried to educate their children in good hygiene as a means of protection; religious teaching was influential in this respect.

The study reported on buying medication from a pharmacy without prescription, and there was a considerable proportion of respondents who did so. In Saudi Arabia many types of medication can be bought without prescription, including antibiotics. This is potentially dangerous as medicine may have side effects if taken inappropriately. Moreover, in the event of any problem with medication, there would be no way of tracing it to the suppliers. Although regulations state that a licence to open a pharmacy can only be given to a graduate from pharmacological college, this is not a sufficient safeguard. Health education is needed to inform people of the adequate of buying medication without prescription.

It sounds as if there is a contradiction between advocating that pharmacists be restricted from giving medicine without prescription and at the same time calling for the use of CHWs to treat some cases, and also for the integration of traditional healers in the health network. In fact, there is no contradiction. CHWs would be limited to particular spheres of activities. They would only be able to supply limited drugs, e. g.. painkillers, and they will work under the supervision of the health personnel at the PHC centres. In cases of difficulties, they would be able to refer the case to the

PHC centre. Similarly with the traditional healers, the professional ones have knowledge and skill gained through long experience and study, and the non - professionals who practice bonesetting or prescribe some types of herbal medicine could work from the PHC centre, where they would be under the supervision of modern medicine practitioners. In contrast, pharmacists work on a commercial basis and there is no control and supervision.

To summarise, PHC is concerned with the main health problems and conditions in the community, and the services to a great extent reflect the political, socio - economic and cultural patterns in the country. The study reported on factors that affect the utilisation of health service facilities, and revealed that the individual's pattern of behaviour is influenced by organisational, personal and geographical factors. Some factors such as problems of transportation and a long waiting time, have been found to be obstacles in connection with widely different economic and cultural characteristics. Other organisational factors that influence the individual pattern of utilisation of the PHC centres vary from one country to another. One issue specific to Saudi Arabia is the utilisation of maternity care clinics. If there was no female obstetricians, many respondents indicated that they would switch to the private sector. Another factor was language, which affected the mutual understanding between providers and utilisers. This may have exacerbated the wider issue of the relationship between physicians and patients, which was also influential, particularly when patients reported that physicians ignored their feelings.

The personal or individual characteristics that influence the utilisation of the health services, include income, age, gender, marital status, level of education, occupation, ethnicity and religion, though their impact varies. In some countries, where health services are provided free, such as NHS in UK (Joseph and Phillips 1984) or Saudi Arabia for example, people might not recognise the importance and influence of income in using health services, but those who can afford private health services in these two particular countries, feel the difference between the public health service and the private in avoiding overcrowding, long waiting list for operations, and the pressure for quick discharge from hospital because of strong demand. Other variables such as age, gender and marital

status might show a similar pattern of utilisation between developed and developing countries. However, these factors would be influenced by some other related factors such as culture, availability of the health services and level of economic development.

The socio - demographic or economic characteristics of the sample were not associated consistently, with any differences of behaviour or attitude. i. e. the findings did not show, for example, that rural or urban people followed different patterns from each other in all circumstances, but they showed various attitudes and behaviours. The same can be said for all the socio - economic and demographic features of the sample. However, one factor which was found to be significant more commonly, was level of education.

An important issue is the relative weight of organisational factors and individual characteristics in influencing attitudes towards public health facilities and their level of utilisation. While both play a part, this study confirm the conclusion of Al - Baz (1992) that organisational factors had more influence in impeding people from using the PHC centre than personal factors. This finding has significant implication for health policy makers, administration and practitioners.

11.6 Women and PHC:

Women constitute a major proportion of those " at risk" while of childbearing age, and play very important roles in the provision of health care and promoting good health - either in the home or in health professions, whether modern or traditional. PHC programmes attach particular importance to women's health. On one hand, services should attempt to meet their specific needs; here, this study has on several occasions stressed the importance of extending the provision of maternity clinics and providing more female doctors. On the other hand, the approach hopes to provide women with the skills and capabilities necessary to increase their involvement.

An important finding was that women had the main responsibility for administering medication. Thus, their awareness of safety in this respect, and general health awareness, could be crucial to the health of the family as a whole. However, women's health awareness like that of men, is still limited as indicated by the practice of shopping from one doctor to another if the child did not recover, or giving the same medication to the sick child, that was prescribed for another one, rather than to take

him to the doctor, or taking a casual approach to child vaccination (here, more female respondents than males failed to have children vaccinated). Regarding maternity care, the study reported that about 12 % of women rarely or never used the available maternity care facilities, and 38 % did so sometimes, rather than regularly. All these patterns of behaviour highlight a need for health education for females, as promoters of health in the family.

11.7 Attitudes to and Use of Traditional Medicine

The Alma - Ata declaration, 1978, emphasised the integration and use of traditional healers after appropriate training. This study has shown that traditional medicine is practised in one way or another in almost every society. In some countries it is accepted and preferred to modern medicine, for some diseases. We have shown that there are two types of traditional medicine, scholarly or professional and non - professional traditional medicine. In some countries the former has been incorporated into the national health service system, and is delivered through PHC centres, for example China (WHO 1983) and Senegal (Asharq Al- Awsat 1993). Although many people use traditional medicine and most health authorities know about the practice and utilisation of such health services, they still have not yet been recognised by many health authorities. In recent years, more attention has been given to the traditional practitioners and traditional medicine. However, the tendency is for WHO and many health professionals and managers to view traditional medical practitioners as a source of health personnel for recruitment to modern medicine, rather than recognise their individual status as an alternative source of health care.

Many studies have reported that there are various reasons why people opt for traditional medicine, such as the nature of the doctor - patient relationship and the psychological dimension of traditional practitioners' practices. Some studies have associated the acceptance of traditional medicine and people's attitudes with religious and cultural aspects. Some modern medicine practitioners have a preconception about traditional medicine and they associate this type of health service with magic and illiteracy. However, utilisation of this type of health care occurs in every age group, gender and level of income as well as education.

Attitudes towards and use of traditional medicine among the Jeddah sample were examined. The analysis of the data indicated that traditional medicine is practised and utilised by a large proportion of the population, and it is one of the health care sources, although it has not been fully recognised by the health authorities. Analysis of socio-economic and demographic features showed there were significant differences in the tendency to consult traditional healers, in relation to age, gender and nationality. The elderly were more likely than the young to consult traditional healers. Although many other studies have reported that females were more likely to consult traditional healers than males, this study interestingly found that more frequent visits to traditional healers were made by males than females. However, these findings should be viewed with caution, since lack of official recognition, and stigmatisation of the utilisers (e. g. as having a low level of education), often make users reluctant to admit their use of these resources, so the finding many not accurately reflect the reality.

Traditional healers are not necessarily consulted because people do not trust modern medicine, but for different reasons, which indicate that the integration of the two branches would be beneficial and productive, as attested by the Chinese and Senegalese experiences. Moreover, many still believe that modern medicine can not cure all diseases and alternative approaches are available. The findings of this study showed that more than two thirds of the sample believed traditional medicine sometimes could be of more benefit than modern medicine in certain circumstances, and many consulted traditional healers as a result of previous experience with particular disorders such as fractures or psychological disorders. It may therefore be feasible for the two systems to work together, particularly if the scholarly or professional traditional healers were allowed to deliver their services from the health centres. Those who are non-professional and have had suitable experience could also be included and deliver their services from the PHC centre. In this case they would work within the health system. Each system might learn from the other.

11.8 Health Education and the Role of Mass Media

The PHC approach is in theory preventive rather than curative, and health education should be one of its main components. However, this study reported many patterns of health behaviour which

revealed the need for health education. Lack of health education leads, undoubtedly, to unhealthy behaviour. Many patterns of behaviour revealed significant differences in relation to education, with increased education tending to be associated with more positive attitudes and greater health awareness.

The study found that mass media played a crucial role in introducing the PHC approach to people and in providing health information. TV was the most effective means of transmitting health education. This is not surprising, as for many people it is the main source of entertainment. Moreover, it is attractive and easy to understand. It was suggested by the sample as the best means to spread and increase people's health awareness. Other media played a role in informing people about the implementation of PHC approach and in broadcasting health messages but not to the same extent as TV. The study found that more than half of the sample watched TV medical programmes, at least occasionally, and more than eighty per cent claimed that they accepted the medical advice heard in these programmes. Moreover, the support for increasing the number and timing of these programmes was overwhelming.

However, the findings of the empirical study, revealed that so far, the influence of these medical programmes is slight. No relationship was found between socio - economic and demographic characteristics and regularity of watching these programmes, except for education. Utilisation of maternity, dental care and vaccination was not found to be significantly related with watching TV programmes. The failure of these programmes, so far, to influence people's attitudes or behaviour, may be attributed to shortcomings in their scheduling and presentation. Thus, an opportunity for health education by a medium which was evidently regarded as attractive, is it would seem, so far not being effectively exploited, .

11.9 Participation:

The strategy of the PHC approach stresses the community's full participation in decision - making, implementation and evaluation of the approach, though forms, scale and scope of participation should be decided according to the county's socio-political system. The Alma - Ata declaration urged all governments and non - governmental organisations to encourage full

participation of the people in PHC, because PHC is not only provision of health services, it involves development and democratisation of the decision - making, for people to have a say in issues related to their health care. Participation can be individual or collective. However, most governmental programmes encourage community participation only in terms of providing some assets to help with the implementation whereas non - governmental programmes are more likely to involve people in both policy and implementation of the projects. The issue of who participates needs to be more debated because most of the existing literature does not give much attention to this very important issue. However, evidence reveals that the patterns and nature of participation differ from one country to another, according to the socio-political system and ideology. In some countries, only the elite or leaders are involved, while in other countries, a wide range of lay persons are to some extent involved. The two examples of implementation of PHC in State of Bahrain and South Yemen showed the influence of the socio-political system and ideology on people's involvement in health care policy formation.

However, the empirical study in Saudi Arabia revealed that few respondents indicated that the programme worked on a community basis. The concept of community participation in public service does not exist, and people are used to being recipients of the public services, without involvement. This is because the concept itself needs to be defined. The Saudi Health Authorities view community participation in a restricted way. The General - Director of PHC programme in the Ministry of Health (Al - Mazrou 1986) defined community involvement in the PHC programme in a passive manner, e. g. to comply with the physician's instructions and to help to convey the health message to other members of the community. He did not mention the political or the developmental role that the community can play by participating in decision-making, implementation and evaluation of the PHC approach, in accordance with the WHO's definition of community involvement. Although there exists a voluntary committee called the " Sick People's Friends Committee", it has no say in health policy or implementation. Its members are mostly the elite of the community (Al - Mazrou and Al - Shammari 1991) and their role is to help poor and needy families whose head is hospitalised, so they have no income. Many officials at the Ministry of Health consider involvement in this committee to

constitute community participation in PHC, but it seems very different from the intention of Alma - Ata. Thus, when respondents expressed doubt about community involvement, they had no clear definition of involvement and no existing example to guide them. The philosophy of the PHC strategy , in some ways, is based on educating people about their rights and duties, the benefit of development and the importance of being effective participants rather than passive recipients only.

11.10 Problems and Prospects:

One of the major problems with the implementation of the PHC approach in Saudi Arabia, found in this study, is its orientation towards curative rather than preventive care. The findings of this study revealed that many health behaviours were curative; even the policy indirectly emphasises curative care. As is known, PHC is intended to be preventive rather than curative, aiming to provide people with the necessary health education to be self - reliant and self - sufficient. Some progress has undoubtedly been made in Saudi Arabia with preventive measures. The increased proportion of children who are vaccinated and the wider provision of maternity and child centre is evidence of this. However, the observation and findings in Saudi Arabia suggest that more research to be done, particularly in health education which is so far largely absent. Also, there was a misunderstanding of the approach among both utilisers and providers of the health service.

Another problem is the misuse of the referral system. Both physicians and patients, as indicated in Chapters Four and Eight, used the referral system arbitrarily.

Effectiveness of PHC in Saudi Arabia has also been undermined by the shortage of medical personnel. The PHC approach services could be delivered to a limited extent by CHWs, after an intensive training course, to overcome this problem. These CHWs could also work in the health centres as auxiliaries and help the physicians by checking the patient's temperature, blood pressure and weight. By performing such services, they would save much time for both physician and patient and at the same time would help to reduce the overcrowding at the health centres.

This study revealed that the majority of the respondents preferred to be treated in the private health sector. The competition between the two sectors will be always in favour of the private as long as they can do what they like, at the time they like, whereas the public health sector is impeded by

bureaucratic and organisational obstacles. Thus, the private and public sector must both be included in an integrated national health policy, which would necessitate some legislation to control the private sector.

The low level of satisfaction of the respondents resulted from the characteristics of the health delivery system and of health care provision at the health centres, more than the respondents' own characteristics. Health administrators, planners and policy makers as well as some researchers might be tempted to attribute the low satisfaction with health services in the public sector to particular socio-economic and demographic characteristics such as poverty, low level of education, or poor health status, with their accompanying values, attitudes and beliefs. However, this study showed that the majority of respondents, whatever their socio-economic and demographic characteristics, would prefer to be treated in the private sector. The main reasons for this, as indicated previously, related to the bureaucracy, to careless behaviour among some physicians, and to the physical situation and shortage of facilities in the public sector. When policy makers and health authorities put the blame for dissatisfaction on the utilisers rather than the system, it implies that the change should be oriented towards the utilisers, not the system. In fact, this study suggests that much of the blame should be put on the system and the intervention should be aimed at the system as well as the utilisers.

Preventive health care should be stressed through comprehensive measures affecting several factors simultaneously in order to break the vicious circle of carriers of ill health. For example, immunisation programmes should be paired with health and nutritional education.

11.11 Limitations of the Study

There were a number of limitations in this study, that have to be identified and acknowledged. For example, there is only limited data available concerning health care in general and utilisation of the health services in particular, as well as basic information concerning the demographic and socio-economic characteristics of the population, which is very important for social research.

Because not much work of this kind has so far been carried out in Saudi Arabia, it was felt necessary to explore many aspects which might relate to the use of PHC. This meant that the questionnaire had to collect a wide range of information on the users of the health centres in terms of

their socio-demographic and economic characteristics as well as their attitudes towards PHC programmes and use of modern and traditional medicine. This meant that it was not possible to explore any one area in depth; this must be left to further research.

These were two major problems with the sample.

Firstly, it did not represent the sexes proportionately, because of cultural obstacles in obtaining access to female respondents. Secondly, the number of non-registered respondents was smaller than desired and because of the problem of sampling may not be representative of the wider population of non-registered people. Both of these shortcomings, may have caused bias in the results, and limit the conclusions that can be drawn from them. A further limitation is that the study explored one side of the "interface" only, that of patients. While some interviews were conducted with health personnel and some observational work was carried out, this was used only as background information.

As indicated in the Chapter on utilisation of health services, three main approaches can be identified in studies of health service utilisation, focusing on either the characteristics of health delivery systems, the characteristics of utilisers or the "health beliefs" of respondents. In this study, most attention was paid to the first two of these factors. A smaller number of questions were included to explore the influence of health beliefs. The results obtained suggested that respondents' health beliefs were of less importance than other factors. However, the questions asked were rather crude measures of health beliefs and did not do justice to this area. It would thus be premature to dismiss the importance of health beliefs without further research.

11.12 Recommendations:

Despite the above limitations, the study has contributed to the understanding of the use of health services in a developing country about which very little information is available. Also, the study has provided a great deal of empirical data and it is hoped that it will establish the foundation for further research in Saudi Arabia in the sociology of health.

As this study revealed, there were organisational and bureaucratic factors that impeded people from seeking medical treatment and made them dissatisfied with the health services. The health planners and administrators need to be aware of the importance of these obstacles to the satisfaction

of the utilisers of the health centres and to try to counteract them through effective measures concerned with the efficiency of the health centre, rather than rhetorical policy statements.

There is a need to increase the number of physicians as well as other personnel, especially females, and also to extend the range of services. This would be in accordance with the cultural, social and religious aspects of the society and would improve the level of utilisation of the service by women, who do not like to be seen by male doctors. Also, increasing the number of doctors at the health centre would reduce overcrowding and long waiting.

There is a need to expand the range of outreach of the services to cover those with special needs, such as the disabled, elderly, females and those with acute or poor health conditions such as diabetes or hypertension. Expanding the outreach may involve home visits, providing transportation from and to patient's homes and extending the working hours to increase the availability of the service.

Communication is a very important element of the provision of the health service. Thus, policy makers should realise the importance of language and they should employ physicians who can speak and communicate with people in their native language, to understand them and to know exactly what are their problems. Also, training courses could be set up to develop doctors' social and communication skills or they could be made part of initial medical training.

One crucial factor is that most health centres have no social workers, who might help in reducing many linguistic and bureaucratic barriers, and also help in understanding other aspects of health problems, such as social problems and psychological factors.

A more effective referral system is also needed. This would depend to a great extent on the communication between the PHC health centres and hospital. A computer network would facilitate communication, speed up the referral process and enable careful follow up between the two health institutions, and would clarify any misunderstanding. It would also help to reduce overcrowding at the hospital if there were visit arrangements between the health centres and consultants or specialists at the hospital. This would in turn increase the patient's trust of PHC centre doctors.

Long waiting times, and inconvenient working hours are factors which may result in fewer visits to the centres or a switch to the private services. If an appointment system were introduced it would undoubtedly reduce the waiting time at the health centre to a reasonable and acceptable level. Working hours of the health centres need to be changed because many of the utilisers complained about the current working hours. The working hours should be prolonged to nine o'clock at night, and one GP should stay late or be on call for emergency cases.

The physical environment of the health centres needs to be improved. Thus, more attention should be paid to facilities such as seats, waiting rooms, telephone and parking areas, to increase consumers' satisfaction. Also, the Ministry of Health should enforce a policy whereby health centres should be located in buildings owned by the Ministry of Health, suitable to accommodate health centres, and equipped with all the necessary facilities. Health centres should be accessible and located close to public transportation or residential areas. Also, it would be better if the Ministry of Health adopted a unified design for the health centres, as the Ministry of Education and the Girls Education Presidency do with schools, to make them easy to identify.

The idea of medical records is very good, but strict measures are needed to maintain the records up to date. Hence, any study carried out in future to measure the utilisation of the health centre will be able to be guided by these records. Such records will also be a valuable source of information for government planning of health services.

The integration of traditional medicine with modern medicine is believed to offer potential to correct the deficiencies of each and to enable the development of medical science for a brighter future. Herbal medication for example, needs to be investigated and explored, because it might provide the medical pharmacy with a rich source of medication. The medicinal plants used for treatment are generally locally available and relatively cheap. Furthermore, as long as there is no conflict between the two systems, why should both not work or operate from one place ?

The relationship between the two types of medicine should be investigated and what is good and scientifically approved treatment, particularly in the professional forms of traditional medicine, should be accepted. Exploring the potential of traditional medicine to contribute in improving health

conditions, particularly in developing countries, is a very important area of study for multi - disciplinary research. In many areas of health care, traditional medicine has proved its capability to cure and it is trusted by many people, especially in rural areas, where in some countries, traditional medicine is the only available source of health care. It may be valuable to allow traditional healers to practice from the PHC centres, so they would be under the surveillance of other branch of medicine and they might co-operate for the benefit of the people.

However, change in the policy and practice of PHC services will require more financial resources to be allocated. Many of these measures (though not all) will require additional funding. This has implications for the allocation of expenditures within the health sector budget. Until now, the country has tried simultaneously to improve and extend hospital facilities and to implement a PHC programme. Now that a number of well-equipped modern hospitals have been built it may be advisable to consider transferring some resources from the hospitals to the PHC programme. This would do much to raise the health standards of Saudi Arabian people, which now, in contrast with other countries, are very low. Infant mortality is high, at 69 per 1,000 live births (MOH 1989 and WHO 1989 a) and life expectancy is estimated to be 64 years (World Bank 1990). Saudi Arabia enjoys a high per capita GNP, and has only a small population of 16.9 million (Al Eqtisadiyah 1992). Economically, therefore, it should be capable of improving the public health service and making it one of the best in the world.

Massive health education programmes should be developed for the population in general and these programmes should work to change attitudes and behaviour of the people towards the health services, diseases and preventive care.

11.13 Recommendations for Further Research:

Due to the limited data and studies on Saudi society in general and in the sociological field in particular, it is believed that there is still some room for further studies. There is a need for further research to examine the utilisation of health centres in rural and urban areas, to compare people's attitude towards the PHC in terms of provision and utilisation of health care services, and to look at

patterns of morbidity. Also, further research is needed to study the most utilised types of traditional medicine, and the possibility of incorporating traditional medicine into PHC.

This study explored the age, education and gender of the utilisers of the health centres, and their impact on the use of the service. Unfortunately it was not possible to include many elderly people. As this group of the population have special needs of health care, it would be desirable for further research to explore the utilisation made by this segment of the population.

Utilisation of the health services in relation to morbidity and the influence of types of ailment in seeking medical treatment were examined in this study. It would be useful for this topic to be considered in more depth using a broader range of ailments, including some which are more age or sex - related than those mentioned here, to help health administrators and planners to assess the future needs for health services. Moreover, the social changes taking place in Saudi Arabia may change the pattern of morbidity, so a periodic update of such information would be a fruitful contribution to health policy and to the sociology of medicine.

This study was limited to the use of PHC centres, while there is shortage of information on utilisation of other health facilities, public or private, so it would be appreciated if more research were conducted to find out about utilisation of the private sector, to compare utilisers of private and public health service.

Women were under-represented in this study. Their utilisation of and satisfaction with the health centre is very important, as they make greater use of the health service, in general, than males. An interesting area of research which would accord with religious and cultural susceptibilities in Saudi Arabia would be a joint research using both male and female researchers to cover the population more evenly. The findings of such research would be beneficial to health planners and decision-makers in Saudi Arabia.

Finally, this study was carried out in an urban site, so it would be hard to generalise its findings , because Saudi Arabia is a large country with various subcultures. It would be desirable for similar studies to be carried out in other cities or in rural areas. A comparative study across both rural areas and urban centres would also be of interest. Again, such study could be carried out by both male and

female researchers, to overcome any difficulty of sample access while adhering to the country's cultural and religious teachings. Then it would be more practical to make generalisations about attitudes to and utilisation of the health services in general, and PHC centres in particular, in Saudi Arabia.

This study was concerned with the utilisation of and awareness of health care. Thus, it mainly focused on the utilisers of the health facilities. It would be of much interest and importance to study health service providers - how they view the relationship with the utilisers, their conception of utilisation, their satisfaction and dissatisfaction. It would be of interest to find out, why so few Saudi physicians work in PHC centres or in rural areas. In a nutshell, there is a need to study the health personnel in general, as a community.

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APPENDIX:

Questionnaire

Socio-economic and Sociodemographic Variables

- 1 - Neighbourhood: (District):
- 2 - Gender :
- | | | | |
|------|-----|--------|-----|
| Male | () | Female | () |
|------|-----|--------|-----|
- 3 - Age:
- | | | | |
|---------------------------|-----|--------------|-----|
| 1- Less than 20 years old | () | 2- 20 - 30 | () |
| 3- 31-40 | () | 4- 41- 50 | () |
| 5- 51-60 | () | 6- 61 Upward | () |
- 4 - Marital Status:
- | | | | |
|----------|-----|---------|-----|
| Married | () | Single | () |
| Divorced | () | Widower | () |
- 5 - If not single, how many children do you have ?
- | | | | |
|-----------------------------|-----|-------------------|-----|
| 1- Without children | () | 2- One child | () |
| 3- Two children | () | 4- Three children | () |
| 5- Four children | () | 6- Five children | () |
| 7- Six children | () | 8- Seven children | () |
| 9- More than seven children | () | | |
- 6 - How many members does your household have? (Family size)
- | | | | |
|------------------|-----|-----------------------|-----|
| 1 - Two - Four | () | 2 - Five - Seven | () |
| 3 - Eight - Ten | () | 4 - Eleven - Thirteen | () |
| 5 - More than 13 | () | | |
- 7 - Nationality:
- | | | | |
|---------------|-----|-----------|-----|
| Saudi Arabian | () | Non-Saudi | () |
|---------------|-----|-----------|-----|
- 8 - Place of birth:
- | | | | | | |
|-------|-----|-------|-----|---------|-----|
| Urban | () | Rural | () | Bedouin | () |
|-------|-----|-------|-----|---------|-----|
- 9 - How long have you been living in Jeddah ?
- () Year (s)
- 10 - Educational level:
- | | | | |
|-------------------------|-----|---------------------|-----|
| Illiterate | () | Read & Write | () |
| primary School | () | Intermediate School | () |
| High School | () | University & Upward | () |
| Others (please specify) | () | | |
- 11 - Type Of Housing :
- | | | | | | |
|-------|-----|------|-----|------------|-----|
| Villa | () | Flat | () | Arab House | () |
|-------|-----|------|-----|------------|-----|
- 12 - Property Status
- | | | | |
|-------|-----|--------|-----|
| Owned | () | Rented | () |
|-------|-----|--------|-----|
- 13 - Monthly Income: In Saudi Arabian Riyals.
- | | | | |
|-----------------|-----|--------------------|-----|
| 1 - 1500 -3000 | () | 2 - 3001 - 5000 | () |
| 3 - 5001 -7000 | () | 4 - 7001 - 9000 | () |
| 5 - 9001 -12000 | () | 6 - 12001 and more | () |
- 14 - Income Source : What is your income source?
- | | | | |
|-------------------|-----|------------------------|-----|
| Salary only | () | Business only | () |
| Salary & Business | () | Others please specify. | () |

- 15 - Employment status:
- | | | | |
|----------|--------------------------|---------------|--------------------------|
| Employed | <input type="checkbox"/> | Self-employed | <input type="checkbox"/> |
| Jobless | <input type="checkbox"/> | Retired | <input type="checkbox"/> |
| Student | <input type="checkbox"/> | Housewife | <input type="checkbox"/> |
- 16 - If Employee, Which sector?
- | | | | |
|---------------|--------------------------|----------------|--------------------------|
| Public sector | <input type="checkbox"/> | Private sector | <input type="checkbox"/> |
|---------------|--------------------------|----------------|--------------------------|
- 17 - If you are married, What is your wife's educational level ?
- | | | | |
|------------------------|--------------------------|---------------------|--------------------------|
| Illiterate | <input type="checkbox"/> | Read & write | <input type="checkbox"/> |
| Primary School | <input type="checkbox"/> | Intermediate School | <input type="checkbox"/> |
| High School | <input type="checkbox"/> | University | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> | | |
- 18 - Does your wife work ?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 19 - If yes, What job does she do?
- | | | | |
|------------------------|--------------------------|----------------|--------------------------|
| Teacher | <input type="checkbox"/> | Nurse | <input type="checkbox"/> |
| Social worker | <input type="checkbox"/> | Civil Employee | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> | | |
- 20 - If she has a paid job , What is her income ?
- | | | | |
|--------------------|--------------------------|---------------|--------------------------|
| 1 - 1500—3000 | <input type="checkbox"/> | 2 - 3001—5000 | <input type="checkbox"/> |
| 3 - 5001—7000 | <input type="checkbox"/> | 4 - 7001—9000 | <input type="checkbox"/> |
| 5 - More than 9001 | <input type="checkbox"/> | | |
- 21 - Does she participate in the household expenditure?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 22 - If you are not a government employee, does your work provide you with health care coverage ?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 23 - If yes, does your work pay for all the health expenses for you and your family ?
- | | | | |
|----------------------|--------------------------|--|--|
| Myself only | <input type="checkbox"/> | | |
| Myself and my family | <input type="checkbox"/> | | |

The second part of this questionnaire is concerned with Health and Primary Health Care. Here are a group of questions about the PRIMARY HEALTH CARE PROGRAMME, the researcher wants to know your opinion about this approach:

- 24 - Have you heard about the Primary Health Care Approach ?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 25 - If yes, Through which of the following means?
- | | | | |
|-----------|--------------------------|--------------------------|--------------------------|
| TV | <input type="checkbox"/> | Radio | <input type="checkbox"/> |
| Press | <input type="checkbox"/> | Friends | <input type="checkbox"/> |
| Relatives | <input type="checkbox"/> | Others (please specify). | <input type="checkbox"/> |
- 26 - Is there any PHC centre in your district ?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 27 - Have you registered with the PHC Centre in your district?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|
- 28 - What made you register with the health centre?
- | | |
|--|--------------------------|
| 1 - The provision of health services may be better | <input type="checkbox"/> |
| 2 - It is the only means to have access to hospital services | <input type="checkbox"/> |
| 3 - I can not afford private health care | <input type="checkbox"/> |
| 4 - I was advised by my friends | <input type="checkbox"/> |
| 5 - I was advised by my relatives | <input type="checkbox"/> |
| 6 - Because all my friends and relatives registered | <input type="checkbox"/> |
- 29 - For how long have you been registered with the PHC centre?
- () Month (s)
- 30 - Have any staff from the PHC centre visited you at home?
- | | | | |
|-----|--------------------------|----|--------------------------|
| Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

- 31 - Did the PHC centre's personnel provide you with any illustrative materials such as leaflets, booklets, instructions, to give you a comprehensive explanation of goals, aims, expectations of PHC programme?
 Yes No
- 32 - If yes, What did you think of those materials?
 1 - Understandable 2 - Difficult to understand
 3 - Too long 4 - Reasonable
- 33 - Do you think other means should be used to convey the aims of PHC programme?
 Yes No
- 34 - If yes, (please specify)
- 35 - Have you been asked to visit (come to) the PHC centre?
 Yes No
- 36 - If yes, what was the reason for the visit ?
 1 - To provide them with more information about your family
 2 - To conduct overall check-up
 3 - To open family's medical profile
 4 - Other (please specify)
- 37 - How did staff interact with you during your visit to the PHC centre?
 1 - Friendly 2 - Fair
 3 - Cold 4 - Ignored
- 38 - When you went to open a medical profile were you asked for any particular documents ?
 Yes No
- 39 - If yes, What were those documents ?
 1- Renting contract
 2- Property legal deed
 3- Others
- 40 - Have you experienced any sort of difficulties during your visit to the PHC centre?
 Yes No
- 41 - If yes, Which of the following:
 1 - Long waiting queue
 2 - Receptionists were not helpful
 3 - No men's waiting room
 4 - No ladies' waiting room
 5 - No car parking area
 6 - Difficulties in communication with staff
 7 - The provision of the services is too slow
 8 - Physician ignored patients' feelings
 9 - Others (please specify)
- 42 - When you went to the health centre for registration, did they carry out any overall health check-up of you and your family members?
 Yes No
- 43 - When you were referred to hospital, how was the procedure?
 Easy Complicated
 Neither easy nor difficult Do not know
- 44 - Do you think the idea of having a family medical profiles practical and beneficial?
 Yes No
- If yes, in what way?
- If no, Why not?
- 45 - Do you think the implementation of PHC approach will contribute to deliver a better quality of health services in the country in general?
 Yes No
- 46 - If yes, why ? Indicate any reasons that apply :?
 1 - The strategy of the approach is based on providing an easy access to every member of the community()
 2 - It is community based.
 3 - It meets the basic health needs of the districts residents.

- 4 - The idea of having a medical profile for each resident in the district speeds diagnosis process and facilitates prescription of appropriate medication. ()
- 5 - The prevalence of PHC centres in every district makes it easy to use them. ()
- 6 - The functions of the programme will meet the lay persons' needs of health care. ()
- 7 - The communication and interaction between patients and the personnel are very close and intimate. ()
- 8 - Other reasons. ()

The following statements are frequently repeated in the community. What do you think about them ?

- 47 - Within the PHC programme people will have easy access to medical care services.
 Strongly agree () Agree ()
 Disagree () Strongly disagree ()
 Uncertain ()
- 48 - The services in the PHC centres are not what they should be (lack of facilities; staff... etc.)
 Strongly agree () Agree ()
 Disagree () Strongly disagree ()
 Uncertain ()
- 49 - Are you satisfied with the standards of the health services in the PHC centres ?
 Yes () No ()
- 50 - Do you see the same doctor when you go for medical treatment?
 Always () Most of the time ()
 Sometimes () Rarely ()
- 51 - If more than one of the family members need medical care we have to go to different doctors.
 Strongly agree () Strongly disagree ()
 Agree () Disagree ()
 Uncertain ()
- 52 - How far is the PHC centre from your house ?
 () metres
- 53 - The location of the PHC centre is very inconvenient
 Strongly agree () Strongly Disagree ()
 Agree () Disagree ()
 Uncertain ()
- 54 - What kind of transportation do you usually use when going to the health centre ?
 1 - Go in own and family car () 2 - Go in someone else's car ()
 3 - Go in taxi () 4 - Go by bus ()
 5 - Walk ()
- 55 - If you go by car, is there any parking area available ?
 Yes () No ()
- 56 - Are the PHC centre's working hours consistent with your working hours?
 Yes () NO ()
- 57 - Do you think the current working time needs to be changed ?
 Yes () NO ()
- 58 - If yes, What hours do you suggest ?
- 59 - Do you usually have an appointment ahead of time when you go to PHC centre
 Have an appointment () Walk in ()
- 60 - If you have an appointment, how is this appointment usually set up ?
 Set up at an earlier visit ()
 Call for an appointment ()
- 61 - How long do you usually wait between the time the doctor is called for an appointment and the date you actually see the doctor ?
 Hour () Day ()
 Week () Month ()
- 62 - How long do you usually have to wait before seeing the doctor once you are at the PHC centre ?
 () Minutes
- 63 - Do you usually have to make any of the following arrangements when you want to go or to accompany a family member to the doctor ?
 1 - take time off from work ()
 2 - ask someone to look after children at home ()
 3 - in the case of children aged 5-16, notify school of absence ()
 4 - Other kind of arrangements (please specify) ()

64 - Before the PHC programme was introduced and started functioning in your district, where did you seek medical treatment?

- | | | | |
|-----------------------|-----|------------------------|-----|
| 1 - Public hospital | () | 2 - Private hospital | () |
| 3 - Public dispensary | () | 4 - Private dispensary | () |
| 5 - Folk healer | () | 6 - Use home remedy | () |

65 - If the case is really serious, Where do you prefer to go ?

- | | | | |
|------------------------|-----|------------------------|-----|
| 1 - Public hospital | () | 2 - Private hospital | () |
| 3 - Public dispensary | () | 4 - Private dispensary | () |
| 5 - Traditional healer | () | | |

66 - If your choice is the private health sector, Why did / do you prefer that?

- | | |
|---|-----|
| 1 - The health services are better | () |
| 2 - No long waiting queue | () |
| 3 - It is easy to make an appointment by telephone | () |
| 4 - The communication and interaction with the personnel are intimate and very smooth | () |
| 5 - It is the only existing health unit in my district | () |
| 6 - Its location is very close to my work place | () |
| 7 - Because everybody I know goes there | () |
| 8 - Provided by employer | () |
| 9 - Other reasons | () |

67 - If your choice was a folk healer, Why did you prefer that?

- | | |
|--|-----|
| 1 - I do not trust modern medicine | () |
| 2 - I have had a successful experience with the traditional healers | () |
| 3 - Traditional medicine has cured illnesses which were thought incurable by modern medicine | () |
| 4 - They use natural herbs which have no side effect | () |
| 5 - Others | () |

HERE ARE SOME QUESTIONS ABOUT CHILD HEALTH CARE.

If you do not have children please skip to the second section which starts at question no. 92.

68 - When a child is sick To whom does the doctor usually give instructions and explanations?

- | | | | |
|---------------------|-----|-------------------|-----|
| 1 - Father | () | 2 - Mother | () |
| 3 - Father & Mother | () | 4 - Elder brother | () |
| 5 - Elder sister | () | 6 - Relatives | () |

69 - Who usually gives children their medicine?

- | | | | |
|---------------------|-----|------------------|-----|
| 1 - Father | () | 2 - Mother | () |
| 3 - Father & Mother | () | 4 - Elder sister | () |
| 5 - Elder brother | () | 6 - House maid | () |

70 - If mother is an employee, who usually looks after the sick child during her working hours?

- | | | | |
|---------------------|-----|---------------------|-----|
| 1 - Mother's mother | () | 2 - Father's mother | () |
| 3 - Mother herself | () | 4 - Housemaid | () |
| 5 - Relative | () | | |

71 - Who usually takes children to the PHC Centre ?

- | | | | |
|---------------------|-----|---------------|-----|
| 1 - Father | () | 2 - Mother | () |
| 3 - Father & Mother | () | 4 - Elder Son | () |
| 5 - Elder daughter | () | 6 - Relative | () |
| 7 - Driver | () | 8 - Housemaid | () |

72 - Have your children had all the necessary vaccinations?

- | | | | |
|-----|-----|----|-----|
| Yes | () | No | () |
|-----|-----|----|-----|

73 - Where did they usually have them?

- | | | | |
|-----------------------------|-----|-----------------------|-----|
| 1 - Maternity hospital | () | 2 - Public hospital | () |
| 3 - Private hospital | () | 4 - PHC centre | () |
| 5 - Private dispensary | () | 6 - Public dispensary | () |
| 7 - Others (please specify) | () | | |

74 - Did the children have all the vaccines at the suggested time?

- | | | | |
|--------------|-----|--------------|-----|
| All of them | () | Most of them | () |
| Some of them | () | None of them | () |

- 75 - Do you think immunisation is very important for both children and the society?
 Yes () No ()
- 76 - If yes, Why?
- 77 - Who took the children to have the vaccination?
 1 - Father () 2 - Mother ()
 3 - Relative () 4 - Father & Mother ()
 5 - Others ()
- 78 - Do you always instruct your children to wash their hands before and after eating?
 Yes () No ()
- 79 - If yes, Why?
 1 - To protect them against disease ()
 2 - General cleanness ()
 3 - According to religious teachings ()
 4 - Habit ()
 5 - Others (please specify). ()
- 80 - Do you ask your children to wash their hands after using the toilet?
 Yes () No ()
- 81 - If yes, Why?
 1 - General cleanness ()
 2 - To protect them against any disease ()
 3 - Habit ()
 4 - According to religious teachings ()
 5 - Others ()
- 82 - If one child got sick and you thought another child had the same symptoms, would you
 1 - take the second child to a doctor ()
 2 - Use the same medication ()
- 83 - If you would use the same remedy, why is this ?
 1- No need to take him / her to doctor ()
 2- Medicine Will do him / her no harm ()
 3- The same medicine will be prescribed for him / her ()
 4- PHC centre's working hours are inconsistent with my working hours ()
 5- Fear of overcrowding and long wait at the health centre ()
 6- Need to make special arrangement ()
 7- Have no one to take him / her ()
 8- Others ()
- 84 - If a physician prescribes a remedy, how precisely do you follow his instructions in term of dosage, time and courses etc?
 Always () Sometimes ()
 Rarely () Never ()
- 85- If the patient does not recover, do you take him back to:
 Same doctor () Another doctor ()
- 86 - If the answer is another doctor, which of the following do you go to?
 1 - PHC centre ()
 2 - Public hospital through emergency room ()
 3 - Private hospital ()
 4 - Folk healer ()
 5 - Ask friends' advice ()
 6 - Ask relatives' advice ()
- 87 - If the mother / father's parents live with you in the same house, do they give any advice about where to seek health care?
 Yes () No ()
- 88 - If yes, how often do you act on their advice, even if it conflicts with your own ideas ?
 Always () Sometimes ()
 Rarely () Never ()
- In this group of questions I would like to know your views about dental care.**
- 89 - Do you and your family members go to the dentist?
 Yes () No ()
- 90 - How often do you go?

- 1 - Once a year () 2 - Twice a year ()
 3 - Only when I \ we have toothache ()
- 91 - Which of the following services did you receive during last year?
 1- Teeth Examined ()
 2- Teeth Cleaned ()
 3- X-ray ()
 4- Tooth or Teeth filled or inlays ()
 5- Dentures, plates, or bridgework made, repaired ,replaced, or adjusted ()
 6- Gum treatment ()
 7 - Tooth or teeth pulled ()
- 92 - Have you ever wanted to go or take any member of your household to the dentist, but could not go for one reason or another?
 Frequently () Sometimes ()
 Rarely () Never ()
- 93 - Which of the following reasons impeded you:?
 1 - Did not know what doctor to go to ()
 2 - Thought there would be a long waiting queue ()
 3 - Thought the visit would cost too much ()
 4 - Had to make special arrangement like getting baby - sitter or someone to go with, time off from work ()
 5 - Felt I could treat the condition myself ()
 6 - Did not think the condition serious ()
 7 - Have a fear of doctor ()
 8 - Other reasons ()

This set of questions is concerned with pregnancy and newborn babies

- 94 - Do pregnant women in your family visit the obstetrician regularly ?
 Always () Sometimes ()
 Rarely () Never ()
- 95 - How often does the pregnant woman visit the obstetrician ?
 1- Once a month ()
 2- When she feels pain ()
 3- Only when she gives delivery ()
- 96 - Does PHC's obstetrician follow up the development of pregnant woman and provide her with advice and instructions during each visit?
 Yes () No ()
- 97 - Does PHC centre run lectures and seminars for pregnant women to make them aware about personal hygiene and ways of feeding the new-born baby?
 Yes () No () Do not know ()
- 98 - For expectant mothers who have not had any experience with pregnancy, delivery or maternity, does PHC centre give any lectures or sessions about caring for the newborn baby, e.g. feeding and changing his / her clothes?
 Yes () No () Do not know ()
- 99 - Do pregnant women in your family follow a special diet ?
 Yes () No () Do not know ()
- 100 - If yes, according to whose advice?
 1- Obstetrician () 2- Mother ()
 3- Relatives () 4- Friends ()
 5- Neighbour () 6- Midwife ()
- 101 - Where does the delivery usually take place?
 1 - At home under midwives' supervision ()
 2- At home in the presence of obstetrician ()
 3- At home with relatives ()
 4- At public hospital ()
 5- At maternity hospital ()
 6- At private hospital ()
 7- Somewhere else ()
- 102 - How do you feed the new born baby ?
 1 - Breast feeding () 2 - Artificial feeding ()
 3 - Breast & Artificial feeding ()

- 103 - If using artificial feeding, how often do you sterilise the bottle?
- | | | | |
|--------|-----|-----------|-----|
| Always | () | Sometimes | () |
| Rarely | () | Never | () |
- 104 - How often is the sterilisation carried out ?
- | | |
|-----------------------------|-----|
| 1 - Every time | () |
| 2 - Once a day | () |
| 3 - Once a week | () |
| 4 - When it looks needed | () |
| 5 - No sterilisation at all | () |

HERE I AM INTERESTED TO KNOW YOUR RESPONSES TO THE FOLLOWING GENERAL CONCEPTIONS ABOUT HEALTH CARE IN GENERAL.

- 105 - How often do you have a general check-up?
- | | | | |
|------------|-----|-----------|-----|
| Frequently | () | Sometimes | () |
| Rarely | () | Never | () |
- 106 - How regularly do your family members have a general check - up?
- | | | | |
|------------|-----|-----------|-----|
| Frequently | () | Sometimes | () |
| Rarely | () | Never | () |
- 107 - When was your last general check-up?
- | | |
|----------------------------|-----|
| 1 - Less than one year ago | () |
| 2 - Two years ago | () |
| 3 - Three years ago | () |
| 4 - Four years ago | () |
- 108 - What was the main reason for having the general check-up ?
- | | |
|--|-----|
| 1 - Required by PHC centre a medical record | () |
| 2 - Enrolling in new job | () |
| 3 - Enrolling in school | () |
| 4 - To join a club | () |
| 5 - To obtain a residence permit | () |
| 6 - My general health condition was not good | () |
| 7 - Annual examination | () |
- 109 - Do you agree with the idea that says " people must be encouraged to have annual check-up".
- | | | | | | |
|-----|-----|----|-----|-------------|-----|
| Yes | () | No | () | Do not know | () |
|-----|-----|----|-----|-------------|-----|
- 110 - If any symptoms or ill health conditions have been noticed, how soon do you usually respond?
- | | | | |
|-------------|-----|------------------|-----|
| Immediately | () | Wait for a while | () |
|-------------|-----|------------------|-----|
- 111 - If you waited for one or more days before went to see the doctor, why did you delay?
- | | |
|--|-----|
| 1 - I was not sure what doctor to go to | () |
| 2 - Felt I could treat the condition myself | () |
| 3 - Believed the doctor could not do anything good for the case | () |
| 4 - Thought the symptoms were not serious enough | () |
| 5 - Thought the visit would cost too much | () |
| 6 - Thought it would take too long or cost too much to get there | () |
| 7 - Believed there would be long wait at the clinic | () |
| 8 - Have fear of doctor | () |
| 9 - I was afraid to find out something was seriously wrong | () |
| 10 - Had to make special arrangement such as time off from work, someone to look after children, someone to drive there etc. | () |
| 11 - Others | () |
- 112 - If there was more than one reason, which one you believe was the main one ?
- 113 - Which of the following symptom (s) make (s) you immediately contact the doctor ?
- | | |
|--|-----|
| 1 - Cough any time during the day or night which lasts for three weeks | () |
| 2 - Sudden feelings of weakness or faintness | () |
| 3 - Frequent headaches | () |
| 4 - Repeated pains in or near the heart | () |
| 5 - Diarrhoea for four or five days | () |
| 6 - Pains or swelling in any joints during the day | () |
| 7 - Repeated indigestion or upset stomach | () |
| 8 - Repeated vomiting for a day or more | () |
| 9 - Sore throat or running nose with a fever for at least two days | () |
| 10 - Toothache | () |

THIS GROUP OF QUESTIONS DEAL WITH TRADITIONAL MEDICINE AND FOLK PRACTITIONERS.

114 - Have you ever consulted any folk healer?

Frequently () Sometimes ()
Rarely () Never ()

115 - Why ?

116 - Do you think the traditional practitioner will treat you better than a modern physician ?

Frequently () Sometimes ()
Rarely () Never ()

117 - Is there any particular disease you believe the folk medicine can treat better than modern medicine ?

Yes () No ()

118 - Some home remedies are still better than prescribed modern medicine for curing illness :

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

119 - Do you use any home remedy such as herbs or other things not prescribed by folk healers to help in curing condition ?

Yes () No ()

THE FOLLOWING QUESTIONS ARE RELATED TO PATIENT'S' AND DOCTORS' INTERACTION.

120 - Doctors always treat their patients with respect.

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

121 - Sometimes doctors make the patients feel foolish.

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

122 - Doctors cause people to worry a lot because they do not explain medical problems.

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

123 - Doctors always respect their patients' feelings .

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

124 - Modern medicine can mostly cure any illness.

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

125 - I will avoid seeing a doctor wherever possible .

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

126 - I would not go to any medical source unless there was no other way to have care.

Strongly agree () Agree ()
Disagree () Strongly disagree ()
Uncertain ()

127 - After PHC programme has been introduced do you still have the same feelings or have new ones emerged?

Yes () NO ()

128 - If yes please state

NOW HERE ARE SOME GENERAL QUESTIONS ABOUT HEALTH CARE AND AWARENESS.

129 - Do you keep a first-aid cabinet in your house ?

Yes () No ()

130 - Is it important to have a first - aid cabinet in the house?

Yes () No ()

131 - Where do you usually keep medications?

- 1- In the refrigerator
- 2- Far from children's reach
- 3- In the first-aid cabinet
- 4- Near the patient
- 5- No particular place
- 132 - How often do you buy medication from a pharmacy without prescription?
 Frequently Sometimes
 Rarely Never
- 133 - Do you wash fruits and vegetables before eating them?
 Always Sometimes
 Rarely Never
- 134 - How often do you buy frozen food- vegetables, meat, fruits?
 Frequently Sometimes
 Rarely Never
- 135 - If you buy canned food, how frequently do you check the validity date?
 Always Sometimes
 Rarely Never
- 136 - If never, Why not?
- 137 - Do you use any germicide ?
 Yes No
- 138 - If yes, where do you keep it?
 1 - In the kitchen
 2 - Far from children's reach
 3 - In a special cabinet
 4 - Others
- 139 - How frequently do you watch medical programmes on T. V. ?
 Frequently Sometimes
 Rarely Never
- 140 - How often do you accept and follow any medical advice you heard, through Radio or TV programmes ?
 Always Sometimes
 Rarely Never
 Depends on the case
- 141 - Do you think radio and TV health programmes are useful and helpful means to increase peoples' health awareness and health education?
 Yes No
- 142 - Do you agree that these programmes should be increased in terms of number and time allocated ?
 Strongly agree Agree
 Disagree Strongly disagree
 Uncertain
- 143 - What do you think is the best means to increase and widen people's health awareness?
 1 - Intensive TV programmes.
 2- Orientated Radio programmes.
 3- Distributing leaflets about health matters.
 4- Magazines.
 5- Annual weekly campaigns.
 6- Health educational programmes in school.
 7- Through mosque preaching.
 8- Regular home - visit by PHC Centre personnel.

Thank you for sparing valuable time to complete this questionnaire. I hope your participation and co-operation, in addition to the findings of the study, will contribute to improving the existing health services and providing access for everyone, regardless of his / her capability to pay for the service.