

THE UNIVERSITY OF HULL

INTERNATIONAL LABOUR MIGRATION AND URBANIZATION IN SAUDI
ARABIA: THE WORKING AND LIVING EXPERIENCES OF EGYPTIAN
DOCTORS AND THEIR FAMILIES IN JEDDAH

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by

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Abstract

This thesis investigates the working and living experiences of temporary Egyptian migrant doctors and their families in Saudi Arabia's major urban centres. The empirical research was conducted in Jeddah city, the largest urban centre in the Western province of Saudi Arabia, where the majority of the Saudi foreign workforce live and work.

Saudi Arabia has experienced enormous economic and social development, including its health care system, over the last two decades. A huge influx of temporary foreign migrant labour was brought into the country to administer and execute economic development projects. With most of the country's infrastructural projects accomplished, the demand on unskilled and semi-skilled migrant workers has begun to decline in recent years and is expected to decline further in the foreseeable future. However, skilled and highly skilled migrant workers are in great demand, as the focus of economic development centres on the maintenance and running of the accomplished infrastructural projects. The health services sector is among the major employers of expatriate migrant workers. This sector relies very heavily on foreign medical personnel at all levels and for most of its activities.

The main concern of the study is the attempt to provide adequate answers to central questions, such as : What are the motives behind the migration of this group of highly skilled Egyptian migrants to Saudi Arabia ? What are the consequences of migration for their medical careers ? How do Egyptian doctors and their families adjust to living and working in Saudi society ? Are they affected in the same way as unskilled and semi-skilled migrants by the kefeel system? Do these migrants and their families expect that they will easily re-adjust to life in Egypt when they eventually return home, or do they anticipate that they will encounter some difficulties ?.

The present study agrees in some respects, and disagrees in others, with other studies on the field of migration in general. The findings of the study also show some similarities and differences between highly skilled Egyptian migrants in Saudi Arabia and other groups of unskilled and semi-skilled migrant workers living and working in the country and in other Arab labour-importing countries of the Middle East.

DEDICATION

TO MY WIFE

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CHAPTER ONE

INTRODUCTION

1.1 THE RESEARCH TOPIC

The topic of this research project was formulated in the context of sociological studies of urbanisation and migration. There has always been a close relationship between research on urban growth and migration processes, particularly so in the context of "developing countries" (e.g. Armstrong and McGee, 1985; Gugler, 1988). This study is concerned with one important section of the huge population of temporary migrants that live and work in one of Saudi Arabia's major urban centres. More specifically, it is concern^{ed} to investigate the working and living conditions experienced by Egyptian doctors and their families in Jeddah.

The oil boom of the early 1970's in the Gulf countries of the Middle East brought a huge influx of temporary foreign migrant labour into the region. It is estimated that there were some 6,000,000 expatriate workers in the Gulf states in the early 1980's, compared with only some 660,000 workers in 1970 and 1,250,000 in the mid-1970's (Owen, 1985:4). This massive wave of migrant workers into the region constitutes a new and extraordinary feature in the history of mankind. It differs in a number of important

respects from the large influx of Mediterranean unskilled and semi-skilled labourers into Western Europe, in the following respect. Firstly, this movement of labour has involved technical and professional personnel, as well as unskilled and semi-skilled workers. Secondly, the scale of labour imported into the small countries of the Gulf by the early 1980's had reached the point where some 70 to 80 per cent of their total work force were workers of foreign nationalities. Thirdly, there has been hardly any official co-operation between labour - exporting and host countries in administering and governing this enormous movement. This contrasts, for example, with the elaborate planning which was undertaken to regulate the movement of Turkish migrant workers to West Germany after 1962 (Owen, 1985).

This movement of labour has been well documented as regards its volume, causes, effect on the sending countries, and to a lesser ^{degree} its impact on the receiving countries (e.g. Birks and Sinclair, 1980; Ibrahim, 1982). However, little or no research has been done on the impact of temporary migration on the migrants themselves and their families, in the Middle East in general and in Saudi Arabia in particular. Saudi Arabia employs the vast majority of temporary foreign migrant workers in the Middle East (Birks and Sinclair, 1980). Therefore, it would seem particularly important for research to be carried out in this area.

The main reason for the large number and importance of migrant workers in Saudi Arabia is the relatively small

national workforce, many of whom also lack the skills and expertise necessary for the implementation of economic development plans. Another factor is the low participation rate of women in the development of Saudi Arabia, due to the tradition which does not approve of womens' employment. In addition to this, a large portion of the Saudi population are Bedouins, who consider manual work degrading.

With the completion of most infrastructural projects and the fall in oil prices in the early 1980's, Saudi Arabia substantially reduced the importation of both unskilled and semi-skilled migrant workers, the majority of whom were employed in the construction sector. In contrast, however, skilled and highly skilled workers are in great demand at the present time and will be so for the foreseeable future, as the focus of economic development centres on the maintenance of the basic infrastructure projects, most of which were created in the 1970's and the beginning of the 1980's. The service sector has not been substantially affected by the economic difficulties of the early 1980's. In fact education and health services continued to expand, despite the economic difficulties. At present they constitute major employers of foreign migrant workers, and are expected to remain so for some time to come. It is the health service which forms the background of the focus of this study. This sector is heavily dependent on a migrant workforce at many levels and for most of its activities. For example, 93 per cent of the doctors in the Saudi health

service are foreign nationals, and the majority of paramedical personnel are also non-Saudis (see Chapters Three and Four). As such, this sector provides a key area for research into the working and living experiences of highly skilled temporary migrant workers in Saudi Arabia.

The concern of this study is to investigate, with particular reference to Egyptian doctors and their families working in the Ministry of Health and private medical care services in the city of Jeddah, the way in which highly skilled temporary Arab migrants and their families adjust to living and working in Saudi Arabia.

The decision to focus on this category of migrants was taken because they, unlike other migrant labour groups (e.g. manual and semi-skilled workers), appear to have escaped the attention of researchers in the field of migration in general and more so in the Middle East as a whole and Saudi Arabia in particular. Further, it was felt that this group would be more likely to co-operate with the researcher and to understand more fully the importance of their participation in research of this kind. Their educational and occupational background could then be used to help the researcher overcome some of the problems which are likely to arise when conducting research on a sensitive topic in a country undergoing rapid change and development.

1.2 THE OBJECTIVES AND CONTENTS OF THE STUDY

The general concern of the present study is to investigate the working and living experiences of temporary Egyptian migrant doctors and their families in one of Saudi Arabia's major urban centres. The empirical research was conducted in Jeddah city, the largest urban centre in the Western province of Saudi Arabia where the majority of the Saudi foreign workforce live and work.

This study seeks to provide the first descriptive account of the working and living conditions of this particular group of highly skilled temporary migrants and their families in Saudi Arabia. The study also seeks to provide some answers to a series of rather straightforward questions, such as: What are the reasons for the movement of this group of highly skilled migrants to Saudi Arabia ? What are the consequences of migration for their medical careers ? How are they affected by the Kafeel system (i.e. the ultimate power of Saudi employers) ? Are they affected in the same way as unskilled and semi-skilled workers, or because of their highly valued skills and expertise, do they receive more government protection from such a system ? How do the doctors and their families adjust to living and working in Saudi society ? Do these migrants and their families expect that they will easily re-adjust to life in

Egypt when they eventually go back home, or do they anticipate that they will encounter some difficulties ?

A further aim of the study is to investigate the way in which the private medical care establishments in Jeddah conduct their business. In particular, whether there is any justification for the general feeling among the Saudi people, which has been reflected by many items in Saudi newspapers, that some private health care establishments tend to exploit patients financially, by over- charging them for their treatment, or persuading them to undergo tests and X-rays which may not be necessary.

The other components of the research were related to its general focus, and are reflected in the chapter headings denoting the structure and contents of the thesis.

The study is divided into 11 chapters. The first chapter outlines the research problem, and the aims and objectives of the study. It also explains the research methodology, including the sampling technique which was employed to collect the necessary information for the study, and the main difficulties which were encountered by the researcher during the fieldwork. In addition, it provides a basic description of the setting of the empirical study, Jeddah city: its histo-geographical characteristics, urban growth, and the reasons for choosing it for the empirical research.

Chapter Two explores the major approaches to the study of migration. Chapter Three is divided into two sections. The first describes the political economy of the kingdom of

Saudi Arabia, with some historical background to establishment of the country and its economic development, which has provided the main reason for the huge influx of temporary migrant workers. The second section of this chapter examines the existing literature relating to international labour migration in Saudi Arabia, in order to give some historical background to the waves of migrant labour into the country from the discovery of oil in the late 1930's, up to the present time. It provides an account of the size and the place of origin of the foreign population in the country, and the impact of this massive movement of people on Saudi society.

Chapter Four presents a historical overview of the evolution and development of the health service in Saudi Arabia, from its establishment up to the present time. It contains an account of the different types of medical care services provided by the Ministry of Health and other government institutions which contribute to health care provision in the country, as well as the emergence of private health care and its expansion in recent years. The issue of manpower in the Saudi health service, in both the public and private sectors, is examined, as is the ratio of Saudi and non-Saudi medical personnel in the country's health service. The chapter concludes with a discussion of the extreme shortage of indigenous personnel in Saudi medical care services.

Chapter Five provides information collected first-hand during the fieldwork, as well as some of the researcher's own observations regarding health service provisions in the city of Jeddah. It contains an account of the type and scale of medical facilities provided by the Ministry of Health and other public agencies. The contribution of the private sector's medical care services to health provision in the city of Jeddah, is also considered. In addition, the manpower dimension of the city's medical care establishments is explored in relation to the proportions of Saudi and non-Saudi personnel working in Jeddah's health care facilities.

The results of the data gathered during fieldwork are presented in Chapters Six to Nine. The respondents' socio-demographic characteristics are presented in Chapter Six. Chapter Seven examines the process involved in the respondents' migration to Saudi Arabia, their work environments, their anxieties in dealing with patients, their interaction with colleagues, and their views on their experiences regarding relationship they have had with managements and employers.

The social life of respondents and their families is examined in Chapter Eight. It examines the ways in which they spend their free time, and whether this differs from the way in which they used to spend their free time back home. This chapter also investigates the degree to which Egyptian doctors and their families interact with other

Egyptian families living in Jeddah, and with the local population.

Chapter Nine focuses upon the strength and nature of the contacts that the respondents have with their country of origin, and the way in which respondents communicate with relatives and friends there. It also discusses where the respondents are planning to go when their employment contracts in Jeddah end. In addition, the chapter explores the ways in which the respondents invest their savings while working in Saudi Arabia, and their future plans for investment when they eventually return to Egypt.

Chapter Ten concentrates on the dependants who accompanied respondents to Jeddah, examining the size of the doctors' families, the problems they experienced upon their arrival in Jeddah, the respondents' children's education in Saudi Arabia, the negative or positive effect that their parents' migration might have on their educational performance, and the kinds of difficulties which they are likely to face when rejoining their native educational system.

The last chapter summarises and discusses the main findings of the study. It presents the major conclusions of the research in the light of the limitations of the study, as well as making some suggestions for further research in the field of international labour migration in the Saudi Arabian context, especially in relation to those migrants who possess high skills and qualifications.

1.3 THE RESEARCH METHODOLOGY AND FIELDWORK

The interviews were carried out in Jeddah city in the period between June 1988 and November 1989. Further fieldwork was carried out later in 1989 and in 1990. With regard to the interviews, a non-probability sample comprising 52 Egyptian doctors were interviewed in-depth, these represented 3 per cent of the total estimated number of Egyptian doctors working in Jeddah province, including those who work in the many towns and villages outside Jeddah city, which could be 4-5 per cent of the total number of Egyptian doctors working in the city itself.

A non-probability sample was chosen rather than a probability sample, because there are no official statistics available on this group of migrants and their families, or any other group of migrant workers for that matter, which would have enabled a random sample to be drawn from a list of their names and work places. Even if such a list was available it is doubtful that it could provide up-to-date reliable data. It would have to be updated very frequently because many doctors take work in Saudi Arabia for only a year or two and many more come as visiting doctors, particularly in the private medical care sector, to take employment for periods varying between a week to a few months. Due to the constraints imposed on the research by limitations of time and resources, a more comprehensive

field survey of Egyptian doctors in Jeddah's medical care services was not feasible.

A snowball sampling technique was used to draw up the sample. Given the absence of a reliable and up-to-date sampling frame such an approach was necessary and proved invaluable to the study, since the in-depth interviews touched on many very sensitive issues, such as the respondents' relationships with their (Kefeels) employers, their contacts with Saudi people and citizens of other nationalities, their relationship with colleagues, their attitudes to working conditions, their views on the behaviour of Saudi patients towards them and their experience, as well as that of their families, of residence in Saudi society.

The use of a snowball sampling approach helped enormously in gaining the confidence and cooperation of the respondents. The researcher was introduced to the respondents, in most cases, by one of their friends or colleagues in their work place. This confidence and cooperation might have been difficult to achieve if other sampling techniques had been utilized. A further advantage of this sampling approach was that it enabled the researcher to trace the doctors' kinship and social relationships, which was an important aspect of the study from the outset. For example, in one instance the researcher was introduced by a female doctor to her husband who worked in another medical establishment in another part of the city. In the

case of a married couple who worked in the same work place, the researcher was introduced to the wife by one of her friends, and she in turn introduced him to her husband.

The inclusion of a substantial number of female doctors was considered to be of a great importance to the study and its objectives. This might not have been possible with random sampling, even if it had been feasible, considering the fact that female Egyptian doctors constitute a small minority in the health services in the country as a whole, Jeddah being no exception. However, choosing a non-probability sample by means of snowballing carried a great advantage in this respect, since in many cases, an interview with one female doctor led to an introduction to another.

The researcher also tried to select respondents according to their places of work, so that they represented the various major types of health care establishments to be found in the private health sector and the public health sector administered by the Ministry of Health.

With regard to the public health sector, respondents were drawn from 1 general hospital, 1 small hospital specialising in infectious diseases, 1 large modern hospital specialising in maternity and child care, and 2 Primary Health Care centres. With regard to the private sector, respondents were drawn from 2 fairly small hospitals, 1 large modern hospital, 4 Health Centres and 1 large and very sophisticated hospital. The latter provides highly specialised medical care services and is the only one of its

kind in the Western region, indeed, in the country as a whole. This hospital has specialists centres for open-heart surgery and cancer treatment. As an indication of its national importance, the hospital was opened officially by His Royal Highness Prince Majid Bin Abdul-Aziz, the Prince of Mekkah Al-Mukkeramah province, representing His Royal Highness the King of Saudi Arabia, in the latter part of the 1980s.

All of these medical care establishments share a common feature, in that the overwhelming majority of the doctors working in them are from Egypt. This was one of the important reasons for choosing these establishments for conducting the field survey. The locations of these health care establishments were selected from different geographical and socio-economic residential areas of Jeddah city; the poor areas in the South of the city, the low-middle class area in the North part of Jeddah, and the middle class areas in the North West of the city, where the Ministry of Health and the private medical care services are concentrated. This does not mean, however, that those who seek medical attention from medical care establishments in these socio-economic areas, necessarily belong to the particular segments of the population living in these locations, as people go to different parts of the city when requiring specialized medical care services.

The interviews with the respondents took place mainly in their work place (e.g. their surgeries). The duration of

each interview was, on average, one and a half to two hours. However, several interviews, particularly with those working in the private sector, took longer, as it was necessary to stop the interview when a patient arrived to consult the respondent. In such cases, the researcher left the doctor's room and waited outside until he or she was free again. Some interviews were interrupted more than once, and waiting-time could be lengthy, particularly when there were many patients to see the doctor being interviewed.

The interviews were mostly carried out either early in the morning or late at night, when fewer patients came for treatment. The evening is the peak time for health care services in both the private and public sectors in Jeddah. Thursday is also a very busy day for the health establishments as it is the beginning of the week-end in Saudi Arabia.

The most convenient times for interviews were late at night or early in the morning, while the doctor was working on the night shift, which usually runs from midnight until 8 a.m. the next day. Many respondents were interviewed at such a time, as the researcher found it very useful to conduct the interview away from the management and with the minimum of interruption by patients. Moreover, at such times the doctors themselves were more relaxed, more talkative and did not mind participating in lengthy interviews, as they worked all night on their own. It was

during such times that very interesting conversations took place and the interviews could take a long time to complete. Of the 52 respondents, 11 of these doctors, as well as another 9 working normal hours, were the subject of more detailed research. Lengthy interviews were carried out with these respondents, and these interviews involved more than one session. These 20 respondents were chosen for more detailed interviews because they had some interesting 'stories' to tell, they had strong and explicit views in response to the sensitive questions of the structured interview schedule, and more importantly, they were willing to participate in prolonged discussions.

The researcher managed to establish and maintain close contact with two young single doctors who worked in the same establishment and lived in the same accommodation sharing one bedroom, and who had also been close friends while living in Egypt. These became friends of the researcher, and were visited regularly in their work place or accommodation, as well as mixing socially, e.g. going together to the sea side area, to town, or for a drive. These encounters provided the researcher with invaluable inside information as to the way that doctors work, their living conditions, and how young single Egyptian doctors spend their free time in Jeddah. They provided the researcher with information pertaining to many important aspects of the study, and acted in the role of "key informants".

The fieldwork began shortly after the researcher's arrival in Jeddah, when the illness of a family member necessitated calling in a doctor from a nearby private health clinic. The doctor was from Egypt, and after his examination, was made acquainted with the researcher, the purpose of the visit to Jeddah and the nature of the research. He agreed to take part and to co-operate in the study, and offered to introduce one of his colleagues, a close friend, who would shortly be starting his shift. After being made acquainted with the research objective, this second doctor also agreed to take part in the study. This encounter was invaluable as it made it possible to begin the fieldwork, with the benefit of personal acquaintances, soon after arriving in Jeddah. Otherwise, it would have been necessary to wait for some two weeks or more until the necessary paper work had been completed in the university in Jeddah, to obtain permission to undertake the research and also to obtain the clearance of the Ministry of Health Directorate in Jeddah for interviews with Egyptian doctors working in the public and private health care services in the city.

1.3.1 THE SAMPLE

As indicated earlier, the sample of doctors which constitute the focus of this study was chosen by means of a snowball technique. When a particular medical care establishment was chosen, the first step was to see the general director of the establishment and explain to him the purpose of the research and present to him the letter obtained from the General Director of Health Affairs in Mekkah province. The letter was addressed to the managing director of each of the medical care establishments chosen for the field survey. The letter requested that they co-operate with the researcher. The director of the establishment would usually nominate one of their Egyptian doctors to interview, and asked the researcher to return to him on completion of the interview with the individual specified, when he could arrange for a meeting with another of their Egyptian medical staff. The impression given to the researcher was that many of the directors wanted to dictate the selection of medical staff for interview, particularly in the private medical care sector. It seems likely that they may have wished to allow interviews only with those who had good relations with the management and to prevent discussion with those who were out-spoken.

In order to limit the distortion of the research arising from this process, the researcher would interview the first doctor nominated, then try to avoid going back to the management, instead asking the interviewee to introduce

another colleague in the same work place. In turn, he or she would be asked to introduce another, in some cases in a different establishment. This strategy was very useful in reducing to a minimum any anxiety or suspicion on the part of the doctors, which might have made them less willing to participate. It was easy to gain the confidence of respondents to whom the researcher was introduced by a friend rather than the work place management. In contrast, doctors introduced by the management, in both the private and public sectors, often displayed some concern as to why it was that they, rather than someone else, had been nominated to be interviewed. It was, therefore, necessary in each and every instance to make extensive efforts to explain the objective of the study to respondents and to stress that the information obtained would be used only for the sake of the research and that it would be treated with absolute confidence.

The researcher tried to include in the sample as many different categories of respondents as possible. It was important to have a sample which contained the main different categories of Egyptian doctors working in Saudi Arabia, e.g. in terms of their sex and age groups, marital status, qualifications, specialities, length of stay in the country, the size of their families, the medical sector in which they worked and the type of their place of work in Jeddah. As far as qualifications were concerned, doctors

were selected according to three major ranks of qualifications: general practitioners, specialists (i.e. those who have a Diploma or Masters degree in medicine), and consultants (i.e. those who have a Ph.D.). Concerning the respondents' type of speciality, the sample included the major different fields of medicine available in the health services in Saudi Arabia. The sample contained both male and female doctors, varying in age and marital status: young single doctors, middle aged and fairly elderly married doctors. The latter groups of respondents were divided into several categories: those who had no children, those who had pre-school age children, and those who had children studying in Saudi schools. The sample also included some who were accompanied by their families, and those who had left them behind in Egypt. The identification of many of these different categories of respondents was made during fieldwork, and the researcher encountered and obtained information on several different categories of respondents which had not been anticipated before commencing the fieldwork (see Chapters Five to Nine for more details).

1.3.2 THE PILOT STUDY

Before commencing detailed fieldwork it was necessary to wait for some three weeks, while the necessary paperwork was completed in order to obtain the permission of the General Director of Health Affairs in Mekkah province for

the research to be conducted in the health services establishments in Jeddah. In the meantime, personal contact had been established with two Egyptian doctors working in a nearby private health clinic. This provided an opportunity to examine the effectiveness as well as the suitability of the wording of the interview schedule which had been prepared before going into the field. These two respondents were interviewed, as well as another two of their Egyptian colleagues in the same establishment.

These pilot interviews were very useful. They indicated shortcomings in the wording of a few questions, which were confusing and out of context, and therefore had to be clarified. These problems arose mainly because the preliminary interview schedule had been originally written in English and later translated into Arabic, where such problems can easily occur. Some questions were also rephrased when it became apparent during these interviews that they sounded threatening. In particular, it was found that questions relating to the kinds of problems respondents had with their managements, patients, and other colleagues, were somewhat bluntly phrased. For example, it was found that using the term 'difficulties', rather than 'problems', seemed to obtain a better response, when asking such questions as "What kind of problems do you have with the management of your work place ?". In addition, further questions were added to the questionnaire as a result of these pilot interviews. These interviews highlighted areas

of investigation which had not occurred to the researcher before going into the field.

The use of a tape recorder was abandoned after recording the first two interviews. In the first interview the respondent was clearly uncomfortable throughout the exercise and stared at the tape recorder most of the time. In the second interview the respondent asked for the recorder to be turned off whenever asked to answer a question which he considered to be particularly sensitive.

The decision not to record the interviews was not felt to be especially detrimental to the reliability of the data, due to the researcher's ability to write very quickly in Arabic, in a manner similar to shorthand. It was, therefore, possible to write down the respondents' words almost verbatim, while maintaining the momentum and informal tone of the discussion. The interview schedule was accordingly prepared in such a way as to allow space in which to note the interviewees' responses. In addition to this, the researcher used a notebook in which additional information was written from memory and against which the respondents' comments were also checked. Periodically, these notes were checked and other information added from memory. Time spent waiting to interview a doctor who was seeing a patient was employed in reading over his or her statements. This time was beneficial in that it provided an opportunity to think of further questions to explore any comments of particular interest made by the respondents.

These pilot interviews also provided important information on the working hours of respondents in the private sector, and the best time to carry out the interviews. The peak working time for the respondents was in the evenings (from 5-9 p.m.) and interviewing was to be avoided at such times.

It became clear during these pilot interviews that the use of classical Arabic sounded very formal. As a consequence, the researcher used colloquial Egyptian during interviews. This made the interviews much more relaxed and informal, however, care was taken to use the same phrases when posing the same questions to different respondents.

1.4 THE COLLECTION AND ANALYSIS OF DATA

The main body of the data collected and analysed in this study was obtained from a structured personal interview schedule, designed for the purpose of collecting detailed qualitative data (see, Appendix I). The interview schedule consisted of two parts. The first part contained a set of questions about the doctors' general characteristics, motivations and reasons for migration, their employment and occupational experiences in Jeddah, their previous employment in Egypt, their personal contacts and social relationships in Jeddah and with their country of origin,

and the doctors' future plans when their employment contracts in Saudi Arabia came to an end.

The second part contained questions concerning the respondents' families. This consisted of questions on the size, composition and place of residence of the respondent's family, their experience on arrival in Jeddah, their children's education in Jeddah, family and friendship relations in Jeddah, and the employment record of respondents' spouses in Egypt and Jeddah.

As the purpose of the interview schedule was to obtain qualitative data, it contained a large number of open-ended questions. Secondary data on the manpower situation in the majority of the private health care establishments in Jeddah, as well as the Ministry of Health hospitals was obtained during fieldwork. Material on the primary health care centres in Jeddah was not available from the Ministry of Health General Directorate in Jeddah. Some information, was gathered, in addition to that provided by the Directorate, from the general directors of some of the health care establishments visited during fieldwork.

The researcher also obtained some highly confidential material on cases of suspected malpractice which were under investigation by the Sheri'a Medical Committee in the Western region, and cases investigated by the Administrative Medical Committee regarding financial disputes between patients and private medical care establishments. In addition, two high ranking officials in the General

Directorate for Health Affairs in Mekkah region were interviewed. The first was the Deputy of the General Directorate of Health Affairs in Mekkah province. The second was a senior Egyptian doctor working in the Al-Tefteash Al-illajy (Medical Inspection) department in the Directorate. These were lengthy interviews, particularly with regard to the second official. The matters discussed included the Ministry of Health's laws and regulations for dealing with cases of alleged medical malpractice, and the procedure followed by the alleged victims or their relatives in order to obtain an official inquiry into their case.

Before going to the field, the intention was to interview the doctors' families. However, it became quite clear in the early stages of the fieldwork that this was not a feasible research strategy. The doctors had a very busy work load. The majority did not finish work until late evening, in the case of those working in the public sector, and those working in the private sector did not finish work until 9 p.m. or later. Visiting the doctors' houses and meeting their wives in their absence was out of the question, for cultural reasons. Interviewing them in the presence of their husbands proved very difficult to arrange since the doctors had very little free time during the week and most of them had only one day off at the week-end.

However, the section in the interview schedule on the family was concerned mainly with general topics regarding

the spouse's employment, social life, the way free time was spent, their children's education, etc. (see Chapter Ten for more details). Given that these were rather straightforward questions, it was felt, therefore, that the doctors themselves, whether male or female, were capable of adequately answering the questions regarding their families.

To make up for not directly interviewing doctors' wives, it was decided to interview as many female doctors as possible. Some of these had first hand experience of being full-time housewives in Saudi Arabia for many months before taking up employment in Jeddah. In addition to their employment a majority of the female doctors carried out the same responsibilities as other Egyptian house wives in Saudi Arabia.

A degree of resentment was encountered from the managements of private health care establishments. Some of whom were very suspicious about the nature and purposes of the project and asked many questions. Some asked to see the interview schedule before allowing the researcher to meet their doctors. In this regard, the letter obtained by the researcher, signed by the General Director of Health Affairs in Mekkah province and stamped by the Medical Licensing Department in the Directorate (the department that deals exclusively with the private medical care establishments in Jeddah) was crucial in gaining their cooperation. This suspicion and resentment was evident in that the researcher had to abandon work in Dr.Suliman Feqqiha private hospital.

This is the largest private hospital in Jeddah, and employs more than 200 doctors, the majority of whom are Egyptians. The intention was to conduct a large number of interviews with Egyptian doctors working in this hospital, as it seemed to provide for particularly good opportunities to meet Egyptian medical personnel. However, neither of the hospital's two Egyptian general directors could give permission to carry out interviews among the Egyptian doctors employed in the hospital, and it was necessary to ask the permission of the owner and director of the hospital. In accordance with his instructions, however, a warning was given that no-one had ever been given permission to carry out such research. Armed with the precious letter from the Ministry of Health Directorate Office in Jeddah, an attempt was made to meet the owner of the hospital but without success. He does not come to the hospital very regularly, and no one was able to say when he would be available. After many attempts, the management suggested that the letter be left with them and that they would present it to him. Many delays and excuses were made, but after considerable persistence, permission was eventually obtained to meet some of the doctors, on condition that the interviews were arranged by one of the directors of the hospital. Unfortunately, the management nominated one of the busiest consultants in the hospital, who besides working in the out-patient surgery, had in-patient duties as well. Although he was willing to co-operate and showed some

interest in taking part in the study, yet he made two appointments which he did not keep because of an unexpected increase in his work load. At this point it was decided that it would be more productive to abandon research in this particular hospital and to concentrate instead on those medical establishments in which contact had already been established with doctors and carry out the interviews in settings where managements were more cooperative.

A further difficulty arose from the nature of the doctors' work. Many of them could not anticipate when they would be available for interviewing. There was no guarantee that the respondent would be free at that time arranged for interview, which meant that another appointment had to be arranged. This proved to be very frustrating and time-consuming. Given the size of Jeddah, it was sometimes necessary to drive for more than an hour in pursuit of an appointment without success.

On returning to Hull, the first task was to translate the data gathered from the field survey from Arabic into English. After completing this rather lengthy process, the respondents' answers to the open-ended questions, as well as the comments of those who were the subject of more detailed interviewing, were written out by hand and kept in a file, in order that each respondents' comments could be quoted, as and when representative examples were required. Furthermore, the respondents' responses to the questionnaire

were collated for each question and, coded alongside other responses to the closed questions. These were then transferred on to computer punch-cards and processed by the University of Hull Computer Centre.

The Statistical Package for the Social Sciences Programme (SSPS X) was utilised for the processing of the fieldwork data, where frequencies as well as cross-tabulation were obtained. Although the size of the sample was fairly small and manual processing of the data would have been possible, the researcher utilized the computer because it provided experience that will be valuable for future research activities.

It should be noted that throughout the presentation of the data, the names of the respondents used in this study are their real first names. The researcher feels that using the real first names of the respondents does not present any major risk of exposing their identity. All the respondents' first names are very common, with the exception of one doctor who has a very unusual name and is therefore identified only by his initial. As a further means to protect and respect the confidentiality of respondents, their places of work are not identified by name; throughout the analysis the researcher refers to the work place in terms of its type (i.e. clinic, primary health care centre, hospital) and sector (i.e. private - public). For the sake of simplicity, the term 'public sector' is used to refer to

medical establishments that are the facilities of the Ministry of Health.

1.5 JEDDAH: THE CONTEXT AND SETTING OF THE STUDY

The city of Jeddah is located on the coast of the Red Sea, on a coastal plain called Tihamah, in the Western region of the kingdom of Saudi Arabia. As Jeddah is a coastal city, its climate is directly influenced by its geographical location, in that it is affected by high humidity most of the year. Humidity reaches its highest level during the summer months, and falls to its lowest level during the winter season. The weather in Jeddah is generally hot all year round. The temperature reaches its maximum from June to August, when it goes well into the 40 degrees Centigrade, while it reaches its lowest of 18 degrees Centigrade during December and January. Rain-fall in Jeddah is infrequent. When it occurs, it is heavy, and accompanied by thunder storms.

It is widely believed that the first inhabitants of the city of Jeddah were the people of the ancient tribe of Quda'a in the second century B.C. However, many historians have traced its history to long before then, believing that its history spans back to the time of Adam and Eve (peace be

upon them). These historians also point out that Eve died and was buried in Jeddah, and that the name Jeddah, which means in Arabic, grandmother, was given to the city for that reason, as early Arabs considered Eve to be the grandmother of mankind (Ibn Al-Migawer, 1951).

The importance of Jeddah, however, was established permanently after the Third Calif of Islam, Othman Ibn Affan designated Jeddah as the port for Mekkah instead of Al-Shabiyah some 115 km to the south, which had been the port for Mekkah shortly before the advent of Islam. Therefore Jeddah became the seaboard gateway to the Holy cities of Mekkah and Medinah, and has remained the major point of entry and exit for overseas Pilgrims to the present day.

In 1511, a wall was built around Jeddah by Sultan Kansuh Al-Ghuri, the last ruler of the Saljuq Mamelukes State to rule the Hijaz region. In the beginning of the sixteenth century, the Ottoman Empire took over Jeddah and the whole of the Hijaz province from the Saljuq Mamelukes of Egypt. Jeddah was under Ottoman rule for four centuries, until it fell to the Arabs in 1915, and Shareef Hussain Bin Ali became the leader of Hijaz. He ruled the province for more than eight years, after which King Abdul-Aziz Ibn Saud, the founder of the Kingdom, took over, and the Hijaz region became part of the newly established country of Saudi Arabia.

For many centuries, Jeddah flourished within the boundaries of its wall, with an almost steady population ranging from between 10,000-25,000 inhabitants. This population increased considerably during the season of pilgrimage, only to return to its normal size when the season ended (Naguib, n/d,:20). However, the city has increased rapidly both in population and area in recent years. In the 1970's, it was transformed from a walled town with a limited population, into a metropolitan city. The beginning of the tremendous growth of the city can be traced back to the time of the consolidation of the Kingdom of Saudi Arabia in 1934. Shortly after that, Jeddah experienced rapid development, when in 1947 the late king Abdul-Aziz ordered the city wall to be demolished, and also encouraged Muslim people to come to work and reside in Jeddah, particularly professionals as well as those with technical and handicraft skills (Naguib, n/d,:24-5). Consequently a population, industrial, and professional urban expansion took place which was supported by increasing oil revenues.

When Jeddah's wall was pulled down, the population was some 40,000 and the area of the city about 1 million square metres. In 1971, a demographical survey indicated that the city's population exceeded a quarter of a million inhabitants (Sert-Jackson, 1979). The census of 1974 estimated that the population of the city of Jeddah was 561,114, of whom 19,386 were foreign nationals, comprising

36 per cent of the city's population. The population of the city continued to expand rapidly during the second half of the 1970's, and it is estimated to have reached one and a quarter million people in 1980 (Farsi, 1980:14).

The evolution of Jeddah as a modern city can be viewed in terms of three distinct stages. The first stage, between 1948-61, is commonly characterised as a period of unplanned development. The second stage, between 1961-70, was the period when the development of the city's modern infrastructure was established based on preliminary studies and planning prior to implementation. The third stage, between 1970-85, has been characterised by comprehensive planning, with urban development carried out on the basis of a succession of Five Year plans. During the first and second stages, the economic development of the city of Jeddah was moderate, reflecting the country's limited resources. By contrast, the third stage coincided with the increase in oil prices of 1973, enabling a dramatic acceleration in the pace of the of the city's development. As a result the existing Master Plan for urban development was revised in the face of rapid population growth and in the light of the considerable resources made available for new construction projects and for the improvement and extension of services. Hence, by the second half of the 1970's and early 1980's the physical, economic and population structure of Jeddah had grown far beyond earlier expectations. In the process new residential, commercial,

and industrial districts were created and the older, well-established districts expanded.

CHAPTER TWO

MIGRATION - APPROACHES AND ISSUES

2.1 APPROACHES

Migration is a phenomenon which has characterized human groups and societies for thousands of years. At different times in history migration has caused a great deal of concern, and many of today's most serious social problems are believed, of unjustifiably, to be associated with migration (Lewis, 1982). The United Nations and its agencies, the European Community, governments, aid-agencies and scholars have engaged in debates about the causes, the trends, the consequences and the kinds of policies that are appropriate or feasible (Johnson, 1988). All this concern is not surprising since migration is both a result of social, economic, political, cultural and geographical changes, and a contributory factor in bringing about further changes (Kammeyer, 1975). For Friedmann and Wulff (1976), migration reflects demographic adjustments to changes in the spatial structure of social, economic, political and cultural institutions, such as investment flows and labour markets, the location of industries and markets, transport and communication links, and the location of administrative, educational and health centres. To this geographical perspective, Lewis (1982) adds that migration is not only a response to social and economic changes, it brings about changes in the lives of the migrants and their families, as

well as acting as a catalyst for change in those areas gaining and losing migrants.

Migration is a general term that refers to both immigration or in-migration and to emigration or out-migration. Immigration and emigration normally refer to patterns of international migration, to population movements or changes of residence between countries. In-migration and out-migration normally refer to patterns of internal migration, to population movements or changes of residence within countries (Heer, 1985: 524). For demographers, patterns of migration together with the balance of births and deaths in particular regions constitute the major components of population change (Te Heide, 1980: 185). For example, the population of an area may grow as a result of the inflow of people, or it may decline as a result of the outflow of people, so that it is important to recognise that migration may be a crucial factor in differential population trends (Woods, 1970). As Lewis (1982) points out, differences in birth and death rates between areas are often smaller than differences in migration rates.

The interests of social scientists in the nature and consequences of migration extends far beyond such demographic concerns, and many have been highly critical of narrowly demographic analyses of migration (see for example, Cicourel, 1974; Van Der Knapp and White, 1985). Indeed, Gilbert and Gugler (1982), Webster (1984), Foster-Carter (1985), Armstrong and McGee (1985), and Findlay (1987) all

comment that no phenomena has attracted the interest of social scientists in developing countries more than migration. Economists (e.g. Harris and Todaro, 1970; Willis, 1974) have studied the economic motives behind decisions to migrate and the role of migration in national economic development. Geographers (e.g. Drakakis-Smith, 1981; Lowder, 1985) have studied different patterns of migration and the resulting housing problems in urban areas. Social anthropologists and sociologists have studied the process of migration as well as the way migrants adapt and adjust to life in their place of destination (e.g. Mangin, 1970; Basham, 1978; Roberts, 1978; Hannerz, 1980).

As research on migration in developing countries has progressed scholars have recognised (a) the importance of distinguishing between different types, patterns and processes of migration, and (b) the importance of distinguishing between regional, national and international variations (Gilbert and Gugler, 1982). For example, in many parts of the developing world migrants tend to come from densely populated areas in frequent contact with cities, while in other parts of the world migrants move in a step-by-step progression up the urban hierarchy (Potter, 1985). In parts of Africa, migration often proceeds directly from small villages to distant urban centres (O'Connor, 1983). It has also become clear that internal and international migration does not necessarily involve a single, one-directional and permanent flow of populations and

individuals (Heer, 1985: 524). As a consequence, different types of migration patterns and processes have been identified and studied, e.g. 'cyclical migration', 'reverse migration', 'chain migration', 'return migration', etc. (see, Friedmann and Wulff, 1976; Ter Heide, 1980; Gilbert and Gugler, 1982; Findaly, 1987; Van Der Knapp and White, 1985).

Although migration has been a topic for research among scholars from different disciplines for over 100 years, researchers have often expressed concern over the lack of a widely accepted and comprehensive theoretical framework which could synthesize existing knowledge from different disciplines and clearly identify the important variables and their relationships (see for example, Ford and De Jong, 1970; Kammeyers, 1975; Ter Heide, 1980). Such a framework would be of great value in providing guide-lines to study different types of migration and the social and economic data to be collected (Goldsheider, 1971). A number of theories, models, hypotheses and variables have been proposed regarding the decision and act of migration. While empirical studies have confirmed some of these hypotheses and variables, they have also revealed other significant variables influencing the decision and act of migration. Many of the theories and models cannot be fully assessed because of a lack of adequate reliable official statistical data (Gilbert and Gugler, 1982). This, together with the needs of policy-makers, has led several researchers (e.g.

Haenszel, 1967) to stress the need for empirical research on migration to be based on the collection and analysis of data not available from censuses and other administrative sources.

There exists a large volume of theoretical and empirical work on migration, much of it of an interdisciplinary nature and relevance. This section will not attempt^{to} provide an exhaustive review of the literature on migration. Instead, the discussion focuses on five prominent approaches which offer different interpretations of the determinants of migration.

The first approach is known collectively as 'the descriptive approach'. The main objectives of this approach are to define the characteristics of migrants, or to predict the amount and size of migration streams, or to estimate under what circumstances it is probable that certain types of people will migrate (Simmie, 1972). The work carried out within this approach is characterized by attempts to derive principles of migration from empirical evidence. The earliest, and simplest, example of this approach is Ravenstein's (1885 and 1889) "six laws of migrating", which was more concerned with systematically describing the patterns and selectivity of migration than with providing explanations. He did, however, observe that the underlying reason for most migration was "the inherent desire in most men to better themselves in material respects". Ravenstein's "laws" represent the first attempt to

demonstrate that migration is not a random phenomenon but a conscious movement which can be investigated and about which generalisations can be drawn. Although Ravenstein's work was heavily criticised, for failing to follow the rigid laws of science, when it was first introduced, it nevertheless generated a great deal of interest in the study of migration.

Through the studies that followed, the complexity of migration became evident and the term "migration laws", which implies universal application, was later replaced by "generalizations". By 1959, when Donald Bogue published his article on internal migration, over thirteen generalizations had been validated by empirical studies in America (Bogue, 1959). Among the variables which were found to influence migration were, the distance between the place of origin and the place of destination (Ravenstein 1885:198), the youthful age of the migrant (Lee, 1968), the degree of diversity between areas (Bogue, 1959:504), the number of opportunities available in the area of destination (Stouffer, 1940), and such intervening variables as education, attitudes and the accessibility of information (Bogue, 1959:504). However, as Bogue pointed out, these generalisations were too fragmented and too limited to portray the complexity of migration.

In an attempt to synthesise the findings from empirical work, Lee (1969) proposed a theory which identified four factors that influenced migration:

(1) factors associated with areas of origin;

- (2) factors associated with areas of possible destination;
- (3) intervening variables or factors associated with the transition from one area to another; and
- (4) personal variables which mediate through the first three factors.

According to this approach, the decision to migrate is a result of an interaction between perceived environmental conditions in the area of origin, the influence of environmental conditions in possible areas of destination, knowledge about intervening variables and personal factors. Lee argued that instead of specifying which environmental conditions will lead to in- or out-migration, the judgement as to which conditions will be considered positive or negative will be individually determined according to the individual's hierarchy of needs. Any perceived or experienced deprivation in a valued need will urge a person to migrate. The choice of destination, in turn, will depend on the individual's evaluation of the potential opportunities available to fulfil perceived or experienced deprived needs in the possible area of destination. Lee points out, however, that such an evaluation is never completely rational since an individual has no way of knowing the actual conditions in the area of destination until he has been there. Further, the extent to which the decision to migrate will become realized will depend upon the intervening variables and the ability of the individual to deal with the personal and practical issues involved.

Lee provided what is probably one of the most concise general frameworks for the analysis of internal migration processes. The relevance of his contribution to the description and analysis of migration resides in his attempt to identify the basic components, the basic processes and the significant factors influencing migration. Instead of trying to develop generalizations which would explain all migration, he presented a basic framework which could be adapted and used to study migration anywhere.

Todaro (1976:19) provides a critique of Lee's theory, which he explains is appealing because of its simplicity. Lee's theory is, however, of limited relevance for policy formulation and analysis in developing countries because of its high degree of generality and because of the interdependence of many of its hypotheses. The apparent validity of many of the hypotheses does not lead one to determine which 'plus' factors and which 'minus' factors at both the place of origin and the place of destination are quantitatively the most important for different groups and classes of people. In Todaro's view, Lee's theory of migration, like most other non-economic social science migration models, offers little practical policy guidance for decision makers in developing nations.

We now turn to what may be referred to as 'economic approach' to the study of migration. Within this approach two prominent lines of investigation have been developed; one focusing on the "traditional competitive wage

determinants" and the other focusing on the concept of "human investment" approach. The "traditional competitive wage determinant" or 'modern sector approach', is based on the work of Lewis (1954) and later modified by Harris and Todaro (1970). This approach regards migration as a means to geographically redistribute labour in accordance with changes in the demand for labour. Migration is held to play an important role in the economic developmental process, since it leads to optimal allocation of resources (Willis 1974). In Lewis's model of development, migration effectively operates ^{to} transfer surplus and underemployed labour from subsistence agricultural sectors to more productive sectors in the urban areas (Lewis, 1954). This, in turn, provides industry with cheap labour.

This emphasis on the importance of migration for the course of economic development has shaped migration policies in both the developed and the developing countries for many years. For example, rural-urban migration is seen as playing an inevitable and key role in the process of industrial evolution. High fertility rates, decreasing land available for agriculture and the low productivity of agriculture will inevitably lead individuals to migrate from agricultural areas to the industrially expanding and employment opportunities of the urban areas. Thus, it is argued that the volume of migration increases as wage differentials increase (Willis 1974). Once the demand for labour in the urban sector is satisfied, wage differentials

will diminish and there will be no further incentive to migrate. At the same time, the number of employable workers in the areas of origin will have been reduced by out-migration, resulting in higher wages and, eventually, to the reversal of the migration trend (Willis 1974:17-18). Therefore, through the elasticity of the market, the process of migration is seen as self-corrective.

In order to understand the implications of this work for the study of migration, it is important to look at the underlying assumptions. Firstly, the approach emphasises the maximization of income, although it recognizes that other factors should be taken into account, such as employment characteristics, working conditions, social status and other benefits in the areas of destination. However, the approach maintains that if wage differentials are high enough, migration will occur regardless of other factors. Lewis (1973) predicted that if there is a large reservoir of labour in the subsistence sector, the wage in the urban area need not be much higher than the wage in the subsistence area to induce migration. In practice, however, he found a wage differential of around 30 per cent. This high wage differential can be attributed to the fact that workers change their consumption patterns once they have migrated and that employers prefer to pay more, rather than to employ new migrants from the agricultural sector. Secondly, the approach assumes that workers in agricultural areas have complete access to information about available

opportunities and make their decisions accordingly. Thirdly, the approach assumes that there is no barrier to mobility which cannot be overcome by the migrant, provided that their motivation is strong enough. Fourthly, it assumes that agricultural workers have the necessary skills, knowledge and attitudes which will enable them to be readily absorbed into the urban market. Finally, implicit in the approach is the belief that agriculture can no longer cope with the increasing size of rural populations. Thus, industrialization and urban employment offer an alternative to the threat of famine and disaster.

Over the years, this 'competitive wage determinant' approach has been challenged and modified. Most notably by Harris and Todaro (1970), who challenged its three basic assumptions. First, they argued that the decision to migrate is not based on simple wage differentials but on expected income differentials from probable employment in urban areas. Second, this in turn, depends on the age, education and skills of the urban labour force. They therefore disagreed with the notion that every migrant can be readily absorbed into the urban labour force. For example, the educated have more access to information than the rural population generally, so are more likely to migrate. Finally, they question the self-corrective mechanism notion which underlies this approach to migration by pointing out that the power of trade unions to fix minimum wages tends to keep urban wage levels high, even

though the demand for labour may have fallen. Despite these criticisms, like other economists, Harris and Todaro accept that the primary motive to migrate is the maximization of income.

However, Sjaastad (1962), as well as other economists, considered that 'competitive wage determinant' approach is no more satisfactory than the 'descriptive approach', and consequently "the human investment" approach was put forward as a more appropriate model for the study of population movements. Bogue (1959) and Lowry (1966) maintained that migration occurs in a direction away from high unemployment areas with low wage rates, to more favorable areas, until their relative attractiveness diminishes as the supply of labour reaches some sort of equilibrium. Harris (1966) has shown, however, that employment and wages usually do not figure high on the list of the reasons given by migrants for moving. Sjaastad (1962) recognised that there are other important factors to be considered in migration besides economic factors. He saw migration not only as a response to income maximization but also as an investment in human capital or utility maximization. Sjaastad produced a "cost-benefit" model for assessing their relative importance. For Sjaastad, migration can be regarded as an activity that involves resources, in which costs are incurred in producing returns. The costs include money costs, both 'opportunities gone' and direct costs of the moment such as the costs of transporting possessions and family. He also included

psychological costs. These are difficult to measure, but include an estimation of the losses involved in leaving a known environment, friends and relatives. When the benefits are greater than the costs, migration is most likely to occur. This work appears to offer a more fruitful approach than other strictly economic approaches. It clearly recognises the importance of social and cultural factors in migration and explicitly acknowledges that they have yet to be explained.

The third major approach to be considered is the social approach. Among the theorists seeking to explain migration in social terms are Leslie and Richardson (1961), Musgrove (1963), and Watson (1964). Some of these writers emphasized the relationship between housing, household structure, the stages of a family's development cycle and migration. Other emphasized the relationship between upward social mobility, a household's values and migration. The former view, which relates migration to household structure, is based on the assumption that families of different sizes at different stages of the family development cycle will require varying amounts of accommodation; if the required accommodation is lacking, then the family will move. Musgrove (1963) points out that the relationships between social and residential mobility are tenuous and should not be overstressed. On the other hand, explanations of a household's behaviour, in terms of the value systems of its members, stress the important aspect of choice in decision-making. Material

goals of households, which are the result of their social class experiences, determine the factors they consider in the decision to move and their reasons for moving (*ibid*).

It seems that strictly 'social approaches' to the study of migration have been unable to produce a comprehensive framework because they tend to over-emphasize particular aspects of migration. For one group of scholars, housing is the main reason for migration, others stress social and employment motives, and others stress the connection between social and geographic mobility and education, while yet others stress the connection between choice and values derived from class position. While each of these positions is supported by empirical evidence, each explains only a part of the overall process of migration. Little attempt, however, has been made to combine and integrate these different positions and their supporting evidence in anything resembling a general theory of migration.

The various approaches to the study of migration which have been referred to so far have all looked at the process in terms of a cause-effect structure. However, this seems to be unduly restrictive, since it fails to emphasize that all components within the migration process are inter-related. A change in the nature of one component can have an effect on all others (Lewis, 1982:29). These inter-relationships can be better understood if migration is conceived of as a system. The 'systems approach' views

migration as an interdependent and self-modifying system in which changes in one part have a ripple effect throughout the whole system (Lewis, 1982). This approach, therefore, makes it possible to identify the interacting elements of migration, their attributes and relationships. In order to illustrate and explain the components of such a "migration system", Lewis (1982) has summarized the arguments contained in Mabogunje's (1970) paper on rural-urban migration. Although Mabogunje's work is concerned with Africa, it nevertheless has a wider relevance. As the rural economy has become increasingly integrated into the national economy, many African states have experienced the break-down of their isolation and self-sufficiency. The result is a change in wage and price levels, as well as a change in levels of expectation and demand, in the countryside. Further, the villagers become aware of the opportunities in the cities. Such an environment determines the extent and nature of migration.

A "migration system" is made up of three elements. Firstly, there is the potential migrant who is encouraged to leave the rural village by the appeal of new environments. Secondly, there are the various institutional or "control sub-systems" which determine the level of flow within the system. In the rural-urban migration system, the two most important sub-systems are the "rural" and "urban control systems". In rural areas the nuclear and extended family,

as well as the local community, possess both negative and positive means of determining the volume of migration. The urban control system, by means of occupation and residential opportunities, regulates the degree of assimilation into the urban environment. Thirdly, there are the various social and political forces or "adjustment mechanisms" which also play a role in the process of migrants' transformation. In rural areas, migration involves a loss of one productive unit as well as one member of a family and of a community, while in the city the migrants are incorporated into a new situation more suited to their needs. Once the rural dweller experiences the driving force or stimuli to migrate (which Mabogunje believes in the case of Africa is related to the degree of integration of the rural economy into the national economy) his role in the system does not end. By feeding back negative or positive information to his original village about life in the city, he can modify the system's behaviour. This feedback in the system can encourage or disrupt the entire system.

Although the 'systems approach' to migration was originally designed to explain rural to urban migration in West Africa, it offers additional insights into the migration process in general. It does so by identifying the main components of migration and their inter-relatedness, as well as by emphasizing its circular nature, in that the effects of changes in one part can be traced through the whole system. This approach to the study of

migration draws particular attention to the fact that it is necessary to be concerned, not only with why people migrate, but also with the implications of the process.

Most of the approaches to the study of migration discussed above were developed on the basis of studies of internal migration, mainly rural-urban migration. However, the issues they raise also provide an essential background to the study of international labour migration. Among many researchers the distinction between internal and international migration is becoming increasingly artificial. For Castles and Kosack (1973), internal and cross-country migration have similar causes and a similar character.

"The same 'push and pull' factors created by events in the international political economic system impel millions of these 'surplus' people not only to move within their own countries but to cross international boundaries".

(Chaney, 1979:205)

A focus on international labour migration characterizes 'the historical structuralist' approach to the study of migration (e.g. French, 1986). Commentators analyzing migration within the historical structuralist perspective, which is based on "dependency theory", view waged labour migrations between under-developed and developed areas as the interchange of two different modes of production, both domestically and internationally. Within this approach

capitalist modes of production deliberately exploit non-capitalist modes of production, widening the economic gap between the two areas. In this respect, migration benefits the "host areas" at the expense of "sending areas" (Castles and Kosack, 1973, Sassen-Koob, 1980). The main loss to the "sending areas" is that of their better-educated and trained manpower, commonly known as the 'brain drain'. Such losses will be greater if this educated and skilled labour force are engaged in occupations in the receiving societies which fall below their qualifications and expertise.

In addition, the 'historical structuralist' approach postulates that the large scale movement of migrant workers between under-developed and developed economies takes place as a result of a response to the problems of overpopulation, poverty, and unemployment ("push" factors) on the one hand, and in order to take advantage of higher wages and better conditions and opportunities, ("pull" factors) in the receiving areas, on the other.

International labour migration is then considered to be one interdependent element in a set of complex exchanges (e.g. trade, technology, capital and culture) between countries which possess differential degrees of economic, military, and political power (Al-Ghamdi, 1985:55). For Kritz (1981), this growing interdependence is associated with the expansion of the international economic system, population growth, growing economic disparities both within

and between countries, and improved communication and transportation systems.

Some historical structuralist writers see the migration of foreign workers to the developed world as part of the continuing exploitation of less developed countries by the more developed capitalist countries (e.g. French, 1986). French argues that capitalist countries are still dependent on their ability to exploit pre-capitalist nations and regions, especially in order to reduce labour cost and therefore to maintain profit levels. Moreover, capitalist countries prefer to employ foreign migrant workers because they are highly productive, accept lower wages and longer working hours than the indigenous labour force, and consume fewer welfare and social services, particularly if they are single (French, 1986:10). For example, Castells (1975) argues that in times of economic prosperity the employment of foreign labourers is intensified, while in times of recession and economic difficulty these workers are repatriated.

Shrestha (1988) argues that labour exploitation was historically the key to the utilization and accumulation of capital. The colonial powers devised various mechanisms to ensure the flow of labour migration to serve in their enterprises in urban centres, mining enclaves and plantations. These mechanisms ranged from slave and forced labour to institutional manipulations such as land-grabbing and taxation (Lappe and Collins, 1978). The colonial powers

pressurized the rural workforce to migrate and work in wage-labour 'cores' dominated by Europeans, while at the same time making sure that these workers did not settle permanently in those 'cores' by forcing them to maintain strong social and economic ties with their place of origin (Shrestha, 1988).

Within this approach all types and processes of migration are seen as inter-related in both the colonial and the contemporary situation. Capitalist penetration emanating from the developed countries of Europe and North America, and operating through the major urban centres in developing countries, forces labour from rural areas to migrate to urban centres or abroad (Long, 1977). The pattern established under colonial powers continues through the dominance of the developed countries over the developing countries, reinforcing and sometimes increasing the regional, national and international socio-economic inequalities that cause internal, rural-urban and international labour migration (Friedmann and Wulff, 1976).

The importance of this approach resided in the way it conceptualizes the relationship between different types and processes of migration in terms of national and international economic systems (Foster-Carter, 1985). While appreciating its value as a conceptual framework, Roberts (1978) notes that it underrates significant regional and national variations, and that it lacks the necessary empirical data. Potter (1985) also notes the lack of

empirical data needed to support the arguments and considers that this approach places too much reliance on Latin American cases. For Armstrong and McGee (1985), the approach has much to offer, but it lacks an established methodology needed to systematically connect different types and processes of migration to specific groups, specific settlement patterns and specific developments in the national and international economic order.

Although there is no general theoretical framework or approach with a fully mutlidisciplinary emphasis for the study of migration, there have been many attempts to construct typologies. Examples include peterson (1968), and many efforts at model-building to explain various aspects of migration e.g. Richardson (1967) and Taft (1975). However, such typologies and models have not been very successful or influential. Writers from various disciplines have acknowledged that real progress in migration studies is hampered by serious inadequacies in existing theories of migration. For Mangalem and Schwarzwel1 (1969: 4), theories of migration tend to be "time-bound, culture-bound and discipline-bound". They consider that a general theory of migration is unlikely to materialize in the near future because such a theory would need to grasp the dynamic interplay among demographic, economic, social, psychological, and other relevant factors that coverage in the process of migration.

While all of the approaches, theories and models discussed here raise and highlight important issues and aspects of migration, none could be said to constitute a fully comprehensive and satisfactory framework. There is no single, ready-made, fully comprehensive and widely accepted theoretical framework for the study of migration. The various approaches, theories and models do, however, provide the essential background for any contemporary study of migration. It is against this background that the next section examines the empirical evidence derived from studies concerned to answer such questions as: who are the migrants ?, Why do people migrate ?, and What are the consequences of migration for the migrants and their dependants ?.

2.2 THE PROCESS OF MIGRATION AND ADJUSTMENT

2.2.1 WHY DO PEOPLE MIGRATE ?

Researchers studying international migration have not addressed this question in as greater detail as those studying internal and rural-urban migration. Internal and rural-urban migration in the developing world takes place as people in rural areas move to urban areas in search of better living conditions and better economic prospects. Social and economic imbalances between rural and urban areas are the main reason for contemporary population movements in

developing countries (Friedmann and Wulff, 1976). The lack of sufficient and productive agricultural land, very low and insecure incomes, very few employment opportunities, inadequate water and sanitation facilities, and poor medical and educational facilities, are often among the important 'push' factors influencing population movements from rural areas. Rural populations are also attracted to urban areas by various 'pull' factors: these include the promise of greater employment and educational opportunities, the greater availability of health and recreational facilities, and the excitement and diversity associated with urban life. These 'pull' factors do not always conform with the realities of urban life. For example, few newly arrived migrants have the means to be able to afford to spend much time enjoying the social and cultural aspects of life in urban areas (Gilbert and Gugler, 1982).

Many years ago Jansen (1969) observed that the question most frequently asked and least understood regarding the reason for migration is, "Why do people move?". Since then many researchers have found that in many cases the migrants themselves are not able to give a precise answer to this question. The migrants give vague and general reasons, such as "work", "family reasons", "education". In their extensive reviews of the literature on this topic Butterworth and Chance (1981), Drakakis-Smith (1981) and Rogers and Williamson (1982) all note that such answers provide little assistance in the construction of a general

explanation or theory of the decision-making process involved in migration.

However, numerous studies of migration have concluded that the vast majority of people move for primarily economic reasons (see for example, Shaw, 1975; Simmons, et.al, 1977; Van Der Knapp and White, 1985). In addition, researchers have found that people migrate (a) in order to improve their education (Caldwell, 1969); (b) in response to environmental disasters, such as soil exhaustion, droughts, flooding, etc. (McGee, 1971); (c) to escape from violence and political instability (Goodman, 1973); and (d) to join family and friends who have already migrated (Caldwell, 1968).

It is widely agreed among researchers that potential migrants are always individuals or small family units, the decision to migrate is rarely taken in isolation from existing social relationships and other factors (Gilbert and Gugler, 1982). The decision to migrate is frequently a collective matter, often involving members of the extended kinship group and occasionally the rural community as a whole (Wilkie, 1968). Many studies reveal that fairly stable perceptions of the economic and residential 'desirability' of different areas are formed among potential migrants during early adolescence (Friedmann and Wulff, 1976). Further, the studies show that the actual decision to migrate is usually based on direct personal information concerning the economic and social opportunities available in the place of destination seen in relation to the

equivalent opportunities perceived to exist in the place of origin (Caldwell, 1969; Rogers and Williamson, 1982).

2.2.2 WHO MIGRATE ?

The social and economic imbalances between rural and urban areas in developing countries do not lead to random population movements from rural areas to urban centres. The 'push' factors associated with rural areas and the 'pull' factors associated with urban areas do not have the same effects on all types of individuals and groups. As Friedmann and Wulff (1976) point out, migrants are 'positively selected' from home populations. Hence migrants are not a random sample of the overall population of sending areas. They have certain characteristics which distinguish them from the rest of the population in their place of origin. (1) Demographic characteristics: many studies in developing countries have highlighted the high proportion of young (15-25 years of age) single males involved in rural-urban migration (see for example, Caldwell, 1969; Byerlee, 1974). Although there is some data to suggest that the proportion of young females migrating is on the increase (French, 1986), in most developing countries the modern urban economy favours the employment of men over women. Studies of female migrants indicate that they are usually employed in unskilled and low-wage occupations in the

'informal sector' (e.g. Yousef, et al., 1979; Martine, 1975). In terms of international comparisons, the high level of female internal and rural-urban migration and employment in the modern industrial sector in South-East Asia is somewhat unique (see, Armstrong and McGee, 1985). (2) educational characteristics: the evidence from many studies of rural-urban migration in developing countries shown a consistent positive correlation between migration and formal educational achievement (Caldwell, 1969; Greenwood, 1971). It seems that the higher the level of education attained by individuals, the more likely they are to be aware of the differential employment opportunities available outside the place of origin (Shaw, 1975).

Despite the fact that numerous studies and commentators emphasise the central importance of economic 'push' and 'pull' factors among potential and actual migrants, little information exists on the economic characteristics of individuals and small family units prior to migration. Friedmann and Wulff (1976) comment on this lack of important information, and conclude that the few studies which specifically address this issue reveal little more than that it is unusual for the very 'poorest' among rural populations to migrate to urban areas. The primary reason for this gap in the literature may be due, as Byerlee (1974) notes, to the difficulties involved in obtaining accurate income data of both a contemporary and retrospective nature.

2.2.3 THE ROLE OF KIN AND FRIENDS

It is widely agreed among researchers and commentators that relatives and friends in the place of origin and the place of destination constitute the primary source of personal security, social control, information and support for the majority of migrants (Butterworth and Chance, 1981; Gilbert and Gugler, 1982; Potter, 1985). Many studies have shown that family and kinship networks play a crucial role in assisting migrants to adapt to their new environment. For example, Stromberg et al. (1974) and Kemper (1977) found that on first arriving at their place of destination, migrants depend on existing kinship and friendship relations for support, shelter and social activities rather than upon members of the receiving society.

There is a great deal of evidence to indicate that kin and friends in the place of origin assist potential migrants to implement their decision to move (see for example, Choldin, 1973). Decisions to migrate are often implemented on the basis of established kin and friendship networks between the home community and the receiving area (Abu-Lughod, 1961; Tienda 1980). These kin and friendship networks provide important information about urban conditions and opportunities on which decisions to migrate are made. Gilbert and Gugler (1982) note that the research

show that very few people would seriously consider moving to a particular destination or city if they did not already have relatives and friends residing there.

Having reached their place of destination, migrants are, more often than not, provided with support and assistance by relatives and friends already in residence (Abu-Lughod, 1961; Al-Nassar, 1990). The support and assistance provided to migrants by relatives and friends in the place of destination extends far beyond the first weeks of their arrival.

"Kinship strategies are regularly employed to find jobs and housing, secure loans, provide child care, procure godparents to baptize the newborn, facilitate dealings with urban bureaucracies, purchase consumer goods at lower prices, place children in school, and provide information".

Butterworth and Chance (1981:94)

In their new home, migrants maintain close relationships with their kin, friends and other people from their community of origin (Abu-laughad, 1961; Ali, 1988). Recent studies of rural-urban migration in developing countries show that migrants prefer to live near relatives who are already settled in the place of destination (Mustafa, 1990; Ali, 1988).

Friedmann and Wulff (1976), Perlman (1976) and Lomnitz (1977) point out that many studies show that migrants move and live in 'spatially extended social fields', through which they maintain steady contacts with kin, friends and

home communities. These 'social fields' are networks of reciprocal relationships and obligations. As Roberts (1978) notes these social networks are less extensive and less well-maintained in Latin America than in the Middle East, Africa, South and South-East Asia. Nevertheless, there is substantial evidence to show that migrants in most developing countries maintain close and regular contacts with kin and friends in their place of origin (Gilbert and Gugler, 1982; Ali, 1988; Mustafa, 1990; Al-Nassar, 1990). These studies show that the vast majority of migrants frequently and regularly visited their home villages. However, in his study of internal migration to Baghdad city, Ali (1988) found that the frequency of his respondents' home visits were affected by two factors. Firstly, the distance between Baghdad and the migrant's home village, e.g. those relatively nearby were visited more often than those further away. Secondly, the migrant's age, e.g. the higher the migrant's age the more frequent and regular were their visits to their home. Further migrants' length of residence in the city seems to be an important factor influencing whether or not strong contacts are maintained with relatives and friends in the place of origin. For example, Mustafa (1990) found that recent migrants visited their home village more regularly than longer-term migrants.

2.2.4 MIGRANT ADAPTATION: PROCESSES AND PATTERNS

There is widespread agreement among researchers that kinship and friendship networks, linking the place of origin and the place of destination, provide newly arrived migrants with support, assistance and a sense of social continuity that deeply influences the way they adjust to life in the new environment. However, there are conflicting views about the precise effect of such networks on the adjustment process. While some studies (e.g. Macdonald and Macdonald, 1967) show that the maintenance of close family ties facilitates the adjustment of migrants with regard to the 'host' society, others indicate that strong and close contacts with relatives in the city may slow the process (e.g. Tilly and Brown, 1967). Clearly at stake in such conflicts are differing definitions of the term 'adjustment'. For one group of scholars 'adjustment' refers to a general process of change and adaptation in the face of new conditions and opportunities, whereas for another group of scholars 'adjustment' refers to a process of change involving 'integration' or 'assimilation' (see, Heer, 1985).

Butterworth and Chance (1981:103) point out that while it is apparent from the research that most migrants adapt more or less successfully to living and working in urban areas, there is as yet no general theoretical model that can adequately explain this adaptation process and its variations. However, based on an extensive review of recent

studies, they identified nine major variables which, taken together, affect the adaptation process: (1) the migrant's ethnic and cultural background; (2) the ecological, economic, political and demographic characteristics of the migrant's place of origin; (3) the selectivity of migrants in terms of their age, personality, skills and wealth; (4) the size of the city; (5) the availability and type of housing in the city; (6) the new urban class status of the migrants; (7) the type and availability of employment in the city; (8) the type of bureaucratic and political structure of the city; and (9) the length of residence in the place of destination.

While many studies report that migrants intend or plan to return to their area of origin, there is little systematic research on this issue. Lloyd (1979: 136) notes the lack of data but says it seems safe to assume that few migrants will in fact return to live permanently in their area of origin. In contrast, Gilbert and Gugler (1982: 64) argue that the limited available data shows that many migrants do realize their aspiration to return to live permanently in their place of origin. Neither Lloyd or Gilbert and Gugler engage in an extended discussion of this issue, nor do they acknowledge that different types and processes of migration may significantly influence whether or not migrants' stated intentions to return to their place of origin are realized.

2.2.5 THE POLITICAL AND LEGAL POSITION OF MIGRANTS

While the political and legal position of migrants is an integral part of the adjustment process, the issues arising are worthy of special attention. In many parts of the developing world rural-urban migration and the existence of poverty-stricken populations in urban areas has been seen as a threat to political instability (Friedmann and Wulff, 1976). Indeed, throughout the world, migration has often been seen as posing a threat to political stability (Castles and Kosack, 1973; Gilbert and Gugler, 1982). In academic circles much of this concern has been displayed in research on Latin American cities. For example, Cornelius (1971) refers to the widely held assumption in Latin America that poor migrants moving to urban centres experience conditions that lead them to become hostile towards the social and political structure, and that they become 'political radicals' and engage in various forms of disruptive behaviour. Much of the empirical research carried out on squatter settlements in Latin America has been specifically concerned to challenge the validity of this assumption (see, Roberts, 1978; Butterworth and Chance, 1981). For example, Portes and Walton (1976:72) point out that the urban poor adapt to their social and economic circumstances in the city in a rational, rather than emotional or political, manner. For Portes and Walton, the migrants and the urban poor employ small-scale political strategies, or 'calculated pursuits', which centre on their specific problems of

adjustment and living by manipulating the available bureaucratic and political channels in order to ensure their survival and to increase their economic mobility. Gilbert and Gugler (1982) note, after reviewing studies from all over the world, that migrants and the urban poor seem much more concerned to survive within existing social and political structures than to challenge them.

Butterworth and Chance (1981) point out that the primary concerns of migrants and the urban poor centre on their ability to attain and maintain access to such basic needs as food, water and shelter. It is these which constitute the primary goals of everyday life.

"Affiliated with but secondary to these goals for many of the impoverished are those of education and ensuing social advancement for their children, and improving economic and social status and material benefits for themselves and their children."

(ibid: 161)

Where these primary and secondary goals actually involve political activities, they usually take the form of 'calculated pursuit' strategies associated with specific social and economic demand-making. According to Cornelius (1974), supported by Armstrong and McGee (1985), this demand-making refers to individual or collective action concerned to obtain specific benefits from the State by influencing governmental decisions. Gilbert and Gugler, (1982) note that individual demand-making often centres on the cultivation and manipulation of patron-client links.

Butterworth and Chance (1981) note that collective demand-making, for the benefit of the community, is largely carried out through two channels: firstly, through community organisations, such as neighbourhood associations, and secondly, through self-appointed political leaders and their organizations. There is, then, little evidence to support the notion that either migrants or the urban poor through their own attitudes and activities constitute a major threat to existing political structures.

It is, however, widely acknowledged that foreign migrant workers often find themselves in a particularly vulnerable and powerless situation (Oranti, 1980). French (1986: 11) provides a description of the situation facing foreign migrant workers in many parts of the world.

"They may have few legal or political rights, and are segregated from the indigenous working classes both in the work place, and socially. They tend to live in the worst housing areas in the shabbiest conditions and they work in occupations which are characteristically 'dirty', unsafe, badly paid and unacceptable to local workers. Indeed, migrant labour itself encourages the persistence of such conditions."

For French, the powerlessness of foreign migrant workers is often the product of a deliberate policy of State control: the vulnerability and powerlessness of foreign migrant workers establishes their position in the work place and in the wider society of the receiving country. According to Freeman (1978) this process has, in the case of Europe and North America, resulted in the creation of 'two

worlds': that of the occupationally mobile indigenous white skilled workers, and the static world of the coloured manual foreign migrant workers. For Freeman, these expatriate workers constitute another working class in the receiving countries, which may lead to the undermining of the indigenous working class.

The political and legal position of foreign migrant workers in the Middle East is similar in some respects to that which prevailed in Western countries during the huge influx of foreign migrant workers after World War II. The vulnerability and powerlessness of foreign migrant workers in Saudi Arabia and the other major labour-importing countries of the Middle East is clearly evident. These workers have few legal or political rights. They are brought into the country on a contractual basis, and they must leave as soon as their contract expires. The government, as well as private employers, (Kefeel) have unchallenged powers over the foreign migrant workforce. Foreign workers can be readily and easily expatriated if they are seen as 'unfit' for the job, or if they express open dissatisfaction with their living and working conditions.

A majority of the labour-importing countries in the Arab world, including Saudi Arabia, have attracted a large Arab and Non-Arab foreign workforce. This workforce is highly productive in that it accepts lower wages and longer working hours than the indigenous workforce, and consume far

fewer public and welfare services. This is particularly the case for the Non-Arab foreign workforce. Further, this foreign workforce displays little active interest in the political affairs of the 'host' country (see Chapter three).

The second half of this chapter has focused on the process of migration and adjustment revealed in the literature on internal and rural-urban migration, with a brief discussion of the political and legal position of foreign migrant workers. This body of work is important because it provides the essential background for any detailed study of specific groups of international labour migrants. In particular, this literature raises questions about the similarities and contrasts there are in the process of migration and adjustment between individuals and small family units involved in internal or rural-urban migration, on the one hand, and those involved in international labour migration, on the other.

The vast majority of studies on internal, rural-urban and international migration have focused on poor, unskilled or semi-skilled, manual workers. By contrast, this study is concerned with a group of Egyptian doctors, and their families, working in Saudi Arabia. Compared to the overwhelming majority of individuals and groups which form the basis for migration research, these Egyptian doctors constitute a highly-educated, highly-valued and well-paid group of foreign migrant workers. As well as investigating

the process of migration and adjustment among these Egyptian doctors and their families, the study will attempt to draw out points of similarity and contrast with the wider literature on migration (see Chapters six, nine and eleven). More specifically, it will attempt to identify similarities and contrast between this particular group of Egyptian doctors and other groups of migrants discussed in the literature in terms of : (a) their motives for moving and the participation of other people in their decision to migrate; (b) their socio-economic characteristics; (c) the role played by kin and friends in moving and in the migrants' initial adjustment to their new environment; and (d) the contacts maintained by the migrants with their place of origin.

CHAPTER THREE

A POLITICAL ECONOMY OF SAUDI ARABIA

3.1 ECONOMIC DEVELOPMENT

The establishment of the modern State of Saudi Arabia is usually traced by historians from 1902, when Ibn Saud took the family seat of Riyadh and captured the Masmak fortress (Hobday 1978:). However, Riyadh was first established in the 1740's, by Dahham bin Dawwas, whose enemy was Emir Mohammed Ibn Saud. Two years before Riyadh was founded, Mohammed Ibn Abdul- Wahab, a religious teacher, arrived in Dir'yah and called on Ibn Saud to return to the strict principles of Islam. A holy war, Jihad, was fought to convert the Najd region. Between 1745 and 1773, 35 battles were fought and finally Dahham Bin Dawwas fled from Riyadh.

After taking Riyadh, the house of Saud, led by Abdul Aziz, continued to fight on and by the 1900's, the Saudi State covered all the Al-Hasa provinces in the East, Asir in the South, and part of Hijaz in the West (Hobday 1978:3). By the time of Mohammed Ibn Saud's death in 1765, most of Najd was under Saudi control and when Mohammed Ibn Abdul- Wahhab died in 1792, control had extended south to Rub Al-Khali. Later, in 1801, Mekkah was captured, followed by Medinah in 1805.

The capture of the Holy cities provoked a response from the Ottoman Government which, in 1814, sent its viceroy in Egypt (Mohammed Ali) to free the cities from the Saudis (Niblock 1982:12). As a result, the Saudis were forced back to Najd and in 1818 the Saudi capital of Dar'iyah was destroyed.

Under Faisal Ibn Torkey, the fortunes of the House of Saud reached their lowest point in the late 19th Century. Eventually, the Al Saud were driven from Najd and took up temporarily residence in Kuwait. This was because of internal conflicts and the support given by the Ottoman Government to their rival, Al-Rashid of Ha'il.

From this brief history one sees that Saudi rulers have a long history, and also that the reconstruction of the Saudi State began from a position of great weakness. According to Niblock (1982:13) both of these aspects were to have a major role to play in the building of the Saudi State:

"The traditional alliance of the religious and the temporal was retained within this strategy, and the difficulties of regaining control of a territory where opposing forces were strongly entrenched were confronted by developing a new type of military force, the Ikhwan."
(Niblock, 1982:13)

The Ikhwan created in 1912, consisted of ex-Bedouins. The territory of the reconstituted Saudi State grew steadily between 1902 and 1926. By 1926 the main part of what is regarded as the Kingdom of Saudi Arabia had been

integrated into the Saudi State. The unification of Saudi Arabia overcame the struggle between the many tribes to dominate the region and in 1934 the kingdom of Saudi Arabia was officially created with the proclamation of King Abdul-Aziz Al Saud.

Although Saudi Arabia was ultimately united under the leadership of King Abdul-Aziz, he was unable, during the nineteen years of his rule, to transform the newly established kingdom into a nation (Lackner, 1978:56). The various regions of the kingdom, particularly the newly acquired ones, had not been fully integrated into the central administration in Najed. King Abdul-Aziz, however, managed to maintain the loyalty of the bedouin tribal leaders through a steady system of subsidies (Niblock, 1982). The king further strengthened his position as the leader of the country by taking wives from the most powerful tribes in the kingdom.

According to Lackner (1978:58), by 1950 the King was receiving \$56 million a year in oil royalties, which allowed him to increase the subsidies to tribal leaders. This gave him greater power than any of his rivals. During the reign of Abdul-Aziz no attempts were made to establish any form of political structure or to utilize the increasing oil revenues to develop the country. Whatever was left over from the country's income after paying the subsidies bill was spent for the comfort and benefit of the royal family. The kingdom had no financial management of

any sort and spending was uncontrolled. It was only under pressure from the United States that, in 1952, King Abdul-Aziz agreed to establish the Saudi Arabian Monetary Agency (SAMA) under American supervision.

After the death of King Abdul-Aziz, his eldest son, Saud assumed power in 1953. King Saud continued his father's style of personal rule with the help of foreign advisors, and pursued an even more lavish life style (Lackner, 1978:59). Although the first official budget was announced in 1954, only a tiny fraction of it was devoted to infrastructural development, especially roads, schools and health facilities. King Saud's approach to the kingdom's finance was similar to that of his predecessor, with government expenditure administered according to the king's desire.

"A number of new palaces were built at great cost - Nasiriyah in Riyadh (\$25 million), Jeddah (\$25 million) - and the King spent a great deal of time travelling through the country to ensure continued support from the tribes, lavishing their leaders with gifts. The subsidy of tribal leaders continued to be a basic element in keeping political support for the regime, and was seen as a necessary expense."

(Lackner, 1978:59)

As a result of the continued mismanagement of the economy, by the early 1960s the country was on the verge of bankruptcy, despite substantial increases in oil revenues. As a consequence King Faisal, then Crown prince, over-threw his elder brother, Saud, and assumed power in 1964. It

was not until King Faisal came to power that the Saudi Arabia's finances were brought under control and with that the modern development of the kingdom really began.

Saudi Arabia is today the largest oil producer in the Arab world. With oil production reaching around 9 million barrels a day in 1979, it accounted for nearly half of the total Arab oil production. The country's oil revenues increased from \$0.6 billion in 1965, to \$1.2 billion in 1970 and \$4.3 billion in 1973. As a result of the 1973 oil embargo the revenue jumped to \$22.5 billion and reached \$80 billion in 1980.

The modern economic development of Saudi Arabia began to take place in the early 1960s, as the government concentrated its efforts on the creation of a much needed physical and social infrastructure, such as roads, ports facilities, airports, communication facilities, education, medical services, etc. However, the scale and impact of these infrastructural projects was limited due to the huge size of the country and the relatively limited oil revenues then available. The sharp increase in oil prices in the early 1970s, however, provided the impetus for much more rapid economic development to take place. With its increasing and massive financial resources Saudi Arabia was able to carry out more infrastructural development projects on a larger scale and at an accelerated rate.

In addition, ambitious industrial development plans were initiated, in order to lay the foundations for a more

diversified economic base. Birks and Sinclair (1980:105) single out three main aspects of Saudi Arabia's plans for industrial development. Firstly, the expansion and development of the already established industrial ventures, such as the cement industry, the steel mill in Jeddah, and subsidiary investments in desalination components. Secondly, the creation of seven new 'industrial sites' providing light industry around major cities. Thirdly, the core of Saudi Arabia's industrial plans was the creation of two industrial cities in Yenbo, in the Western province, and Jubail in the East of the country. These two cities were established and built specifically to manufacture a whole range of petrochemical products. By the second half of the 1980s the factories in these cities were in full operation, generating significant revenues.

The rapid post-1975 growth in the Saudi economy was motivated by the belief that, the sooner the economy becomes diversified and moves away from its narrow oil base, the sooner economic independence from Western nations can be achieved (Birks and Sinclair, 1982). The kingdom also faces external as well as internal pressures to pursue plans to policies designed to bring about speedy economic growth. On the one hand, Saudi Arabia is under considerable international pressure to 'recycle' its oil wealth, while on the other, there are domestic pressures from those such as the Royal Family, in whose interest it is that the rapid domestic growth of the country should

continue (ibid:206). However, despite the kingdom's extensive and rapid economic development in recent years, it has primarily involved the urban populations, and it has been the urban populations which have taken part in, and have most directly experienced its effects (ibid:198).

Saudi Arabia's economic development has largely evolved along 'dual economy lines'. While modern economic development moved steadily forward in the urban areas, the rural economy remained relatively traditional. In 1966, for example, approximately half of the Saudi workforce were engaged in agriculture, fishing, and livestock production, and by 1975 less than half of the country's active workforce were involved in the modern sector of the economy (Birks and Sincliar, 1980:107). This low level of indigenous participation in modern economic development has been attributed to a variety of cultural, economic, and political factors (ibid:107-110). 1) The sheer size of the country and the lack of communication and other links between the expanding urban centres and the rural areas is an important factor. 2) The continuation of the traditional way of life in the country's rural areas has to be seen in relation to the relatively recent growth of extensive economic development in the country. Prior to 1973 there was neither sufficient employment opportunities for the population in rural areas, nor pressures on them to leave their work in the traditional sector. 3) The government's attempts to modernize small-scale farming by

providing loans and grants to land owners in rural communities indirectly played a crucial role in the survival of the traditional rural economic activities. The farmers regarded these loans and grants as a source of extra income which they spent mainly on consumption goods rather than on the improvement of their farms' output. 4) The high regard that the rural population associated with leisure activities of time, together with their reluctance to work in demanding manual jobs are also contributing factors for the low level of participation of the rural population in the modern sector. 5) The high rents and poor conditions in the cities have also inhibited or prevented the movement of large numbers of families from rural to urban areas.

One additional major factor for the low level of participation of many active Saudi labourforce in the modern sector of the economy, including those in rural areas, is the fact that the modern sector required a labourforce "with skills and also, importantly, with aspirations that Saudi Arabians did not possess in the 1950s through to the 1970s" (Birks and Sinclair, 1982:202). Few Saudis possessed professional qualifications and only a small proportion of the population had completed secondary or primary education. The provision of basic educational facilities was very limited in rural areas until as recently as 1970. Quite surprisingly, 70 per cent of those

of the age of 10 years and over were illiterate in 1974 (ibid).

As a result of the acute shortage of skilled indigenous workforce, a huge number of foreign migrant workers were brought into the country. During the 1950's, many Omani refugees arrived in Saudi Arabia, followed by people from North Yemen in the 1960s. Many of these worked as builders or traders. In addition to these there were pilgrims who worked in the modern sector, in the period between the 1950's and early 1970s, in order to pay for their journey home (ibid:202). The presence of these groups of expatriate workers contributed to the further exclusion of the majority of the nationally active workforce from the modern sector. As a result, much of Saudi Arabia's continued development in the 1970s was almost exclusively dependent on migrant workers.

Although the increasing influx of migrant workers into Saudi Arabia in its early years of economic prosperity and since is an indication of the expansion in the modern sector, this migrant labour force has nevertheless absorbed most of the jobs in the modern sector. Birks and Sinclair (1982:203) show that even in 1974, 52 per cent of Saudis were recorded in the census as farmers, and by 1975 the modern sector was still small, and only a small proportion of the indigenous population were involved in the activities associated with it. The dominance of migrant workers in most of the activities in the modern economic

sector was underpinned by the political desire of the Saudi Arabian rulers to keep the majority of Saudi Arabians away from the possible 'immoral' influences of modern sector developments (*ibid*). However, the government's adoption of a more rapid economic development approach in its Second Development Plans (1975-80), reveals that it has now, apparently, changed its view concerning the involvement of Saudi nationals in modern sector development. The changes in government policy towards giving more encouragement to the increased participation of Saudi nationals in modern sector development does not seem to be simply a move towards a more 'progressive' philosophy but seems more likely to reflect increasing awareness of the implications of a continuing over-reliance on an expatriate work force.

However, it would appear that the private sector in Saudi Arabia has been indirectly responsible for the presence of large number of foreign migrant workers in the country's modern sector and the exclusion of a large proportion of the indigenous workforce. The Central Department of Statistics Census of private establishments in Saudi Arabia, published in 1981, indicated that the overwhelming majority of migrant labourers were employed in the private sector. The Census was the most complete economic survey ever undertaken in the country. It represented 111 cities country wide and covered 151,000 private establishments involved in the economic areas of mining, manufacturing utilities, construction, business

trade, transportation, finance, community, social and personal services. The total number of workers in the enumerated private establishments was over a million employees, a 191 per cent increase over the 348,000 workers recorded in the 1976 Census. The number of migrant workers in the 1981 Census stood at 828,990 which represented 82 per cent of the work force in the private sector.

Birks and Sinclair (1982:205) conclude that, since most of the economic development in the kingdom is being carried out by the private sector:

"Market forces ... have continued to work strongly against full participation of nationals in the modern sector. As long as development is executed by private bodies, and as long as these employers are concerned to maximize profit, then development in the kingdom will always be executed using the most cost-effective labour available. While alternative supplies of Egyptian, Jordanian, Syrian, Pakistani, Indian or South-East Asian labour remain easily available, Saudi Arabians will not be employed widely in the private modern sector."

It would appear that, although the Saudi government had changed its attitudes towards the employment of Saudi nationals in the modern economic sector as a result of growing officials concern over the continued dependence on a foreign workforce, non-national labour is, in reality, indispensable to the economy of Saudi Arabia. This fact becomes clear when we consider the structure of the country's labour force.

The main feature of the Saudi Arabia's indigenous work force is its relatively small volume. In addition, a large proportion of the active work force has remained engaged in occupations in the traditional sector, and the population has attained a low level of educational qualifications. There are, however, some other factors which contribute to the shortage of manpower in the Saudi labour market. One significant factor underlying the high demand for foreign workers is the small size of the country's population in relation to its immense geographical area. According to the 1974 Census, the total population of the kingdom stood at slightly over 7 million, but this figure is generally believed to be an over-estimate. The majority of commentators estimate that the population of Saudi Arabia in 1975 stood at between 5 and 5.5 million.

Another major characteristic of the Saudi population is its 'youthfulness'. Ibrahim (1982:161) points out that Saudi Arabia has one of the highest birth rates in the Arab World. The large proportion of children in the total population is reflected in the low level of Saudi participation in economic activities. In addition, many Saudi nationals, particularly those of bedouin origin, consider manual work degrading and the traditional view of the role of women in Saudi Arabian society has been a key factor in limiting their participation in economic development. All of these factors have increased the demand for both female and male foreign workers.

3.2 INTERNATIONAL LABOUR MIGRATION IN SAUDI ARABIA

Although oil was discovered in Saudi Arabia in 1938, modern economic development did not begin to take place until the early 1960s. The creation of modern physical and social infrastructure projects soon became a governmental priority. These modern enterprises led to a demand for both skilled and non-skilled workers. As a result, the influx of migrant workers from the neighbouring poor Arab countries increased significantly.

In the early years of Saudi economic development Arab workers from elsewhere in the region took full advantage of the employment opportunities available in the country. Their migration was supported by the capital-poor countries of the Middle East, where there was a need to reduce unemployment and underemployment, and the remittances of workers promised to improve foreign exchange levels. The remittances of Arab migrant workers have played a major role in earning hard currency for their respective countries. It seems to have been widely believed that labour migration from poor Arab countries with surplus labour, (such as Egypt, Jordan and Yemen) to the wealthier Arab countries, would help to reduce unemployment without hindering or effecting the level of production or development programmes in the different sectors of the economy of these states. However, the evidence in recent years has contradicted this belief. Since labour migration

is usually selective of certain occupations and skills, it has led to notable shortages in the supply of skilled workers in the labour markets of all the labour-exporting countries of the Arab World (Ibrahim and Abdul-Fatheal, 1983:103). In the case of Egypt, for example, it soon became very clear that the large-scale migration involved highly skilled and educated individuals as well as a large portion of the unskilled and semi-skilled individuals, which constitute, a major loss to the Egyptian economy.

3.2.1 MIGRANT LABOUR FLOWS, 1975

The pace of economic development in Saudi Arabia remained moderate until the 1973 oil price rises, which dramatically transformed the pace and scale of Saudi development. This in turn transformed the pattern of labour flows into the country. As oil revenues increased, Saudi Arabia launched a number of ambitious industrial projects. The second Five-Year Development Plan, 1975-1980, called for an expenditure of \$145 billion. As a consequence large numbers of migrant workers were imported in order to staff and construct the development projects.

In 1975, there were some 773,400 foreign workers in the country, 91 per cent of whom were Arab nationals (Table 1). The largest single group of Arab migrants at the time came from North Yemen, followed by Jordanian and

Palestinian workers. These groups of Arab workers, together with Egyptian migrants, comprised 71 per cent of all the foreign workers in the country. Birks and Sinclair (1980) argue that the predominance of Arab workers in the Saudi workforce has arisen because: (1) the Saudi Government gives preference to Arab nationals for work permits; (2) Saudi Arabia has common borders with major Arab labour-sending countries, namely North Yemen, Jordan, Oman and South Yemen; and (3) the wages and salaries in Saudi Arabia are higher than those in the other labour-importing countries of the Middle East. An additional factor here may be the government's concern to maintain harmonious social and cultural relations internally and within the region.

Although migrant workers comprised 43 per cent of the total Saudi Arabian workforce in the mid 1970s, the contribution of these migrant workers to the total number employed in some sectors was much higher. Table 2 shows that migrant workers constituted more than 50 per cent of the workforce in five major economic sectors: manufacturing, electricity, construction, trade, and the finance and insurance services. In contrast, over 90 per cent of the labour force in the agriculture and fishing sector were Saudi nationals, which constitutes 52 per cent of the country's total active workforce. As Ibrahim (1982), observes that although the agriculture and fishing sector is dominated by indigenous workers, that sector's

contribution to gross domestic product is only 5 per cent. Thus, the majority of the Saudi indigenous workforce plays a small and comparatively unimportant role in the national economy.

Table 1
Migrant Workers in Saudi Arabia by Place
of Origin, Ranked by Size for 1975

COUNTRY OR AREA OF ORIGIN	N	%
Yemen	280,400	36.3
Jordan & Palestine	175,000	22.7
Egypt	95,000	12.3
Democratic Yemen	55,000	7.1
Sudan	35,000	4.5
Lebanon	20,000	2.6
Oman	17,500	2.3
Syrian Arab Republic	15,000	1.9
Somalia	5,000	0.6
Iraq	2,000	0.3
Total Arab Migrant Workers	669,900	90.6
Pakistan	15,000	1.9
India	15,000	1.9
Other Asian	8,000	1.0
Total Asian Migrant Workers	38,800	4.8
Europe & America	15,000	1.9
Africa	10,000	1.3
Iran	10,000	1.3
Turkey	500	0.1
Total Migrant Workers	773,400	100.0

Source: Birks and Sinclair, 1980:159

Table 2
Saudi Arabian Employment by Economic
Sector and Nationality, 1975

Sector	No. of Saudi	%	Non- Saudi	%	Total	Saudi Share of all Employ.
Agriculture & Fishing	530,700	51.7	54,900	7.1	585,600	90.6
Mining & Petroleum	15,400	1.5	11,600	1.5	7,000	57.0
Manufacturing	21,550	2.1	94,350	12.2	115,900	18.6
Electricity, Gas & Water	7,200	0.7	13,150	1.7	0,350	35.4
Construction	35,900	3.5	203,400	26.3	239,300	15.0
Wholesale & Retail Trade	60,600	5.9	131,500	17.0	192,100	31.5
Transport & Communication	72,900	7.1	30,950	4.0	103,850	70.2
Finance & Insurance	5,150	0.5	6,950	0.9	12,100	42.6
Community & Personal Services	277,100	27.0	226,600	29.3	503,700	55.0
Total	1,026,500	100.0	773,400	100.0	1,799,900	57.0

Source: Birks and Sinclair, (1980:160)

During the second half of the 1970s, the preference given to Arab migrant workers by the Saudi Government, as well as other Gulf states, changed in favour of South Asian migrant workers. Various economic and non-economic reasons have combined to make Arab migrant workers less attractive in the Middle Eastern labour market and to make Asian workers more preferable. One reason is that at the beginning of the second half of the 1970s, Arab labour-exporting states were unable to meet the increasing demand for labour by the Arab labour-importing countries. This increasing demand for labour was the result of a simultaneous expansion in those states for the creation of their physical and social infrastructure (Shaw, 1983; Choucri et al., 1978; Berouti, 1978). To satisfy their labour needs, the oil-rich countries recruited workers first from the Indian sub-continent, and later from East and South East Asia. Further, South Asian workers are thought to be economically preferable to Arab labourers, because they were willing to accept lower wages and salaries than those asked for by Arabs (Pennisi, 1981; Nagi, 1986).

The construction sector in Saudi Arabia, for example, was dominated by North Yemen migrant workers for many years. However, the presence of South Asian workers in the Saudi labour market on a large scale brought the level of wages down, and led to return migration among North Yemen workers (Hill, 1981).

The increased utilization of South Asian migrant workers in the Middle East has been accelerated due to the fact that their recruitment is more organized than that of their Arab counterparts. Many private agencies have been set up in different South Asian countries in order to meet any labour requirements quickly, efficiently and cheaply. The activities of these agencies served to increase the number of workers coming from the Indian subcontinent employed in Saudi Arabia and the Gulf States. These agencies have the ability to recognize the demands of the labour markets in Saudi Arabia and the Gulf States and the ability to meet these requirements with appropriately qualified and low-waged workers (Ibrahim and Abdul-Fatheal, 1983:146). The recruitment procedure by which these private agencies supply migrant workers to clients in the Gulf countries reveals a highly organised operation.

"The recruiting agents, normally private-sector Asian entrepreneurs and their representatives in the Gulf States, identify categories of labour and skills requirements. These requirements are speedily met from a list of applicants. Trade-tested before their dispatch, workers are flown by agents to the Gulf States... The success of these agencies is attributed to their ability to identify and match a contractor's specific requirements to dependable workers quickly, efficiently and with maximum back-up services."

(Nagi, 1986:50)

Ibrahim and Abdul-Fatheal (1983:151) point out that these agencies provide employers in the receiving countries

with comprehensive information regarding their recommended workers with regard to their qualifications and experience. They are also ready and able to examine the worker's skills and make the necessary tests on behalf of prospective employers. Private agencies also provide guarantees, in that they will send back any worker the employer is not satisfied with, and replace him with another one at the agency's expense.

The introduction of South Asian workers in the workforce of the oil-rich countries, including Saudi Arabia, can also be attributed to political factors. In this respect, South Asian workers are widely believed to be less likely to become involved in the local politics of the host countries than their Arab counterparts.

According to Smart (1982), the Saudi government is very sensitive to the employment of Arab migrant workers from left-wing countries, such as Syria, Iraq and South Yemen. The Saudi government is also cautious about the employment of Arab Shi'ites, who became very politically active in the Arab world after the rise of the Khomeini regime in Iran. Moreover, the rulers of Saudi Arabia became very suspicious of Arab migrant workers after some were involved, along with Saudi citizens, in the seizure of the Grand Mosque in Mekkah in 1979. Some authors also claim that the rift between Egypt and the rest of the Arab world over the Camp David Agreement with Israel, has increased the influx of Asian workers into the region

(Richards and Martin, 1983; Nagi, 1986). There is, however, no evidence to support this argument, since the severance of political relationships with Egypt by most of the Arab countries in the Middle East went no further than the withdrawal of ambassadors. Further, the political tension decreased considerably, shortly after the death of President Sadat.

However, by the late 1970s the increasing number of South Asian workers had begun to arouse domestic resentment in the Arab labour-importing countries (Weiner, 1982). Matters grew worse when South Asian labourers rioted in protest over poor working conditions and wage inequities in Bahrain (1974), Saudi Arabia (1976) and Dubai (1977) (Pennisi, 1981:75). As a result, the Gulf countries reshaped their migration policy for a third time. The labour-importing countries embarked upon a policy of 'enclaves' or 'work camps', which located migrant workers around industrial projects, away from the major population centres. Planners sought, through the creation of these 'work camps', to alleviate local social disruption, reduce infrastructure costs, complete projects with maximum efficiency (Birks and Sinclair, 1980), and cut down on recruitment costs (Kuthiala, 1986).

The 'work camps' style of locating and accommodating migrant workers in the Middle East is provided mainly by multinational corporations from different East and South-East Asian countries. Among the multinational corporations

in Saudi Arabia, South Korean firms dominate the construction industry (Ling, 1984). South Korean construction firms are very popular in the Middle East as a whole. Korean firms entered the construction market in the Middle East in the early 1970s. The number of Korean construction companies in the Middle East increased very rapidly in the second half of the 1970s, and by the end of 1982 there were 54 Korean firms operating in the region (Kim, 1986:165).

The multinational construction companies recruit their own workers and are responsible for their accommodation, medical care, food, etc. The majority of their recruits come from South Korea, the Philippines, China, and to a lesser extent, from Thailand, Indonesia, and Malaysia.

The East and South East Asian workers have become the favorite migrant group in the Middle East, because they accept working and living in 'enclaves'; they are less likely to settle permanently in the receiving countries, which is the tendency of Arab and South Asian workers (Serageldin et al., 1981); and they are very hard working and highly disciplined workers (Kuthiala, 1986).

According to Ibrahim, and Abdul-Fatheal (1983:148), the Gulf states take strong measures in order to prevent such migrant workers from becoming long-term or permanent residents. Contracts with Far Eastern companies include a clause that stipulates that all of their workers must leave the country immediately after the completion of the

projects, even if the company itself has contracts for other projects in the country. Moreover, some of the labour-importing countries of the Middle East tend to grant contracts to different countries in order to prevent the same workers from a particular country from remaining in the country for a long period of time.

Estimates of the stocks and flows of Asian migrant workers into Saudi Arabia, and the Middle East in general, varies considerably from one source to another. It is generally acknowledged that statistical estimates of this phenomenon are of uncertain value. Arnold and Shah (1984) believe that the lack of reliable data has led to major disagreements between commentators. The inadequacy of Asian labour migration data has often been noted.

"Because of the nature of the subject itself, as this migration being short term, circulatory, and inherently difficult to measure from a sampling point of view, and partly because its recent appearance on the international scene has caught data gathering agencies of the sending countries by surprise."

(Demery, 1986:18)

The receiving countries in the Middle East are reluctant to release reliable data regarding the size of their migrant workforce, for of political and commercial reasons (Arnold and Shah, 1984). While there are major disagreements between commentators as far as the flows and stocks of Asian migrant workers in the Middle East is

concerned, there is considerable agreement that the vast majority of them are found in Saudi Arabia.

3.2.2 MIGRATION FLOWS IN THE 1980s

Between 1981 and 1983 Saudi Arabia oil revenues dropped by over a half as a result of the slump in oil prices on the international market. Oil production was reduced substantially, from around 9 million barrels a day in 1979, to around 4 million for much of the 1980s. Consequently, government expenditures fell from S.R.287.7 billion (\$79.1 billion) in 1981/2 to S.R.212.9 billion (\$59.2 billion) in 1984/5, and the 1985/6 budget expenditure was further reduced to S.R.200 billion (\$55.6 billion) (Mees, 1985). The construction sector seems to have borne the brunt of the cuts in government expenditure. Owen (1985:15) points out that the value of government contracts was reduced substantially and that several huge construction projects were cancelled. Furthermore, the fourth Five-Year Plan 1985-1990 indicated a reduction of government expenditure of 2.8 per cent a year, and it was hoped that by the end of 1990 the number of unskilled workers would be reduced to half a million (Mees, 1985).

The economic difficulties experienced by Saudi Arabia in the 1980s, however, did not result in a sharp decline in

the number of foreign workers in the construction sector. On the contrary, the number of expatriate workers in the construction sector continued to increase for much of the 1980s. Table 3 shows that in 1982 the number of foreign migrant workers employed in the construction sector stood at over 300,000 and increased substantially in 1984-85 after a slight drop in 1983. The construction sector saw a relatively small decline in 1986-87 in comparison to the figures for 1982. (This was a result of a slow down in the government loans to Saudis who had embarked on building their own houses). By 1988, the number of migrant workers in this sector had shot up to a record high of more than 460,000.

Table 3
Number of Foreign Migrant Workers Employed
in The Private Sector, 1982-1988

Economic Activity	1982	1983	1984	1985	1986	1987	1988
Mining &	18,8	19,4	22,3	18,8	15,3	12,6	11,3
Quarrying & Manufacturing	161,3	176,6	185,9	227,2	229,2	228,5	209,4
Construction	326,9	323,8	396,6	450,6	347,5	298,0	464,4
Wholesale & Retail Trade	249,6	261,4	295,5	398,7	418,1	433,7	492,9

Source: Ministry of Finance and National Economy
Statistical Year Book, Various Issues

The community, social, and personal services sector appears to have been hard hit by the reduction in government expenditure in the 1980s. Table 3 shows that in 1982, the number of migrant workers employed in this sector stood at less than 79,000, a fall of over 188 per cent compared with 1975. However, the number of expatriates working in this sector began to rise up during the second half of the 1980s.

Reductions in government expenditure were not evenly distributed between all sectors of the economy. Education and public health, for example, which employ large numbers of migrant workers, are thought to have suffered less than the construction sector (Owen, 1985:16). In addition, Table 3 shows that the manufacturing, trade and community and personal services sectors grew considerably during the 1980s, despite the economic recession, thereby creating further demand for migrant workers. Considering that these sectors employed many more expatriate workers during the 1980s than they did in the 1970s, and the fact that most of the occupations in these sectors required skilled and highly skilled workers, it would seem that the structure of labour demand in Saudi Arabia shifted from unskilled and semi-skilled to more highly skilled and professional occupations.

3.2.3 THE FLOW AND STOCK OF EXPATRIATES BY THE END OF THE 1980s

Despite the reduction in government expenditures in the early 1980s, the number of foreign migrant workers in Saudi Arabia grew steadily throughout much of the decade. The foreign labour force in 1988 was over one and a half million compared to 829,000 workers in 1981, an increase of more than 50 per cent, and double the number in 1975.

These migrants workers come from more than 110 countries world-wide. Contrary to the situation during the 1960s and 1970s, the majority of them were of non-Arab origin. Table 4 shows that the overwhelming majority of ~~came~~ came from the Indian subcontinent and South-East Asian countries.

The vast majority of these migrant workers were males, with the exception of those from Indonesia and Sri Lanka, where female migrant workers outnumbered male workers. Indonesia and Sri Lanka are the main suppliers of housemaids to Saudi householders.

With regard to the size of the foreign worker population in Saudi Arabia, statistics on the number of residence permits issued by the Immigration Department in the Ministry of Interior in 1989 indicate that the total number of the expatriate population in Saudi Arabia amounted to 2,877,234: an increase of more than a quarter of a million over 1982 (Ministry of Finance and National Economy Statistical Book, 1989).

Table 4
Saudi Arabia: Migrant Workers by Place
of Origin, Ranked by Size for 1989.

COUNTRY OR AREA OF ORIGIN	N
Yemen	95,587
Jordan & Palestine	8,436
Egypt	67,441
Democratic Yemen	14,219
Sudan	19,207
Lebanon	1,098
Syrian Arab Republic	2,305
Somalia	1,109
Iraq	89
Tunisia	1,511
Morocco	1,959
Algeria	162
Libya	54
Djibouti	30
Mauritania	343
Total Arab Migrant Workers	231,550
Pakistan	45,037
India	89,595
Bangladesh	28,041
South Korea	6,266
Philippinaens	44,003
Thailand	32,172
Indonesia	31,509
Sri Lanka	29,651
Other Asian	2,229
Total Asian Migrant Workers	308,503
Europe & America	8,728
Africa	4,426
Turkey	20,197
Total Asian Migrant Workers	555,404

Source: Ministry of Interior Statistical Year Book, 1989

The geographical distribution of foreign migrant workers in Saudi Arabia varies from one region to another. Table 5 shows that in 1989, the majority of expatriate migrant workers lived in the Western region, which is the commercial centre of the kingdom. This, however, has not always been the case; over the years many of them have lived in the Central region. Table 5 shows that in the first half of the 1980s, Central province absorbed the majority of migrant workers. The foreign population was been concentrated in the Central region, and in the capital city of Riyadh in particular, where government, financial and related activities are found. This concentration was reinforced by the transfer of all foreign Embassies from Jeddah, in the Western province, to Riyadh in the early 1980s. However, by the mid 1980s, the number of expatriate migrant workers in the Central region had begun to fall, while their number was on the increase in the Western region throughout the second half of the 1980s.

Table 5
Residence Permits Issued to Foreign Workers at Various
Passport Offices by Regions, 1977-89

Year	Western	Central	Northern	Eastern	Southern
1977	113,586	187,121	35,373	164,733	21,272
1978	240,263	159,134	45,805	140,821	20,380
1979	223,500	209,451	48,007	169,656	36,660
1980	216,911	199,017	28,373	176,299	48,331
1981	161,829	213,604	19,080	197,394	40,249
1982	179,424	217,376	18,897	202,811	44,605
1983	282,534	248,750	37,041	198,780	52,508
1984	284,609	394,210	27,280	175,267	69,360
1985	238,371	287,948	28,684	181,738	66,118
1986	199,048	198,816	16,923	97,351	51,609
1987	217,261	190,944	16,747	105,914	60,395
1988	267,192	158,050	20,104	125,712	70,111
1989	237,144	161,180	22,369	124,564	70,295

Source: Ministry of Finance and National Economy
Statistical Year Book, Various Issues

3.2.4 THE SITUATION IN 1989 AND 1990s

Since the beginning of the large influx of foreign migrant workers into Saudi Arabia in the early 1960s and up to the 1990s, the Yemenis have played a vital role in the economic development in the country, particularly in the construction sector. Yemeni migrant workers were, until the mid-1970s, the largest single group of workers in Saudi Arabia. Even though Asian migrant workers have come to out-number Arab migrant workers since the second half of the 1970s, Yemenis have been always the single largest group of Arab migrant workers. By the end of the 1980s, North Yemenis constituted more than 41 per cent of the total number of Arab migrant workers. Saudi Arabia has a strong political relationship with North Yemen, and the common borders between the two countries have facilitated the flow of migrant workers. Unlike other foreign nationals, Yemenis did not have to secure work contracts before coming to Saudi, nor did they have to work under a Saudi Kefeeel (sponsor). This meant that they could work in any part of the country and take any employment they chose without the need for government consent, a privilege which no other group of migrant workers have had. Yemeni migrant workers also had a special renewable Iqqama (residence card) valid for four years, whereas other foreign workers were given an Iqqama valid for only two years.

This special treatment changed dramatically after the Gulf War because the Yemeni government maintained its relations with, and support for, Iraq and opposed the measures taken by Saudi Arabia and its allies for the liberation of Kuwait. Shortly after the crisis began, the Saudi government came to see the people of both North and South Yemen (which had become a united country in 1990) as a potential threat to national security. Therefore, in order to reduce their numbers and, perhaps, to be able to monitor their movements, the Saudi government announced that Yemeni migrant workers would no longer be given special privileges and that they would be bound by the same Saudi migration regulations as any other group of foreign workers. Those who were already living and working in Saudi were required to have a Saudi Kafeel, and this meant also that no Yemeni would be allowed to come to work in Saudi unless they had secured a work contract before arriving in the country. The vast majority of Yemenis did not like this new situation and thousands left the country. To minimize the effect on the Saudi labour market, the government encouraged Egyptian workers to come to the country. For a few months, it opened its doors to any Egyptian to enter and take any available employment, without the need to have employment contract beforehand. The government also encouraged Saudi employers in the private sector to employ Egyptian workers when importing foreign workers from abroad.

The government's preference for Egyptian workers was due mainly to the fact that Egypt was a major ally of Saudi Arabia during the Gulf crises. It seems safe to assume that Egyptian migrant workers will be the largest group of Arab migrants in the country for many years to come. It appears also that the increase in the number of Egyptian migrant workers in Saudi Arabia will coincide with a decline in the number of Sudanese, Jordanian and Palestinian migrant workers, as a result of the rift between the governments of these countries and Saudi Arabia over the Gulf issue. An additional consequence of the Gulf crisis on the composition of the Saudi labour market, in terms of the origin of migrant workers, is the expected large increase of Syrian migrant workers as a result of their government's support for the Gulf War effort and Syria's recent shift from being a 'hard liner' to adopting a 'moderate' approach to politics in the region.

3.3 THE CONSEQUENCES OF INTERNATIONAL LABOUR MIGRATION FOR SAUDI SOCIETY

Foreign migrant workers have played a key role in the infrastructural development of Saudi Arabia. The rapid transformation of the country into a 'modern' state would not have been possible without the labour and expertise provided by foreign migrant workers. In 1955, for example, there were only three secondary schools and there were no

universities. By the early 1980s, there were 1.3 million pupils in thousands of schools throughout the country, as well as 60,000 students enrolled in five universities and a number of colleges (Ibrahim, 1982:166). Ibrahim also points out that between 1970-80, 2,000 houses were supplied with electricity, 15,000 paved roads were constructed, some three quarters of a million telephone lines were installed, and 300,000 accommodation units were built.

However, the indispensable contribution of migrant workers to Saudi Arabia's growth, in Ibrahim's view (*ibid*), lies not only in the creation of the country's economic and social infrastructure, but more importantly, in the role they play in operating as well as providing the maintenance for these facilities. For example, expatriate workers have not only built the 3,000 or so schools in the country, but more than 70 per cent of the total number of the teaching staff in these schools are foreign nationals (*ibid*:167). The other main sectors of the economy are also mainly operated on the basis of the labour of migrant workers: the health services, manufacturing, and construction which would come to a stand still if the migrant workers were to leave the country. The Saudi business sector has expanded greatly as a result of the consumer demand and purchasing power of migrant workers. Further, the presence of large expatriate populations in

many of Saudi Arabia's cities has given those cities a more cosmopolitan character (ibid:177).

The enormous influx of migrant workers into Saudi Arabia in the last few decades has, however, not always been positive with regard to the impact on Saudi society. The precise degree and nature of the adverse consequences of international labour migration on Saudi Arabia are quite difficult to establish. The issues involved are very broad and diverse, and much more extensive research is required by scholars on the economic, political and social aspects of consequences before a clear picture can be drawn with any degree of confidence. This section will, therefore, limit itself to discussing three of the main areas where some of the negative effects of the huge influx of expatriate workers have been felt in Saudi society.

3.3.1 THE IMPACT ON MANUAL AND PRODUCTIVE WORK

As noted earlier, it is in the private sector of the Saudi economy where most of the productive and physically demanding work exists and this sector is dominated by foreign migrant workers. By contrast, the majority of the indigenous labour force is concentrated mainly in military and 'quasi-military' employment and in the civil service.

Ibrahim and Abdul-Fatheal (1983:158) argue that the indigenous workforces of the Gulf countries look on government employment as part of their right to share in the wealth arising from oil revenues, and that they are not always as committed to their duties.

It is widely believed that many of the Saudis employed in government jobs also have their own personal business as well, and that it is not uncommon for one to pay more attention to his additional duties than to his main job in the government (Ibrahim, 1982:176). It is also not unusual for an employee in a government job to 'sign-in' in the morning and then leave the office for many hours in order to attend to private business or work. According to Ibrahim (*ibid*), this practice reached such proportion in such a highly sensitive Ministry as the Ministry of Interior that the Minister introduced severe punishment to combat the problem in 1977. In other government agencies with less sensitive responsibilities, the government simply ignored what its employees were doing, since most of the officials responsible for the work and work attendance were involved in the same practices and activities.

In recent years the government has made it illegal for anyone in the civil service or armed forces to be engaged in private business activities in addition to their official employment. However, it is well known that government employees can still easily become involved in

private business activities simply by opening a business and registering it in the name of his wife or other relative. Ibrahim and Abdul-Fatheal (1983) point out that many government employees, in Saudi Arabia and other major labour-importing countries of the Arab World, attend work in the early part of the day and then leave to run their private business, leaving most of their official duties to be carried out by expatriate employees. Although this practice is associated with the large scale importation of migrant workers into the region, it is difficult to conclude that the existence of foreign labourers alone constitutes the major reason for this kind of behaviour. However, Ibrahim and Abdul-Fatheal are in little doubt that the ability of the rich countries in Arab World (including Saudi Arabia) to satisfy their manpower requirements from abroad using cheap labour, allows the governments of these states to tolerate indigenous employees' negligence towards their duties, but it also encourages these governments to replace them with foreign migrants.

Thus, the employment of foreign workers is a general practice in almost all areas of Saudi society, whether working in productive jobs or in performing personal services in homes and private businesses, even where the indigenous workforce is available and able to do the same work (Ibrahim, and Abdul-Fatheal, 1983). Ibrahim (1982:177) points out that it is not uncommon to find a middle class Saudi family living in the city, with an

Indian house-maid, an Ethiopian baby-sitter, a Lebanese or Palestinian employee to manage the family private business, employing a group of Yemeni or Pakistani labourers to build their new villa, while the head of the household employs an Egyptian assistant to perform his government duties for him. The oil wealth of the labour-receiving countries in the Middle East has enabled the indigenous population to become a class of 'masters' who confine their duties to supervision, leaving physical and mental work to be carried out by foreign migrants from all over the world. Therefore, Ibrahim and Abdul-Fatheal (1983) concluded that the wealth of these countries and the ease with which cheap labour can be imported from nearby poor countries, has contributed to and deepened the negative attitude of the indigenous population towards manual and productive work. This attitude has a long history in Arab culture and tradition, and has resulted in wide-spread underemployment in these countries, even though they characteristically possess a small indigenous workforce.

3.3.2 THE IMPACT ON WOMEN

It has been estimated that by the mid-1970s Saudi women comprised less than two per cent of the total active workforce (Al-Issa, 1983). The Third Development Plan 1980-85 anticipated that the Saudi female workforce would reach about six per cent of the total labour force in the country. This low level of women's involvement in the Saudi workforce can be attributed to several socio-cultural factors. Firstly, the women in Saudi Arabia were deprived of any formal education until the opening of the first school for females in 1960. Secondly, women are only allowed to work in certain types of jobs; namely teaching, medical care, and social services. Thirdly, there is a lack of facilities which may encourage women with children to enter the labour market, such as nursery centres. Finally, the typical negative attitude of many Saudis towards the employment of women has been a significant factor in the low level participation of Saudi women in the workforce.

Ibrahim and Abdul-Fatheel (1983:160) rightly argue that the traditional view regarding women's employment has been reinforced as a result of the ease of importing cheap foreign migrant workers. In fact, migrant workers have taken over some of the jobs which Saudi women had carried out for many years. In rural areas, for example, the labour of Saudi women was crucial to the household and

village economy, as women worked in farming and in making dairy products as well other related activities. Beduin women also were deeply involved in raising and herding animals in their desert communities. In recent years, however, women have been ousted from working in many of these activities by the employment of migrant workers in almost all aspects of the Saudi economic life, including those at the village level. Foreign migrant workers from Egypt, Sudan, Yemen, and Pakistan have become a major feature of farming occupations in Saudi Arabia's rural areas. Moreover, in recent years the presence of expatriate migrant workers in Bedouin communities has also become increasingly common. The rearing and herding of animals in Bedouin areas is to a much greater extent carried out by migrant workers. The growing demand for farmers and herdsmen has encouraged private agencies supplying foreign workers in Saudi Arabia to add these groups of workers to their list of services, and to supply 'qualified' farmers and herdsmen to local employers.

In Saudi Arabia's urban centres, women have also lost many of their traditional occupations. For example, self-employed women tailors used to make most of the women's clothing. However, since the early 1980s, this work has been increasingly performed by male tailors largely from the Indian subcontinent. Thus, in recent years a huge number of tailor's shops have been opened, and they are found in every district of cities throughout the country.

Although the government has provided some courses to train Saudi women in the tailoring occupation, the number of these training facilities is very small and they are only available in major cities. More recently, however, a small number of tailoring businesses owned and managed by Saudi women have been opened, but the majority of their employees, if not all, are female migrant workers.

3.3.3 THE CONSEQUENCES OF INTERNATIONAL LABOUR MIGRATION FOR URBANIZATION

Urbanization in this context is used in a demographical sense to refer to the change in the proportion of people living in urban centres, as compared to the total number of a country's population. This section therefore will concern itself with the impact of international labour migration on urban growth in Saudi Arabia.

The population of Saudi Arabia is divided into three distinct groups: urban, rural, and bedouin. The level of urbanization in Saudi Arabia was quite low in 1960, slightly less than 30 per cent of the population lived in urban areas (Ibrahim and Abdul-Fatheal, 1983:157). The reason being that economic development in the country's urban centres up to the early 1960s was very limited, and did not spark off any large scale internal migration from

rural and nomadic areas to the cities. In addition, there was only a small number of resident foreign migrant workers. However, the level of urbanization in Saudi Arabia increased substantially in the period after the early 1970s, when large scale economic development began to take shape. In 1970, for example, the kingdom's level of urbanization reached more than 48 per cent, and further increased to 66.84 per cent in 1980 (Ibrahim and Abdul-Fatheal, 1983). According to Moawad (1987:190) those dwelling in urban areas in Saudi Arabia in 1983, constituted 71 per cent of the total population. He estimated that urban population growth in Saudi Arabia increased by an average of 8.4 per cent annually between 1965 and 1973, and 7.4 per cent a year between 1973 and 1983.

The impact of foreign labour migration on the level of urbanization in the labour-importing countries of the Middle East is very apparent when compared with non labour-importing states. Ibrahim and Abdul-Fatheal (1983:156), note that the level of urbanization is generally high in Arab Gulf states. They further point out that the change in the level of urbanization between 1960 and 1980 was at its highest in the oil rich countries of the Arab World in general and in the major labour importing countries in particular; and that the greatest change in the level of urbanization for the same period was recorded in Saudi Arabia, where it reached 37.12 per cent. This is not

surprising, since Saudi Arabia is the largest labour-importing country in the region.

Moreover, Moawed (1987:192) compared the average annual increase of urban population growth in five of the Gulf States, namely Kuwait, United Arab Emirates, Iraq, Oman, and Saudi Arabia, with other Arab countries. He found that, in the period between 1973-83, the number of urban inhabitants of these Gulf States increased by 7.9 per cent a year, compared to 4.1 per cent in other Arab countries. He also observed that the vast majority of the urban population in most of the Gulf States were concentrated in the capitals and other big cities, to a larger degree than in other Arab nations. One other major difference between urban growth in the Gulf States and other non-oil producing Arab countries, is that in the latter the main causes of urban population increase are internal migration from rural areas, as well as natural increase in urban centres, while urban growth in the Gulf States is due primarily to international labour migration (ibid:193).

The speed of urban growth in Saudi Arabia, particularly after 1973, as a result of increased internal and international migration with little government planning and organization, led to the appearance of a number of serious problems in urban areas. Ibrahim (1982:185), for example, argues that one of the major problems that resulted from the increased number of foreign migrant

workers in the first half of 1970s was the increased pressure on services. The service sector could not cope with the high demand, nor did it expand quickly enough to meet the demand stemming from the new arrivals or the increased demands from the Saudis. In the Summer of 1977, for example, there were fuel shortages in most of the Saudi Arabia's urban centres. Moreover, power failures and the mechanical problems with electricity generators were very common because of the heavy demand for power resulting from the rising electricity consumption as a result of the increased use of air-conditioning and other electric appliances (*ibid*:185). Shortages of fuel and electricity supplies became much less of a problem by the beginning of the 1980s, when many of the infrastructure projects were completed. Indeed, these problems are unheard of today in Saudi Arabia.

One of the most crucial problems which occurred as a consequence of the steady increase in the number of migrant workers to Saudi Arabia's major cities, and to a lesser extent, the internal migration of the 1970s, was the problem of housing. This problem reached its peak in the mid-1970s to early-1980s, as the amount of available housing in major Saudi cities failed to meet the increasing demand. As a result, land prices and rents reached astronomical levels. Ibrahim (*ibid*) points out that housing shortages, high house prices and high rents led to the establishment of shanty towns around the major urban

centres, particularly in Riyadh and Jeddah. These shanty towns were very crowded and lacked electricity supplies, running water, and adequate sanitation facilities. They were inhabited largely by menial migrant workers, some of whom were illegal migrants, as well as by Saudi migrants newly arrived from rural and beduin areas.

The government responded to this problem in the late 1970s by establishing the Real Estate Development Agency (R.D.A.); whereby the government provided interest free loans with easy repayment terms to Saudi citizens not owning houses in order to enable them to build their own houses. In addition, the government undertook massive building projects to provide for accommodation in the three cities of Riyadh, Jeddah and Dummam, where the majority of foreign migrant workers were concentrated. These projects consisted of many large apartment blocks, each of more than 22 stories high.

Although many of these projects were finished by the end of the 1970s, they have remained closed and empty to the present day, apart from a few months during the Gulf crisis when the government accommodated Kuwaiti people in some of them. No official reason have ever been given for this state of affairs, although there have been rumours, unsupported by concrete evidence. Now and then one hears that the government is looking for ways to distribute these flats. It has recently been rumoured that the government is considering selling these flats to the general public.

Nevertheless the D.A. has been a real success and has contributed significantly to the long-term reduction of housing shortages in Saudi Arabia's urban areas. By the mid-1980s, a large number of houses were available in the major cities and consequently rents have come down considerably. Jeddah, for example, experienced acute housing shortages between the mid-1970s and the beginning of 1980s, and rents were among the highest in the country. However, by the second half of the 1980s rents in Jeddah had come down significantly. For example, whereas an average 3-4 bedroom flat used to be rented at around S.R.25-30,000 a year in the mid-1970s, at present, it would cost around S.R.12-15,000.

CHAPTER FOUR

PUBLIC HEALTH AND MEDICAL CARE IN SAUDI ARABIA

4.1 HEALTH PROVISION IN SAUDI ARABIA: AN OVERVIEW

Many of the health problems and diseases of the developing countries are associated with extreme poverty, poor environmental conditions, lack of clean water, and poor nutrition. All of these contribute to the widespread incidence of such diseases as typhoid, cholera and infectious diarrhoea (Bryant, 1969; Gish, 1977). Modern curative medicine, rather than preventive medicine, dominates the health services of developing countries (Cumper 1984). As the costs of modern curative medicine have risen beyond the means of many developing countries, and chronic shortages in human health and medical resources have been exposed, particularly in rural areas, the task facing social planners and health personnel is to try to provide low-cost preventive health programmes for the largest number of people (Benyoussef, 1977).

Although social planners believe that it is the government's responsibility to care for the health of it's people, there is general concern that many governments give too low a priority to public health. In contrast, economists, often hold the view that health expenditure in developing countries is a diversion of scarce resources

away from the productive investments needed for economic development (Hardimann and Midgley, 1982 : 153).

This is undoubtedly a complex issue and as Abel-Smith and Leiserson (1978:22) point out, "the precise relationship between expenditure on health services... and improvements in health are hard to establish", but the evidence nevertheless suggests that ill-health is economically wasteful in developing countries. Based on the few available studies, the World Bank provides an indication of the impact of ill-health on economic activity.

"Illness disrupts normal activity for roughly one-tenth of people's time in most developing countries. Many of the 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."
(World Bank, 1980 :11)

Abel-Smith and Leiserson (1978) also point out that water-borne diseases in developing countries have led to undercultivation, underproductivity and migration from certain areas. Clearly, from this evidence, cost factors must be given a great deal of consideration in the formulation of health and medical policies and in deciding between different types of health services in developing countries.

There appear to be wide variations among developing countries in both the level of provision^{of} health resources

and their distribution among the various types of facilities and human resources categories; particularly with regard to the distribution between rural and urban areas (see, for example, Navarro, 1974:22; Macpherson, 1982:99). In general, developing countries experience a great shortage of trained health and medical personnel (Fendall 1972:207).

An additional problem arises because of the fact that existing health and medical training is primarily modelled on western systems of education. More often than not, this training proves inappropriate or inadequate for dealing with the health and medical problems of developing countries, which require a more preventive approach to health provision (Hardiman and Midgley, 1982 :174).

In one analysis of the provision of health resources major variations were noted among the various regions of the Third World (Golladay 1980). Latin America had the most developed health infrastructure, South-East Asia appeared to be relatively well developed, Africa was poorest on virtually all measures but the Middle East contained enormous variations which could be largely explained in terms of the oil rich states.

The oil-based wealth of a country such as Saudi Arabia provides a context within which to examine the influence of economic factors on the availability of resources and the development of health and medical services. It is against this background that the provision of health services and

medical care in Saudi Arabia, as well as the issue of health and medical human resources, will be considered.

Prior to the creation of the kingdom of Saudi Arabia by the late king Abdul-Aziz in 1932, there were hardly any formal health care facilities in the Arabian Peninsula, apart from the Hijaz region in the West of the country. In 1926 there were 2 small hospitals in Mekkah and Jeddah, which were founded by the Ottoman Empire during its rule of the Hijaz region, to care for pilgrims. When king Abdul-Aziz took over the Hijaz, these 2 hospitals became the basis of the evolution of the Saudi Ministry of Health. At first they operated under the Health Directorate in Mekkah, which was the first government body for health provision in Saudi Arabia. The services were expanded mainly in the Western region and later to other parts of the country, as other branches of Health Directorates were opened in Medinah, Jeddah, Asir, Riyadh and Al-Hasa. In, 1931 the Directorate of Health and its branches were integrated into the Ministry of Interior. Health provision continued to expand steadily to cover all parts of the country. In 1951 the Ministry of Health was founded and became the major provider of health services.

The Saudi health service, from its establishment in the 1950s until the 1960s, developed slowly because of limited financial resources. Indeed, the early stages of the development of the health services in Saudi Arabia

experienced some serious difficulties. For example, in its early years of growth the health system was not guided by specific plans and strategies. It was not until the 1960s that the Ministry of Health and the Central Planning Organization, with the help of the World Health Organization, constructed a plan to provide comprehensive health services for the inhabitants of Saudi Arabia (Al-Ribdi,1990:45). The development of Saudi health services was also constrained by a lack of competent management. Al-Mubarak (1989:192) points out that the efficient management of the health services did not develop with the same pace as the organizational structure of the health system. Gaznawi describes the way in which the Ministry of Health conducted its operation during the early stages of its establishment:

"Beginning with its establishment in 1951, the Ministry of Health functioned for years on the basis that the personal efforts of operation depended more on individuals than on an objective management structure or plan. However, as the demand for a more improved health service occurred, this method of operation proved unworkable to all and the development of an organizational manual was agreed upon as the focus for that organization".

(Gaznawi, 1982:103)

In 1969 the Ministry of Health underwent major organizational and managerial changes, based on a detailed study of the Saudi health system by the Ford Foundation (Al-Mubarak,1989). The rapid rate of growth in the health

services during the second half of the 1970s led to yet another major reorganization of the Ministry of Health in 1983. Among the changes involved were a series of reorganizations of the regional health authorities. When regional health authorities were first established in the 1950s, there were six of them. These were increased to ten in the 1960s, only to be cut down to eight in the 1970s, and were finally expanded to fourteen to cover all the fourteen provinces of the country (Al-Ribdi,1990:52-3). These fourteen regional health authorities are situated in major urban areas, each headed by a General Health Director. However, they have very limited influence over formulating health policies and decision-making concerning their provinces. In fact, their prime duty is to implement the health policies and regulations made by the Ministry of Health headquarters in Riyadh. The communication between the General Directors of the various regional health authorities and the Minister is quite poor, as there are no direct links between them, nor among the General Directors themselves. This means that there is a lack of proper exchange of experiences and resources between the various regional health authorities (Al-Mubarak,1989:196).

This centralized system of control by the top management level in the Ministry of Health headquarters is a reflection of the political structure in the country as a whole, where policy formulation and decision-making are strictly controlled by the government and its various

Ministries. Al-Ribdi (1990:57) identified three main consequences of adopting this centralized system of control for health provision. Firstly, the General Directors of regional health authorities have to rely on personal contact with top people in the Ministry of Health for help in accomplishing their requirements. This may lead to inconsistencies in decision-taking and therefore in health provision. Secondly, as a result of decision-making being controlled by the Ministry of Health, there is a lack of trained administrative personnel in the regional health services establishments. The policy of the Ministry to favour the use of doctors and pharmacists to administer these establishments, instead of a trained administrators, suggests that resources are being used inefficiently. Thirdly, the financial system of the Ministry of Health and its relations with other government funding agencies are both centralized. This means that the Ministry of Health cannot fund new projects without the approval of other concerned agencies, and this inevitably leads to slow and extended decision-making.

4.2 MINISTRY OF HEALTH

The wealth arising from oil revenues provided Saudi Arabia the impetus for rapid development in various sectors, including the health sector. The budget allocations for the Ministry of Health have increased immensely over the years, in conjunction with the rise in government oil revenues. For example, the first budget for the health services, in 1948, amounted to only S.R.5 million (Al-Ribdi,1990:59). In 1961, the Ministry of Health received over S.R.58 million, and the allocation more than doubled by the mid-1960s. Table 6 shows that a huge growth in budget allocations for the health services took place throughout the second half of the 1970s. The 1975 budget, for example, amounted to S.R.1,163 million, an increase of more than 85 per cent over that at the beginning of the decade. By 1980 it had trebled. Furthermore, government expenditure on the health service continued to rise during the 1980's, despite the decline in oil revenue during the second half of the 1980's. Although Table 6 shows that in 1987-88 the Ministry of Health budget fell slightly, as economic conditions in the country deteriorated, yet the Ministry continued to receive a larger overall proportion of government resources than in previous years.

Table 6

**The Growth of the Ministry of Health Budget,
in Selected Years (million Saudi Riyals)**

Year	National Budget	Ministry Budget	% of Total Budget
1961	1,786	58,4	3.3
1963	2,452	87,5	3.6
1965	3,112	117,4	3.8
1967	5,025	160,0	3.2
1970	5,966	168,3	2.8
1973	13,200	420,9	3.2
1975	45,734	1,163,0	2.5
1977	131,296	2,972,2	2.3
1979	144,558	4,040,5	2.8
1980	180,285	4,177,0	2.3
1982	298,000	7,709,7	2.6
1984	260,000	8,401,0	3.2
1985	200,000	8,814,5	4.4
1986	200,000	8,814,5	4.4
1987	170,000	8,333,4	4.9
1988	141,200	7,735,0	5.5

**Source: Ministry of Finance and National Economy,
Statistical Year Book, Various Issues; Ministry
of Health Annual Medical Report, 1988**

4.3 PUBLIC HEALTH SERVICES

The Saudi Ministry of Health is formally the major provider of health services and medical care to the general public. It provides both free medical treatment and free prescriptions, from its general as well as specialized hospitals, and primary health care centres.

The government's high spending on Ministry of Health medical care services, has resulted in a dramatic increase in the number of medical care facilities. Table 7 shows that in the period from 1970 to 1980 the number of hospitals grew from 47 to 69, an increase of around 32 per cent; the total number of beds rose by 40 per cent over the same period. The table also shows that the growth in the number of Ministry of Health hospitals from 1979 to 1983 remained moderate, although they increased by slightly more than 10 per cent and number of beds was 40 per cent higher in 1983 than in 1979. However, the number of hospitals and beds in the period between 1983 to 1987 increased by 112 per cent; the number of beds grew from 15,387 to 25,902, at an average annual rate of more than 13 per cent.

Prior to 1981 the Ministry of Health operated two main types of health facilities. The smallest were the health posts, which used to function in rural and remote regions. These health posts were run by a single doctor and a small number of nursing staff, who provided basic medical care services. The second type of medical facility, no longer

in existence, were known as "health dispensaries", and were mainly located in towns and major rural centres. These dispensaries were operated by a few doctors and nursing staff, and supplied general medical care and emergency services on a larger scale than those provided by the health posts. Table 7 shows that during the 1970s their number grew at a relatively moderate annual rate.

Table 7

The Growth of Health Facilities Provided by
The Ministry of Health, Selected Years

Years	No. of Hospitals	NO. of Beds	No. of Primary Health Centres
1970	47	7,165	519
1973	51	8,132	533
1975	62	9,250	631
1979	67	10,978	824
1980	69	11,968	889
1981	70	13,066	935
1982	72	14,333	973
1983	74	15,387	1,084
1984	86	17,961	1,119
1985	105	20,796	1,306
1986	141	23,862	1,431
1987	157	25,902	1,438

Source: Ministry of Finance and National Economy,
Statistical Year Book, Various Issues; Ministry
of Health Annual Medical Report, 1987

Early in 1981 the Ministry of Health changed the names and operations of these medical establishments, and they became known as "primary health care centres". In that year, the Ministry established 78 new primary health care centres around the country, and their number has steadily increased ever since. In 1983, more than 100 primary health care centres were opened, bringing their total number to over 1,000 centres. By 1987 their number had risen to 1431, an increase of more than 32 per cent over the 1983 figures (see Table 7). This newly-formed type of health care service is designed to function as the first point of contact between patients and the public health and medical care system. Through them, general, and some specialized, treatments are readily available to the general public in their localities. After the introduction of primary health care centres on a larger scale in rural and urban centres, the average number of people benefiting from any single one of these facilities has dropped in recent years. In 1987, for example, the average number of individuals served by each one of the centres stood at 7774, compared to 8280 in 1983 (Ministry of Health Annual Medical Report, 1987:32).

4.3.1 HEALTH PROVISION BY OTHER GOVERNMENT AGENCIES

In addition to the medical care provided by the Ministry of Health, many other government ministries and agencies provide health services for their employees and their dependants. These services include hospital and primary health care. The scale and the type of provision varies considerably from one ministry or agency to another.

The Ministry of Defence and Aviation is the major provider of health services among these government institutions in Saudi Arabia. Its medical care services are available mainly to the Saudi armed forces personnel and their dependents, other members of the security forces, and to a lesser extent to the general public, through the referral system. The Ministry of Defence and Aviation facilities, which include large hospitals and primary health care centres are generally of better quality than that provided by the Ministry of Health.

The Ministry of Defence has large modern hospitals in major cities and in strategic areas. It has 4 hospitals with 851 beds in Central province, 3 hospitals with 652 beds in Eastern province, 4 hospitals with 863 beds in Western province, 6 hospitals with 482 beds in the Southern province, 1 hospital with 300 beds in Northern province, and 3 hospitals with 487 beds in North Western province (Ministry of Health Annual Medical Report, 1988).

The National Guard also provides medical care services for its employees and their families through a large network of primary health care centres in many parts of the country, particularly in the Central, Western, and Eastern provinces where many of the National Guard centres and complexes are found. In addition, two large hospitals have been built in recent years. These are: King Fahad Hospital in Riyadh which has a total capacity of 406 beds, and King Khalid Hospital in Jeddah with facilities for 316 beds (ibid: 263).

The Ministry of Interior is the smallest provider of health services for its employees and their families. It was only recently that the Ministry opened a hospital in Riyadh with a capacity of 116 beds (ibid: 341). Apart from this, the Ministry has only a limited number of health centres. Its employees, however, have access to free treatment in the Military and National Guard health facilities. The Ministry of Interior also provides health care facilities for prisoners. It has 34 primary health care centres in prisons around the country (Al-Mubarak, 1989:203).

Other government agencies providing health services are the Boys' and Girls' School Health Units. These provide health care to school students and staff through a large number of primary health care centres all over the country. The Ministry of Education is primarily responsible for the provision of health services to school

children and members of staff, while the General Administration for Girls' Education is the chief provider of education and health care to female pupils in Saudi Arabia. Both School Health Units also provide vaccination treatment to school pupils through a comprehensive immunization programme.

University students, members of staff and their families are provided with health and medical care facilities by the Ministry of Higher Education. Saudi Universities and their branches provide medical centres on their campuses. Three Universities have hospitals which belong to their medical faculties. In addition to being used to train medical students, these provide health care for staff, students, and the general public in their area. The largest of these University hospitals is King Fahad Hospital in Kobar, part of the King Faisal University in Dammam, with a capacity of 420 beds. The King Abdul-Aziz University Hospital in Jeddah has a capacity of 234 beds, and King Abdul-Aziz University Hospital in Riyadh, with a capacity of 132 beds (*ibid*).

The Saudi Red Crescent Society also plays a vital role in providing health care for the general public. The Society has 140 First Aid Centres, and 498 emergency and ambulance centres all over the country (Ministry of Finance and National Economy, Statistical Year Book, 1989:173). Its main duties are to provide emergency services to those who are involved in road accidents, fire victims, and other

types of casualties. The Society's emergency services include first aid treatment and transporting the injured and the sick to hospitals. Another major duty of the Society is to provide emergency services to Pilgrims during Hajj, when it intensifies its work in the Holy places in Mekkah and Medinah. The Society provides its services through a fleet of ambulance stations, some of which have first aid facilities, in urban areas, as well as on road-side and motorway positions. In addition, the Society operates 14 primary health care centres supplying primary medical care and emergency services to the general public, and to those involved in accidents in major cities (Alshammasi,1986:117).

One additional public health service is provided for the general public through King Faisal Specialist Hospital and Medical Research Centre in Riyadh. The hospital is the most well-equipped and sophisticated of its kind, not only in Saudi Arabia, but in the Gulf region as a whole. It provides advanced and specialized treatment to any patient on a referral basis. The hospital has an overall capacity of 508 beds. It provides cancer treatment, and carries out organ transplants and other delicate and complicated surgical operations which are not readily available in other medical care establishments.

In addition to these public health services there are a number of other government agencies which provide limited medical care facilities for their members and

their families, as well as the general public in their areas. These include: The Royal Commission for Jubail and Yanbu, The General Organization of Social Insurance, Ministry of Labour and Social Affairs, Ministry of Municipal and Rural Affairs, and The General Presidency of Youths.

The involvement of such a large number of public institutions in the provision of public health and medical care means that some services are duplicated, and there seems to be little attempt to co-ordinate between the various providers of public health at the national or local level (Al-Mubarak,1989:213). A number of problems have been arisen due to this lack of co-ordination. Al-Mubarak (*ibid*), for example, points out that the absence of co-ordination between the various governmental providers of health care have prevented co-operation among them, leaving the Saudi health system fragmented and disorganized. He goes on to argue that, the fact that the Saudi health system is not unified provides scope for the many different public health service agencies to develop and implement their policies and plans in accordance with their own needs and objectives. This creates duplication in health provision, and in turn increases the likelihood of wasting valuable resources. A special report by one of the Saudi Arabia's leading weekly magazines (Al-Yammama, 1987-Issue:932; referred to by Al-Mubarak,1989), concluded that the lack of coordinated public health services

resulted in confusion among the people with regard to which appropriate health care establishment to approach. The report also indicated that some patients may need to obtain health care in more than one health care facility, and because the various public medical care agencies do not co-ordinate their efforts for the treatment of patients, there may be unnecessary delays in the treatment of patients, with undesirable repercussions.

The participation of many different public institutions in the provision of health and medical care in Saudi Arabia has meant that some cities enjoy more health and medical care services than others; e.g. depending on within which cities the ministries and other public agencies, or their branches, which provide health services are located. In addition, the fragmentation of resources allocated to so many different government providers of health services has resulted in variations in the quality of medical care provided. In this regard, the larger institutions are able to provide better services than others. The inefficiencies of the Saudi health system can be further illustrated by noting that, although the Ministry of Health provides health and medical care services to about 80 per cent of the Saudi population, it only receives 49 per cent of the resources allocated to health and medical care provision in the entire country (Al-Ribdi, 1990:51).

4.4 THE GEOGRAPHIC DISTRIBUTION OF PUBLIC HEALTH SERVICES

With the exception of the Ministry of Municipal and Rural Affairs and the Red Crescent Society, the majority of the government institutions providing health and medical services are concentrated in major cities, especially in the two largest cities of Riyadh and Jeddah. Published official statistics concerning the distribution of health facilities of these agencies are lacking in detail and scarce. The following discussion therefore concentrates on the geographical distribution of the Ministry of Health's health and medical care services.

4.5 MINISTRY OF HEALTH HOSPITALS

Kanauarhase (1975) and Lackner (1978) pointed out that at in the mid-1970s most of Saudi Arabia's health care services were situated in urban areas and major population centres. This is still largely the case today. The Ministry of Health Annual Medical Report for 1988 shows that the overwhelming majority of general and specialist hospitals as well as hospital beds were concentrated in the major cities of Riyadh, Jeddah, Mekkah, Medinah, and Taif. The Report also shows that the capital city of Riyadh possessed the lion's share of the total number of hospitals

and the number of beds for the entire country. The city possessed 16 per cent of the total number of hospitals and slightly under 20 per cent of the total number of beds in the kingdom. These percentages would have been even greater if the similar facilities provided by other government institutions had been taken into account. The uneven distribution of hospital care services clearly manifests itself with regard to the distribution of maternity hospitals. The 1988 Annual Medical Report shows that whole regions as well as relatively large cities are deprived of these essential health services. For example, the cities of Jizan, Najran, and Aseer region, which comprises a prominent part of the South Western province and which accommodates 17 per cent of the total population of Saudi Arabia, have no maternity hospitals. Similarly, Ha'il city, the largest city in the Northern province which inhabited by more than half of the population of that province, also lacks such facilities.

4.5.1 MINISTRY OF HEALTH PRIMARY HEALTH CARE CENTRES

The main purpose of primary health centres is to provide health care services as close as possible to the localities in which patients reside, and particularly to those populations who live far away from hospital-based

care facilities. However, the major urban centres, which possess most of the hospital facilities, also possess a large share of the primary health centres. As with the location of hospitals, the five major cities of Riyadh, Jeddah, Mekkah, Taif, and Medinah, contain almost 39 per cent of the total number of primary health care centres in the country (Ministry of Health Annual Medical Report, 1988). Over 16 per cent of primary health care centers are located in the city of Riyadh. By contrast, the whole of the Eastern and Northern provinces, which consist of a large number of rural and remote settlements where there is a great need for primary medical care services, have only 11 and 10.8 per cent respectively of the total number in Saudi Arabia. This clearly indicates a serious imbalance in the distribution of basic health care services among the various regions of the country.

In recent years, the Ministry of Health has added dental treatment to the services provided by its primary health care centres. Again, the provision of those basic and important services seems to follow the same general pattern of uneven geographical distribution, with major cities absorbing the largest share of the facilities. Not only do the remote and relatively small towns and cities of Saudi Arabia have fewer primary health care centres, these centres are also less well-equipped in terms of the availability of diagnostic facilities such as laboratories and X-ray services.

4.6 PRIVATE HEALTH CARE SERVICES

The health and medical care provided by the Ministry of Health and other government establishments is complemented by the private health and medical sector. The private sector provides four different types of medical care facilities. The main such service is hospital care. The overwhelming majority of private hospitals in Saudi Arabia provide both out-patient and in-patient facilities, as well as 24-hour emergency services. The second main type of private health care provision is that supplied by health clinics. These provide general as well as specialized out-patient medical care services. The most commonly provided specialized health and medical services include, internal medicine, pediatrics, gynecology, and treatment for ear, nose and throat disorder. These clinics are also required by Ministry of Health regulations to provide diagnostic facilities such as X-rays and laboratories. The majority of private health centres also provide 24-hour emergency services, 7 days a week.

Another type of private health and medical care provided is that which is known locally as 'Collective Private Surgeries'. These mainly provide a number of specialized out-patient services. The main difference between these "Collective" surgeries and the private health clinics, is that the latter do not provide diagnostic facilities or 24-hour emergency services. Single-handed

private surgeries are the fourth basic type of private medicine found in Saudi Arabia. In these a doctor, assisted by one or two medical personnel, provides general, as well as a whole range of different specialized, treatment.

The emergence of the Saudi private health sector has been relatively recent. However, the number of private medical care establishments has dramatically increased in recent years. Table 8 shows that in 1970 there were 19 hospitals, in the private sector, with less than 1,000 beds in the entire country. Although the number of private hospitals had risen only slightly by the end of the 1970s, the number of beds in private hospitals more than doubled. The same trend continued until the mid-1980s, when the number of both private hospitals and beds in those hospitals rose considerably. Table 8 shows that in one year, between 1984-85, eight more hospitals were opened in different parts of Saudi Arabia. Another major upsurge in the number of newly established private hospitals occurred in 1988. Twelve private hospitals were established in that year alone, bringing the number of private hospitals in the country to 55 with 5,906 beds, an increase of 96 and 54 per cent, respectively, over their number in 1981 (see Table 8).

Table 8

The Growth of Private Health Facilities
in Saudi Arabia, Selected Years

Year	Number of Hospitals	Number of Beds	Number of Health Centres
1970	19	944	-
1975	22	1,195	-
1978	22	1,328	-
1979	25	2,019	22
1981	28	2,685	64
1982	31	3,264	105
1983	32	3,440	164
1984	31	3,412	184
1985	40	3,993	224
1986	41	4,474	226
1987	43	5,019	272
1988	55	5,906	313

Source: Ministry of Health Annual Medical Report,
various issues.

As regards the growth of private health centres in Saudi Arabia, Table 8 shows that their number has immensely increased in recent years. This huge increase came about from 1983 onwards as a result of a new government regulation introduced in that year. This regulation made it much easier than before to obtain permission to operate private health centers (see below). Table 8, for example, shows that 59 new health centres were opened in 1983, and that their numbers continued to increase at an average of around 26 units a year.

There is a general lack of available official statistics concerning the emergence and activities of collective and single-handed surgeries in Saudi Arabia. It was only during the early 1980's that the Ministry of Health began to release very limited information regarding the number of these establishments and the type of medical services and specialities they offer. In 1983, for example, there were only 2 collective surgeries in Riyadh and Jeddah, and 473 single-handed surgeries, the vast majority of which offered general medical care (Ministry of Health Annual Medical Report, 1983:264). In 1988, the number of collective surgeries stood at 37 establishments, a huge increase over the figure for 1983. The number of single-handed surgeries in 1988 stood at 592 units. About 33 per cent of the doctors running these services were general practitioners, 20 per cent were dentists, 10 per cent were pediatricians, and another 9 per cent were gynaecologists (Ministry of Health Annual Medical Report, 1988).

The rapid growth of private health and medical services can be primarily attributed to the strong encouragement given by the government to the participation of the private health sector in health provision, in order to take the pressure off the Ministry of Health. The government's commitment to the private health care manifested itself in the immense financial support given to these enterprises. The government provides interest-free

loans of up to 50 percent of the cost of establishing private medical enterprises, including hospitals, health centres, and collective private surgeries. The loans themselves involves easy, long-term repayments. The Ministry of Health also guaranteed payments to the value of 10 to 15 percent of private hospital beds annually (Ministry of Health Annual Medical Report, 1983).

The accelerated growth of the private health sector also resulted from a simplification of the licensing procedure, introduced by the Ministry of Health in 1983. Consequently the number of private medical care establishments continued to increase throughout the 1980s (see Table 8). The new regulations make it possible to obtain licenses in order to open health centres, collective surgeries, and single-handed surgeries from any branch of the Ministry of Health's regional General Directorates where the private health enterprises are to operate. Licenses can be obtained without the need for direct approval from the Ministry of Health. Permission to open private hospitals, however, still must be obtained directly from the Ministry of Health headquarters in Riyadh.

The new regulations have also made the procedures and processing of license applications as easy as possible. For example, applicants are required to complete an application form designed by the Ministry of Health. This form can be obtained from any General Directorate of the Ministry of Health in the country. The application form is

short and straightforward. The applicant must specify the type of private medical care establishment he intends to operate; whether it is a private health centre, collective surgery, laboratory, specialized health club, private surgery, or hospital. The area of the country (i.e. city, town's name) and the address of the proposed service must be identified, together with an estimate of the capital to be invested. The remainder of the application form concerns basic information about the applicant; such as the applicant's name and qualifications, date of birth, nationality, and address. After filling in the required information, the applicant then submits the application to the Medical Licensing Department of the General Directorate of Health in his region. A committee from the department meet to discuss the application and to prepare a memorandum about whether or not the application has gained initial acceptance. If the application is initially accepted, a letter will be given to the applicant with the other papers required, and details of the requirements which the applicant must meet before final acceptance is granted. In accordance with the regulations of the Ministry of Health, the items an applicant is required to supply include: 2 passport-size photographs of themselves; a photocopy of their identity card; a photocopy of the building rental contract or the building lease; a detailed drawing of the building, showing surgeries and other facilities; and details of the number and names of the

medical team for which the applicant needs to obtain work permits. The committee will then check the building identified as the site of the proposed project to see if it meets with the requirements of the Ministry of Health. This is done within approximately one week of the applicant's submission of the required documents. If the committee is satisfied that the building complies with the regulations, the applicant will be granted permission. The applicant will also given a date to obtain work permission for the medical team, with a time-scale of one to two weeks, depending on the number of persons needing work permits.

The Ministry of Health regulations also permit Non-Saudi doctors working in Saudi Arabia to open their own private surgeries, on the condition that they have worked in the Ministry of Health or in some other public health services for at least six years. The regulations also permit distinguished Non-Saudi specialists and consultants from outside the country to open their own private surgeries.

An additional factor in the expansion of the private health care services in Saudi Arabia is the increasing demand from the general public for these services. Their high standard of living allows Saudi nationals to constitute a major part of the client groups who use private health and medical facilities (Alshammasi, 1986:126). Foreign migrant workers also constitute an

important group of users of private health and medical services, since Saudi labour laws oblige any employer employing more than 20 workers to be responsible for their health requirements. Such employers either have to provide their own health and medical facilities, or approach the private medical care services. In most cases, the latter alternative proves to be better from a cost-benefit viewpoint.

It is widely believed that the quality of medical care in the private health sector is much better than that found in the Ministry of Health's health and medical facilities. One important reason for this belief is that health and medical establishments in the private sector employ a large number of qualified specialists and consultants in almost all medical specialities to whom there is easy access, which is not the case in the public sector. For example, the majority of doctors in the primary health care centres provided by the Ministry of Health are general practitioners, in contrast to the situation in private clinics. The Ministry of Health employs a large number of specialists but it has a limited number of consultants, whereas the private health sector provides substantial consultancy services, even in health centres and collective surgeries.

Opening hours in the private sector are longer and held at convenient times for the public. All over Saudi Arabia private surgeries, clinics and hospitals, open in

two sessions; one in the morning and the second in the evenings. Large private hospitals tend to provide consultants' and specialists' services as late as 11 pm, whereas the Ministry of Health hospitals close at 5.30 pm, and no later than 7 pm in the case of primary health care centres. Although only public hospitals offer emergency medical services 24 hours a day, private hospitals and a majority of private clinics provide similar services in addition to sending medical personnel on home visits, and providing ambulance services, which are not available in the Ministry of Health run medical care services. The private medical sector also provides some forms of treatment which are not widely available in the public sector, such as plastic surgery and in vitro fertilization. In addition, private hospitals frequently bring visiting consultants and well known specialists from the Arab World, Western Europe and the United States of America. Doctors in private medical care establishments give patients a great deal of time and attention during examinations. The majority of these establishments also usually give patients up to 7 days to come back for consultation and a follow-up examination free of charge. In contrast, doctors in the public sector tend to examine a large number of patients and therefore are not able to allow for long periods for examination. Patients seeking treatment in the private sector do not have to spend lengthy periods waiting to see the doctors. These private

establishments are not very crowded, unlike public medical care establishments. Another factor contributing to the popularity of the private medical facilities is their location in the cities. In large cities, there is at least one private health centre in almost every district.

4.7 HEALTH, MEDICINE AND HUMAN RESOURCES

Saudi Arabia's health and medical services in both the Ministry of Health and the private sector are extremely short of indigenous personnel. As far as health and medical personnel are concerned, Table 9 shows that Saudi doctors account for only 7 percent of the 16,270 doctors working in the Ministry of Health. The Table also shows that the number of Saudi doctors working in the Ministry increased steadily between 1977 and 1988, when their number rose by an average annual rate of around 8 per cent. However, the proportion of indigenous doctors working in the public health and medical services remained very small, and in some years this proportion has fallen as a result of the rapid expansion of Ministry of Health services (see Table 9).

Table 9

The Number of Doctors Working in the Ministry
of Health by Nationality in Selected Years

Year	Saudi	Non-Saudi	Total	% of Saudis
1977	144	2054	2198	6 %
1979	229	3835	3378	7 %
1980	201	4343	4550	4 %
1981	277	5313	5585	5 %
1982	346	6303	6649	5 %
1983	464	8101	8566	5 %
1984	592	9374	10966	5 %
1985	726	9438	12199	6 %
1986	900	12426	13326	7 %
1987	1139	13738	14877	8 %
1988	1161	15109	16270	7 %

Source: Ministry of Finance and National Economy
Statistical Year Book; Ministry of Health Annual
Medical Report, Various Issues

However, the proportion of Saudi doctors employed in the Ministry of Health is much lower in some specialities, which are predominantly occupied by foreign doctors. Table 10 shows that the overwhelming majority of Saudi doctors working in the public sector are general practitioners; they constitute around 72 per cent of the total number of doctors in the Ministry of Health. The table further discloses that the public health services are extremely short of indigenous general surgeons as well as specialist surgeons such as those trained to perform plastic, bone, heart, brain and nerve surgery.

Table 10

The Distribution of Doctors Working in
The Ministry of Health Doctors by
Speciality and Nationality, 1988

Speciality	Saudis	Non- Saudis	Total	% of Saudis
General Medicine	775	5706	6481	12 %
Dentistry	51	803	854	6 %
Internal Medicine	26	429	455	6 %
General Surgery	2	45	47	4 %
Chest & Heart Surgery	2	25	27	7 %
Plastic Surgery	-	31	31	0.0 %
Brain & Nerve Surgery	1	44	45	2 %
Bone Surgery	1	205	206	0.5 %
Urinary Tract	7	122	129	5 %
Gynaecology	47	574	621	7 %
Paediatrics	31	473	504	6 %
E.N.T.	8	185	193	4 %
Ophthalmology	19	195	214	9 %
Chest Diseases	3	117	120	2 %
Dermatology	14	107	121	11 %
Psychiatry	16	132	148	11 %
Community Health	21	97	118	18 %
Radiology	9	173	182	5 %
Laboratory Specialists	8	280	288	3 %
Anaesthesia	2	352	354	0.6 %
Physiotherapy	2	39	41	5 %
Others	12	276	288	4 %
Over all total	1081	10859	11940	9 %

Source: Ministry of Health Annual Medical
Report, 1988

The majority of Saudi doctors work in the Ministry of Health hospitals in the major cities. Table 11 shows that 78 per cent of the total number of Saudi doctors employed by the Ministry work in the major cities of Riyadh, Jeddah, Mekkah, Medinah, and Taif. Table 11 also shows that some small cities and remote areas have very few Saudi doctors

working in their hospitals. Indeed, some have none at all. Furthermore, the table shows that only a small minority, less than one-and-a-half per cent, of indigenous doctors are to be found working in Ministry of Health run primary health care centres. The reason for this may well be that Saudi doctors are attracted to work in hospitals because medical facilities and working conditions are far better there than those found in primary health care centres. In addition, doctors employed in primary health centres tend to perform only routine duties, whereas in hospitals there is the opportunity to deal with advanced and complicated cases in a good working environment and thereby gain more and valuable experience. Further, in hospitals doctors have the opportunity and advantage of working with a large team of doctors who provide a whole range of different specialties, and who possess higher qualifications than those working in primary health centres.

Table 11

The Distribution of Doctors working Hospital
and Primary Health Centres of the Ministry
of Health by Area, and Nationality, 1988

Area	Hospital				Primary H centres			
	Saud	Non-Saudi	Total	% of Saud	Saud	Non-Saud	Total	% of Saudi
Riyadh	243	1366	1609	15.1	14	688	702	2.0
Jeddah	327	510	837	39.0	16	238	254	6.3
Mekkah	108	574	682	15.8	2	161	163	1.2
Taif	32	438	470	6.8	1	200	201	0.5
Al-Baha	21	253	274	7.6	-	123	123	-
Medinah	42	597	639	6.5	1	294	295	0.3
Tabuk	1	205	206	0.5	-	56	56	-
Al-Sherqia	155	521	676	22.9	8	253	261	3.0
Al-Ahssa	12	204	216	5.5	2	82	84	2.4
Hefer Al-Battin	-	82	82	-	-	59	59	-
Aseer	6	590	596	1.0	1	355	356	0.3
Najran	1	205	206	0.5	-	96	96	-
Jizan	7	468	475	1.4	-	219	219	-
Qaseem	3	674	677	0.4	-	278	278	-
Northern Border	1	96	97	1.0	-	58	58	-
Al-Joff	-	107	107	-	-	43	43	-
Al-Qriyat	-	81	81	-	-	19	19	-
Hayil	1	159	160	0.6	-	137	137	-
Total	960	7121	8081	11.9	45	3359	3404	1.3

Source: Ministry of Health Annual Medical Report, 1988

The Ministry of Health also depends very heavily on foreign paramedical staff in its hospitals and primary health care services. As shown in Table 12, Saudi nurses account for only about 10 per cent of the total number of nursing staff working in Ministry of Health run hospitals

and primary health care centres. By contrast, the proportion of Saudi technicians in the Ministry of Health is much higher in comparison with that of the nurses; Saudi technicians constitute one third of the total number of medical technicians in the national health service (see Table 12).

Table 12

The Percentages of Saudi Nurses and Technicians Working in the Hospitals and Primary Health Care Centres of the Ministry of Health, 1988

Medical Personnel	Hospital				Primary Health Centres			
	Saudi	Non-Saudi	Total	% of Saudi	Saudi	Non-Saudi	Total	% of Saud
Nurses	1575	16433	20167	7.8	773	5897	6670	11.5
Techn.	2679	8034	10713	25.0	869	2670	3539	24.5

Source: Ministry of Health Annual Medical Report, 1988

As regards the health and medical human resource situation in the private sector, only a small minority of Saudi medical personnel are employed in private hospitals and health clinics. Foreign medical personnel dominate all levels of the medical profession in the private sector. The 1988 Ministry of Health Annual Medical Report discloses

that out of the 10,669 nurses and technicians employed in private hospitals and clinics, only 319 or 3 per cent, were Saudi nationals.

However, the number of Saudi doctors in the private sector has very slightly increased over the years, unlike that of their counterparts in the Ministry of Health. Table 13 shows that the proportion of Saudi doctors in the private health sector fell from around 5 per cent during the late 1970s to about 2 per cent for most of the 1980's. On the other hand, the number of foreign doctors working in private health care services rose dramatically during the same period of time. Table 13 shows that the number of expatriate doctors working in Saudi Arabia doubled between 1977 and 1979. By 1988, the number of such doctors exceeded 4,000 , an increase of more than 5 times their number in 1980 (see Table 13).

It is worth noting that the majority of the Saudi doctors working in the private sector perform administrative tasks, since most of them are the owners of the private medical establishments where they work. This is particularly so for private hospitals, where the Ministry of Health regulations in recent years require the owners of such medical facilities to be qualified doctors and of Saudi origin.

Table 13

The Number of Doctors Working in the
Private Sector by Nationality
in Selected Years

Year	Saudi	Non-Saudi	Total	% of Saudis
1977	18	317	335	5 %
1978	16	330	346	5 %
1979	30	626	656	5 %
1980	34	723	757	4 %
1981	20	947	967	2 %
1982	29	921	950	3 %
1983	24	1116	1140	2 %
1984	39	2437	2476	2 %
1985	46	2896	2942	2 %
1986	54	2913	2967	2 %
1987	64	3487	3551	2 %
1988	80	4250	4330	2 %

Source: Ministry of Finance and National Economy
Statistical Year Book; Ministry of Health Annual
Medical Report, Various Issues

4.8 THE TRAINING OF HEALTH AND MEDICAL PERSONNEL IN SAUDI ARABIA

One of the main reasons for the acute shortage of Saudi medical personnel in the health services is the relatively recent establishment of institutions concerning with the training and production of doctors and paramedics. Prior to 1969 there was no school of medicine in Saudi Arabia and the Saudi government sent medical students to universities abroad for their education. By 1981 four medical schools had been established in different parts of

the country. However, Table 14 shows that a relatively low number of Saudi qualified doctors have graduated from Saudi universities over the years. This was particularly the case during the late 1970s, when King Saud University in Riyadh was the sole source of locally trained doctors in the country.

Table 14

The number of Medical Graduates from Saudi Universities, Selected Years

Year	KSU-Riyadh	KSU-Abha*	KAU	KFU	Total
1975	--	--	--	--	--
1976	22	--	--	--	22
1977	27	--	--	--	27
1978	26	--	--	--	26
1979	41	--	--	--	41
1980	76	--	35	--	111
1981	53	--	54	18	125
1982	78	--	66	20	164
1983	107	--	76	42	225
1984	102	--	96	40	238
1987**	100	9	96	73	278
1988**	93	12	75	79	259

* The faculty of medicine of King Saud University- Abha branch was opened in 1981.

KSU = King Saud University

KAU = King Abdul-Aziz University

KFU = King Faisal University

Source: Alshammsi (1986) P.150; ** Ministry of Health Annual Medical Report, 1987-1988

The Ministry of Health began training paramedical personnel some time before it undertook the training of doctors. The first Males' Secondary Health Institute was opened in Riyadh in 1959. The second was opened in Jeddah in 1963, the third three years later in the city of Dumam, and a decade later the fourth one was opened in Mekkah (Ministry of Health Annual Medical Report, 1988).

Females' Secondary Health Institutes were opened a little later than those for males. The first two Institutes were opened in 1962 in Riyadh and Jeddah, the third was opened six years later in Hafof (*ibid*). However, the first real sign of the government's commitment to overcoming the acute shortage of Saudi paramedical personnel did not come until the first half of the 1980s. Between 1982 and 1988 15 new Secondary Health Institutes, of which 6 were for females, were opened in different parts of the country. Although the number of Females' Secondary Health Institutes reached 16 units in 1988, equalling the number for males, the number of female enrollments and graduates remains far less than those of their males counterparts (see Table 15). This seems to be due mainly to the fact that Saudi traditions still consider female employment undesirable. The low participation rate of women in the labour market is also a reason for manpower shortage, not only in the Saudi Health system but in the country's labour market in general.

Both male and female Secondary Health Institutes produce qualified health and medical personnel in a range of specialities: nurses, radiologists, assistant statisticians, health inspectors, assistant pharmacists, assistant anesthetists, laboratory assistants, physiotherapists, and assistant surgeons.

Table 15 shows that the number of health personnel graduating from the Health Institutes remained low until the early 1980s, when the number of graduates began to increase in accordance with the expansion of these facilities in many parts of the country. However, the proportion of Saudi medical personnel in the Ministry of Health and private medical care services remained very low, due to the rapid expansion of health and medical care services in the country as a whole.

It seems safe to conclude that, the small number of doctors and other health personnel produced in the country is an important factor in the acute shortage of Saudi nationals employed in the health services. This has, in part, been a result of:

" The failure of some medical and related educational institutions to attain and maintain full capacity enrollment, in addition to the relative newness of most of the educational programmes offered by them."

(Alawy and Mujahid, 1982 cited
by Alshammasi, 1986: 151)

Table 15

The Number of Graduates from Secondary Health Institutes, Selected Years.

Year	Male	Female	Total
1970	136	25	161
1975	217	63	280
1980	144	39	183
1981	175	37	212
1982	140	55	195
1983	183	92	275
1984*	435	127	562
1985*	426	199	625
1986*	667	270	937
1987*	1011	272	1283
1988*	1197	308	1505

Source: Alshammasi (1986) p.151; * Ministry of Health Annual Medical Report, 1988

An additional factor in the small number of medical personnel produced in Saudi Arabia is the low intake of health training institutions. Alshammasi (1986:152) analyzed the statistics of the number of male graduates from Riyadh Male Secondary Health Institute, the oldest training organization in the country. He found that the average annual number of graduates from the Institute, from its establishment at the beginning of the 1960s until 1983, was 78 personnel. This figure included candidates taking short training courses, which were available at the Institute in the 1970s. If these were excluded, the average annual number of graduates fell to 63, despite the

fact that the Institute had the capacity to train from 150 to 200 students a year.

Although the number of indigenous paramedical staff has increased in recent years, the numbers still fall far short of meeting the ever-increasing demands of the Saudi medical labour market. Close examination of the statistics on the health and medical workforce in both the Ministry of Health and the private health care services for 1988 shows that Saudi doctors comprised only 6 per cent of the total number of doctors working in the country, while Saudi nurses and technicians accounted for around 11 per cent of the total number of personnel working in these professions.

The shortage of indigenous health and medical personnel is made up by the recruitment of expatriate personnel from many different countries. Expatriate health and medical personnel have played a vital role in the rapid expansion of the Saudi health system. The recruitment of expatriate doctors has also facilitated an improvement in the ratio of doctors to population. For example, in 1975 there were 3.8 doctors per 10,000 people, compared to 6.7 doctors per 10,000 in 1980, and in 1984 the percentage stood at 11.5 doctors per 10,000 (Ministry of Planning, 1985).

It is generally agreed that the largest single group of foreign doctors in the Saudi health services come from Egypt, while the majority of nurses and other medical personnel come from the Philippines. Saudi official

statistics do not show the nationalities of expatriate health and medical workers employed in the country. The only description given is based on the distinction between Saudi and Non-Saudis. However, during fieldwork the researcher managed to obtain a list of the nationalities of the foreign doctors working in Jeddah, which shows that they come from 54 different countries. These findings will be discussed in the next chapter.

CHAPTER FIVE

HEALTH SERVICES IN JEDDAH

5.1 HEALTH PROVISION IN JEDDAH

The previous chapter has shown that Jeddah and Mekkah were the only parts of Saudi Arabia which enjoyed formal health care services before the creation of the country. When Jeddah became part of the Kingdom of Saudi Arabia in 1932 its small hospital, established under the Ottoman Empire, continued to provide health care services to the inhabitants and surrounding areas. In 1949 the hospital was rebuilt, enlarged and renamed as Jeddah Central Hospital (Jamjum, n/d). The hospital remained the only provider of health in the area until the establishment of the Infectious Diseases Hospital in 1952. Jeddah Central Hospital was closed down in the mid-1970s, and all the health and medical personnel were transferred to other medical institutions under the Ministry of Health. By this time, a number of government hospitals and primary health care centres had been established in the city.

Although Jeddah has a relatively long history of health provision, there is very little detailed information available on the development of health services and medical care in the city. This chapter, therefore, will attempt to go some way towards filling this gap. Aim of the chapter

is to outline a basic description of health and medical care services in Jeddah provided by the Ministry of Health, other government agencies providing health and medical care, and the private sector. Most of the data presented in this chapter is derived from material collected during fieldwork in Jeddah. The materials discussed here were gathered from the General Directorate of Health Affairs in Mekkah province, from interviews with the managing directors of the medical establishments visited during fieldwork, government statistics, and the researcher's observations.

5.1.1 PUBLIC HOSPITALS

Table 16 shows that there are 9 hospitals in Jeddah run by the Ministry of Health. Four of these hospitals are general hospitals with an overall capacity of 969 beds. King Fahad Hospital is the largest and newest of these general hospitals. It has a huge number of health and medical personnel, technicians, and administrators, amounting to over one 1,000 employees, as well as a total capacity of 619 beds. The hospital is housed in a large, modern, purpose-built structure, with advanced medical equipment and staffed by a large number of highly qualified specialists from Saudi and abroad. The hospital provides a

range of medical care services which are not widely available in other hospitals in the city or in the region. For example, hospital is equipped to offer open-heart surgery and organ transplants, for which the hospital has one of the top surgeons in the country. The hospital also carries out delicate and sophisticated operations such as brain and nerve operations, as well as plastic surgery. In 1988, for example, the hospital carried out 3,343 general surgical operations, 171 heart operations, 510 plastic surgery operations, 307 brain and nerve operations, 833 ear, nose and throat operations, 759 urinary tract operations, and 1,485 bone surgery operations (Ministry of Health Annual Medical Report, 1988).

There are also four specialized public hospitals in Jeddah. Two are maternity hospitals, one specializes in ophthalmology and the other deals with infectious diseases. The largest of these specialized units is the Maternity and Paediatric Hospital. The hospital was established in 1972, and was located in a rented building with a total capacity of 220 beds while awaiting completion of permanent, purpose-built premises. In 1977 the hospital moved into its new premises, which enabled it to operate with a larger capacity of beds, and an increased number of specialized departments. This hospital receives delivery cases as well as providing specialized medical care services for children. It has a special unit for out-patients as well as in-patient treatment facilities for children of all

ages. In addition, the hospital provides 34 out-patient specialized surgeries; 23 for obstetrical and gynecological treatment, 8 paediatric clinics, a dental clinic, a pathology clinic, and a nursery department. The hospital's in-patient and bed resources have continued to increase over the years with additional medical treatments. For instance, in 1988 the hospital had 621 beds, and admitted 5,193 cases of delivery, and obstetrics and gynecology, in addition to carrying out 673 general operations, 233 ear, nose and throat operations, 15 heart operations, and 92 urinary tract operations.

The other maternity hospital is the Mother and Baby Hospital, a relatively small hospital with a total capacity of 150 beds and employing a limited number of medical personnel. The hospital only provides medical care services for delivery cases and related treatments.

The third specialist public hospital, the Infectious Diseases Hospital, was opened in 1952 primarily to deal with contagious diseases, particularly among Pilgrims coming from overseas for the Haji. In those days the Pilgrims were examined upon arrival in Jeddah, at health posts in the city port and airport, to establish whether they showed any sign of transmittable diseases. Suspected cases were transferred to the Infectious Diseases Hospital, where they were detained for further examination and subsequent treatment. The hospital also receives cases of contagious diseases referred by various health service

establishments in Jeddah. However, in recent years the hospital has ceased to deal with Pilgrims as the Saudi government requires anyone applying for a Pilgrimage visa to obtain a Health Certificate.

The Ophthalmology specialist hospital in Jeddah was opened in 1970, and deals exclusively with eye diseases, including eye operations. It is also used for training medical school graduates from Saudi universities, as well as resident doctors (Jamjum, n/d). This hospital is the second of its kind in the Western province, and the third in the country as a whole. The hospital provides both in- and out-patient medical care services, and attracts a huge number of patients from Jeddah and elsewhere. In 1988 it was estimated that 151,678 cases visited the out-patient surgeries and that 7,029 patients were operated upon (Ministry of Health Annual Medical Report, 1988). The hospital is relatively small, with a capacity of 112 beds, 35 doctors, 73 nurses, and 26 technicians. This small number of medical staff and the relatively small bed capacity, as well as the fact that the hospital occupies a rented property rather than purpose-built premises, means that it is unable to cope with the large number of patients requiring eye operations. As a consequence, many cases requiring operations are referred to Al-Thager hospital, the second largest general hospital in Jeddah (see, Table 16). This hospital, among its other work, carries out a substantial number of eye operations a year. In 1988, for

example, 111 eye operations were performed (Ministry of Health Annual Medical Report, 1988).

Table 16
The Distribution of Ministry of Health Hospitals
in Jeddah by Opening Date, Number of Beds,
and Number of Medical Personnel

Hospital	Opening Date*	N.of Beds	N.of Dr.	N. of Nurses	N.of Techn.	N.of Admin
King Fahad	1980	619	215	448	224	176
King Hospital	--	28	29	57	40	20
Maternity & Paediatrics	1977	621	195	394	120	72
Eye Hospital	1970	112	35	73	26	35
Al-Thagher	1984	160	98	177	86	32
Al-Shatti	1982	162	116	145	85	44
Mother & Baby	--	150	28	71	21	22
Infectious Diseases	1952	215	21	98	46	36
T.B. & Chest Diseases	--	--	--	--	--	--

Source: Ministry of Health, Annual Health Report, 1988,
*Bureau, 1986 "Medical Directory: Kingdom of Saudi Arabia

5.1.2 HEALTH CARE SERVICES PROVIDED BY OTHER GOVERNMENT AGENCIES

There are three government institutions which provide free hospital medical care services for their employees and their dependants in Jeddah: the King Fahad Military Hospital, which is run by the Ministry of Defence and Aviation; King Khalid Hospital for the National Guard; and King Abdul-Aziz University Hospital, which is supervised by King Abdul-Aziz University.

The King Fahad Military Hospital is situated inside the Air Defence Base in Jeddah, and provides on-site health and medical care services to members of the armed forces and their families working on the base, as well as other military installations in the city. The hospital is a typical Ministry of Defence and Aviation run-hospital. It is modern, sophisticated, supplying advanced medical care and treatment, and employing Western, Saudi and other highly-qualified Arab doctors. Only a limited number of the general public benefit from the advanced health and medical care provided by the hospital through the referral system.

King Khalid Hospital for the National Guard is one of the most modern and sophisticated hospitals in Saudi Arabia. It is situated in the small village of Um-Alsalem some 21 km outside Jeddah, and is housed in a single-storey building occupying an area of 60,000 square metres with a total capacity of 500 beds. The hospital employs 2,295 employees: 100 doctors, 525 nursing staff, 207 technicians, 262

administrators, and other hospital workers (Jamjum, n/d). The hospital's services are available only to members of the National Guard and their families, and some patients from the general public who require treatment not available in the Ministry of Health's hospitals. As the hospital was built in a secluded area, far away from urban areas, a city was created for the hospital's employees.

"A medical city was built to provide hospital employees and their families with attractive houses within the precincts, nicely furnished and with beautiful gardens. Educational facilities, sports grounds and entertainments for the employees form part of the central services provided to this community. There is an Olympic-size swimming-pool..., tennis and badminton courts, a gymnasium, billiard tables, and a large hall for social gatherings. The medical city, being a self-sufficient housing area for hospital staff and their families, such as shops, hair-dressers, restaurants, and a central supermarket. Moreover, there are schools, large playing grounds and facilities for children's recreation and sports."

(Jamjum, n/d: 170)

King Abdul-Aziz University Hospital is an additional source of health and medical care services in Jeddah. Although the main purpose of the hospital is to provide health and medical care for the university students, members of staff and their families as well as to train medical students, it provides in-patient and out-patient facilities for the general public. Unlike the two hospitals described above, the people living around the University campus benefit greatly from this hospital. In

1988 the hospital, for example, provided medical services to over 10,000 patients a month through a range of specialized out-patient surgeries, and admitted 10,822 in-patients (Ministry of Health Annual Medical Report, 1988). This report shows that the hospital has an overall capacity of 234 beds, 283 nurses and 162 doctors, many of whom are highly-qualified specialists and members of staff in the Faculty of Medicine.

Furthermore, the Ministry of Education has a School Health Unit which provides primary health care facilities for boys' schools in the city. The General Administration for Girls' Education, Jeddah Branch, provides primary health care facilities for girls' schools in the city.

The Saudi Red Crescent Society provides 12 first-aid and emergency centres for the general public. It also runs a large health centre providing such specialized facilities as internal, chest, dermatology, minor surgery, ophthalmology, E.N.T., and mental and nerve spasms.

In addition, there are a number of government companies in Jeddah which provide free health care facilities for their employees and their families. Saudia Airlines provide primary health care facilities for their employees who live in Saudia City accommodation complex and also pays all private medical care fees for any who need hospital treatment. The General Corporation for Petroleum and Minerals (Samaric) provides similar health care services for employees and their dependants.

5.1.3 PRIMARY HEALTH CARE CENTRES

Like other major cities in Saudi Arabia, Jeddah has experienced an explosion in the number of primary health care centres since their introduction in the early 1980s. Table 17 shows that the number of such centres had almost doubled by 1988 compared with 1981. These centres are located in highly-populated areas of Jeddah and provide mainly general medical treatment and limited specialized care such as paediatrics and gynaecology. An increasing number of primary health care centres provide dental treatment. The Ministry of Health Annual Medical Report for 1988, shows that 41.4 per cent of primary health care centres in Jeddah provide dental treatment. The same report also shows that 51 out of the 70 primary medical care centres in Jeddah (72.8 per cent) have laboratories, while only 25 (35.7 per cent) have X-ray facilities. The number of patients benefiting from primary health care centres has increased dramatically as more centres opened. Over three-quarters of a million people visited these centres in 1979, and by the mid-1980s the numbers had risen to around three million people a year (*ibid*).

Table 17
The Number of Primary Health Care Centres
in Jeddah, in Selected Years

Year	1981	1982	1983	1984	1987	1988
No. of Primary Health Centres	38	38	58	59	68	70

Source: Ministry of Health Annual Medical
Report, various issues.

5.2 PRIVATE HOSPITALS

For many years the Ministry of Health and other public institutions were the major, if not the only, providers of health and medical care in Jeddah. However, in recent years private health and medical care establishments have become major providers for the city and surrounding areas.

The first private hospital to open in Jeddah, and in the country as a whole, was Al-Maghraby Hospital in 1955. This hospital specialized in ophthalmology treatment, and for 13 years remained the only source of private medical care in the city. In 1968 the Dr.Khalid Idrees and Partners Hospital opened, providing specialized treatment in most areas of medicine. Five years later Dar Al-Shifa Al-Saudi Hospital was opened, providing a wider range of out-and in-patient care facilities. From the mid-1970s to the end of the decade an average of one new private hospital a year was established in Jeddah.

Rapid growth in the number of private hospitals and the number of beds provided occurred during the 1980s. Table 18 shows that the number of private hospitals has steadily increased. By 1988 there were 23 private hospitals, an increase of more than 60 per cent over 1980. As a consequence, Jeddah has the highest number of private hospitals than any other city in the country.

The number of beds provided by private hospitals in Jeddah has also increased dramatically in recent years. Table 18 shows that the number of private beds rose from 1,031 beds in 1981 to 2,252 beds in 1988, an increase of 218.5 per cent. In comparison with the number of beds provided by the Ministry of Health, the private health sector in Jeddah provides 185 more beds (*ibid*).

Table 18
The Number of Private Hospitals, Number of
Doctors, and Number of Beds in Jeddah,
in Selected Years

Year	No.of Hospitals	No.of Doctors	No.of Beds
1980	9	--	598
1981	10	230	1031
1982	11	--	1201
1983	12	357	1225
1984	13	415	1296
1985	18	479	1499
1986	19	509	1784
1987	20	636	1906
1988	23	701	2252

Source: Ministry of Health Annual Medical Report;
Ministry of Finance and National Economy Statistical
Year Book, various issues.

A large number of the private hospitals in Jeddah are large and occupy modern, purpose-built premises. Furthermore, the major private hospitals possess the most up-to-date medical technology, some of which is not available in Ministry of Health hospitals. Local newspapers frequently contain many advertisements for private hospitals, emphasising their latest techniques and treatments. For example, the removal of kidney stones and other types of delicate operations, without carrying out surgery and using telescopes.

In addition, private hospitals are able to provide more advanced medical care than that supplied by the Ministry of Health, because they employ a large number of highly-qualified doctors and paramedical staff. Moreover, many of these hospitals, and private clinics to a lesser degree, regularly bring in highly-specialized consultants and surgeons from Western countries and the Arab World for short periods of time. Their arrival and the duration of their stay in Jeddah are often reported in the press.

One other significant feature, which distinguishes private hospitals from those run by the Ministry of Health, is that the former are very clean and well organized. No-one visiting one of these hospitals could fail to notice the cleaners constantly at work in the corridors, particularly outside peak hours.

5.2.1 PRIVATE HEALTH CLINICS

Table 19 shows that there are 57 private health centres in Jeddah, which makes them the second largest provider of this type of medical care in the country. The Table also shows that Jeddah, like any other part of the kingdom, had hardly any private clinics prior to the 1980s. The first health centre to open in the city was Al-Rashad Private Dispensary, in 1978 (Bureau, 1986). From the beginning of the 1980s onwards there has been a rapid increase in the number of private health clinics in the city. Table 19 shows that three clinics were opened in 1980, representing a significant increase in the number of private health care facilities. The number of private health clinics had nearly trebled three years later. By the 1985 there were 31 such centres, only to drop back the following year to the 1984 level of 26 centres (see Table 19). Two explanations may be given for this. Firstly, some of the clinics experienced financial difficulties and closed down. Secondly, a small number developed into hospitals. During fieldwork some cases of such changes were encountered. For example, Al-Anssar private hospital, one of the hospitals visited for the purpose of interviewing Egyptian doctors working there, was first established as a private health clinic in 1984. Two years later the owner of the clinic extended the building and changed it into a private hospital. Interviews were also conducted with two

doctors who worked in private clinics which closed within two years of being established because of financial difficulties and who had moved to other medical establishments. In 1987 the number of private health care centres increased to 52 (see Table 19).

The bulk of these clinics provide general as well as specialised medical care. The most commonly provided specialist treatments include: internal medicine, paediatrics, gynaecology and obstetrics, general surgery, and E.N.T. The majority provide 24-hour emergency services, 7 days a week. All private health clinics have X-ray and laboratory facilities. Ministry of Health regulations make it obligatory for such private medical establishments to provide these facilities. The private health clinics also have pharmacies outside the premises or nearby, usually owned by the owners of the clinics.

The majority of private health clinics in Jeddah are owned by Saudi businessmen, who in many instances have no medical background. In such cases the clinics are managed by one of the doctors in order to comply with Ministry of Health regulations.

Table 19
The Number of Private Health Centres,
and Doctors in Jeddah, in Selected Years

Year	1980	1981	1982	1983	1984	1985	1986	1987	1988
No. of Centres	4	9	12	20	26	31	26	52	57

Source: Ministry of Health Annual Medical Report;
Ministry of Finance and National Economy
Statistical Year Book, various issues.

5.2.2 PRIVATE SURGERIES

There are two types of private surgeries in Jeddah: collective surgeries and single-handed surgeries. Both types provide general as well as specialized medicine. As with other types of private medical care, the number of collective surgeries increased steadily in the 1980s. In 1983 there was only one collective surgery in Jeddah, but the number increased substantially in following years to reach 11 establishments in 1988 (Ministry of Health Annual Medical Report, 1988).

The number of single-handed surgeries has changed only slightly in recent years, rising from 151 to 156 surgeries between 1983 and 1988 (*ibid*: 302). These surgeries are run by a single doctor with the help of one or two nurses. The doctors normally operate from a flat in a residential building alongside a number of other surgeries, and

sharing the building with other occupants. The overwhelming majority of doctors working in single-handed surgeries are of Arabic origin, as indicated by the names on the list of those working in such establishments obtained from the Ministry of Health General Directory office in Jeddah. The family names of these doctors would also seem to suggest that only a minority are of Saudi origin. The list of doctors' names indicates that very few female doctors work in such surgeries.

Both types of private surgeries are complemented by 9 privately-run laboratories, providing various medical testing and X-ray facilities. Since private surgeries do not possess such facilities, patients are usually referred to the laboratories for any tests considered necessary.

5.3 HEALTH AND MEDICAL HUMAN RESOURCES IN JEDDAH

As in other parts of Saudi Arabia, Jeddah relies very heavily on expatriate medical personnel in both the public and the private sectors. Table 20 shows that Saudi doctors working in the Ministry of Health hospitals and primary health care centres constitute less than half of the total number of doctors employed. The majority are to be found working in Ministry of Health hospitals. Saudi doctors form a small minority (just under 8 per cent) of all

doctors working in primary health centres (Table 20). The majority (60 per cent) of Saudi doctors who work for the Ministry of Health are general practitioners, while the majority of foreign doctors working in the Ministry are specialists (Ministry of Health Annual Medical Report, 1988). However, 71 per cent of specialized medical treatment is performed by doctors of foreign origin, and even higher in some areas of medical treatment. For example, more than 80 per cent of ophthalmologists, surgeons, and internal specialists working in the Ministry of Health in Jeddah are non-Saudis (*ibid*).

Table 20
The Percentage of Saudi Doctors and Medical
Personnel Working in the Hospitals and Primary
Health Care Centres of the Ministry of Health
in Jeddah in 1988

Medical Personnel	Hospital				Primary Health Centres			
	Saudi	Non- Saudi	Total	% of Saudi	Saudi	Non- Saudi	Total	% of Saud
Doctors	327	510	837	39.1	16	238	254	7.9
Nurses	220	1505	1725	12.8	78	378	456	17.2
Techn.	313	490	803	39.0	49	177	226	21.7

Source: Ministry of Health Annual Medical Report, 1988

The Ministry of Health's medical facilities in Jeddah are extremely short of indigenous nursing staff. Table 20 shows that the overwhelming majority (70 per cent) of nursing staff working in the city's public health services are expatriates. However, Saudi personnel form the majority of technicians employed in public hospitals and primary health care centres (Table 20).

The private medical care sector depends almost entirely on foreign medical personnel and other workers at all levels. Table 21 shows that Saudi doctors constitute only 2 per cent of the doctors employed in private hospitals and clinics in Jeddah. Most of these doctors are the owners of some of the private medical establishments, and they work mainly as administrators. Furthermore, indigenous paramedical staff normally constitute a tiny proportion of those employed in private hospitals and clinics (Table 21).

Table 21
The Percentage of Saudi Doctors and Medical
Personnel Working in Private Hospitals
and Health Centres in 1988

Medical Personnel	Saudi	Non Saudi	Total	% of Saudi
Doctors	24	1220	1244	2.0
Nurses & Technicians	12	3037	3049	0.4
Administrators	159	2283	2442	6.5

Source: Ministry of Health Annual Medical Report, 1988

The vast majority of paramedical personnel working in Jeddah's health services come from South-East Asia, especially from the Philippines, while foreign doctors come from many nations (see Table 22). This Table also shows that the largest group of foreign doctors are of Arab origin. These constitute slightly over 40 per cent of the total number of expatriate doctors working in the Jeddah area, which includes many towns and villages in Jeddah province. The largest single groups of foreign doctors, however, come from Egypt and the Philippines (see Table 22).

General practitioners are the predominant type of doctors working in the Ministry of Health medical services in Jeddah, where they constitute 59 per cent of the total number employed. By contrast, 78 per cent of the doctors working in private hospitals and health centres are specialists. This suggests that private medical care is better placed to provide a higher standard of care than that provided by the Ministry of Health. Evidence, based on the qualifications of doctors working in some Ministry of Health hospitals and primary health care centres in Jeddah, and of those working in private hospitals and clinics, indicates that a large number of highly-qualified foreign consultants (some of whom are members of staff in schools of medicine in their home countries) work in the private sector. For example, 5 per cent of the doctors who work in 42 private clinics are consultants. Moreover, 10

of Jeddah's private hospitals, where information regarding the qualifications of their doctors were available, employ 118 consultants specializing in a wide range of different types of medicine. These constitute 39 per cent of the doctors working in such hospitals. On the other hand, only a limited number of consultants are employed in public hospitals and none in the primary health care centres.

Table 22
The Distribution of Foreign Doctors
in Jeddah by Country of Origin, 1987

Country	N. of Doctors	Country	N. of Doctors
Egypt	1833	France	46
Lebanon	127	Holland	2
Thailand	201	Korea	134
Ethiopia	4	United States	159
Mauritius	33	Germany	33
Indonesia	133	Australia	15
Malaysia	21	Ireland	28
Somalia	80	Morocco	27
Sudan	167	Syria	102
Tunisia	103	Palestine	152
South Yemen	2	Algeria	12
Libya	1	Iraq	3
Djibouti	1	Ghana	3
Sierra Leone	6	Portugal	2
Switzerland	1	Uganda	9
Japan	6	Canada	8
Italy	13	Eritrea	53
Singapore	19	Greece	1
Jamaica	2	Finland	1
Tanzania	1	New Zealand	1
Norway	1	Nigeria	1
Pakistan	325	India	413
Sri Lanka	11	Bangladesh	14
Afghanistan	2	Turkey	15
Philippines	1427	United Kingdom	456
Turkustan	2	Sweden	23
China	332	Jordan	94
Overall Total		6,661	

Source: Compiled During Fieldwork

5.4 MALPRACTICE LAWS AND REGULATION IN SAUDI ARABIA

Saudi Arabia has no health insurance requirements for medical personnel working in the country. Indeed, other types of insurance, such as motor insurance and property insurance, etc. are very limited in the country, since it is forbidden by Islamic Sheri'a (Law). Also there are no trade unions in the country. Doctors and other medical personnel have no formal organisation to which ^{they} may turn when difficulties arise, such as problems with management or when accused of malpractice. The only government organisation which deals with disputes between workers and their employers is the Saudi Labour Office, which only deals with administrative disputes. The Labour Office usually deals with disputes between workers and their employers when, for example, one of the parties breaks a condition of the work contract, regarding such matters as wages, working hours, accommodation arrangements etc.

Medical malpractice cases are dealt with by the Ministry of Health, regardless of whether the suspected case of malpractice occurred in the public or private medical sector. In the past, the police dealt with cases of malpractice. However, after the large increase in the number of medical care establishments, particularly in the private sector, and due to the increasing number of cases of malpractice and medical negligence, the Shari'a Medical Committee (S.M.C) was established. In 1962, a Royal Decree ordered the formation of the S.M.C. in order to deal with

malpractice cases against medical personnel. The S.M.C. consists of a doctor from the Ministry of Health, a doctor from the Ministry of Education, a doctor from the Ministry of Defence, a doctor from the College of Medicine in King Saud University in Riyadh, and an expert in Islamic Shari'a from the Ministry of Justice. This member acts as an adviser on the position of the Shari'a regarding the case under investigation, after the medical members of the committee have given a technical assessment of the case. From its formation in 1962 until the beginning of 1988, the S.M.C. remained the only government body dealing with medical negligence disputes, operating from the Ministry of Health in the capital city, Riyadh. As a consequence, the continued expansion of the health services together with the increasing number of complaints and accusations, the S.M.C. found it difficult to cope with the workload. Inquiries into accusations of malpractice took a long time, in some instances three years or more. However, in 1988 the government established four more S.M.C.s: in Mekkah province, the Eastern province, Al-Qassame province, and Asir province.

When someone submits a complaint to the head of the General Directory of Health in his province, the Minister of Health, or to the office of His Majesty the King of Saudi Arabia, the case is referred to one of the S.M.Cs. If the complaint is submitted to the head of the General Directory of the province, the case is referred to the

S.M.C. of the province and the malpractice inquiry takes place. If the complaint is submitted to the Minister of Health or to His Royal Highness the King, the case is referred to the General Directorate of Health in the province where the suspected case of malpractice occurred. A complaint can be made if someone dies or suffers permanent disability as a result of undergoing medical treatment.

When an inquiry into an incident begins, one or more consultants in the same speciality as the doctor or medical team responsible in the suspected case of malpractice are appointed by the General Directorate of Health in the area in which the incident took place. The consultants carry out a thorough investigation into the case and submit a report to the S.M.C.. The S.M.C. then sets a date for the person or persons under investigation to attend a hearing and answer further questions about the incident. The S.M.C. then arranges another meeting with all of the people involved in the case, and presents its verdict. If found guilty of medical negligence which led to the death or permanent disability of a patient, then the person or persons who carried out the treatment must pay compensation to the patient or their next of kin, or face disciplinary action, or both.

compensation for malpractice is paid according to Islamic Shari'a, where it is known as Diyah. In Islamic Shari'a, the Diyah is required of a person who accidentally

causes the death of another person, or inflicts upon him/her a permanent disability. The amount of Diyah varies according to type of injury and the part of the body affected. For example, if a patient's hand was disabled as a result of an operation, the patient would receive less Diyah than if he had lost the use of his leg. However, the full amount of Diyah is paid in the case of death. The amount of Diyah is calculated in Islamic Shari'a to the equivalent of the price of 100 camels, which stands at 100,000 S.R. (about \$27,000). In some cases, as will be shown later, a number of medical personnel will share the payment of Diyah to the family of the deceased, if it was found that they were involved in some way or another in the cause of that person's death.

However, the Diyah is only paid if those who won the case ask for it. This is known as asking for Al-Heqq Al-Khass (personal right). However, some people demand that the health authorities take disciplinary action instead against those found guilty. This is known as asking for Al-Heqq Al-A'mm (public right). Such cases are dealt with by the Administrative Medical Committee, which was formed in 1984 to deal with suspected cases of malpractice from an administrative point of view.

While an inquiry into malpractice is taking place, the person or persons under investigation, especially non-Saudi nationals, are not allowed, under any circumstances, to leave the country. It is for this reason that foreign

medical personnel cannot leave the country for a holiday, or at the end of their contract, without obtaining a letter from the licensing department in the Ministry of Health General Directorate of the province where they are employed, confirming that they are not involved in any malpractice investigation.

5.4.1 EXAMPLES OF MALPRACTICE CASES DEALT WITH BY THE S.M.C.

This section will report on two malpractice cases handled by the S.M.C. in Jeddah province, in order to illustrate the types of cases which the S.M.C. investigates and the kind of sentences that the committee passes.

CASE NO. 9/409 in 5/5/1409 A.H. (1989)

This case concerned a man who was admitted to a private hospital in Jeddah for a sinuses operation on 6/5/1407 A.H. (1987). While under anaesthetic, his heart stopped and he went into a coma for 3 days and died. His wife accused the anaesthetist of having given her husband an excessive dosage, so causing his death. She demanded Diyah from the anaesthetist.

The S.M.C. met on 5/5/1409 to study the file of the case and give a verdict on it, the complainant and the

accused were both present. After hearing the accusation made by the representative of the deceased's family and hearing the defence of the accused, the members of the S.M.C. found the accused responsible for the patient's death.

The two parties came to the following settlement. The accused had paid S.R.25,000 to the family of the deceased shortly after the accident as well as S.R.1,000 for treatment expenses in the hospital where the patient was first admitted, and a further S.R.13,389 to another specialist private hospital where he was taken in a coma. The representative of the deceased's family agreed to consider these payments as part of the Diyah, and to accept in addition, the payment of a further S.R.25,000. After the payment of the required amount of money, the S.M.C. decided: that the two parties were bound by the agreed settlement, and that the accused was absolved of any further responsibility in the case.

CASE NO. 1/408 in 7/11/1408 A.H. (1988)

This case concerned the death of a nine year old girl after undergoing a tonsillectomy operation in a Ministry of Health hospital in Jeddah. The inquiry lasted for 8 months before the final verdict was given. It was established that the girl had died of suffocation because

the anaesthesia tube which had been inserted in her throat had been only partially removed after the operation and part of it remained inside the girl's throat. Her father complained to the health authority in Jeddah, accusing the medical team which had treated his daughter of medical negligence resulting in her death.

After preliminary investigations, undertaken by a medical expert from the General Directorate of Health Affairs in Jeddah, the S.M.C. in Mekkah /Jeddah province held a meeting of all its members in the General Directorate on Monday evening, 6/11/1408 A.H. The accuser (the deceased's father) and the accused (4 doctors, 2 nurses and a technician) were also present.

The S.M.C. listened to the accusations made by the deceased's father and his demands for the settlement of the case, and to what the members of the medical staff who had treated the girl had to say in their defence. After a lengthy interrogation of the medical team, lasting two days, the S.M.C. decided that the death of the girl was the result of medical negligence, and recommended that all members of the medical team, except for one nurse, share the Diyah, as follows :

- 1) Consultant X, the head of E.N.T. department had to pay S.R.20,000, and was sacked from his job with the Ministry of Health, since he was considered to have ultimate responsibility for patients in his department. He had not set up a defined and reliable work system for the medical

team in the department to follow in dealing with patients before and during operations, nor did he closely monitor their condition after they left the operating table. He was also accused of making medical errors while operating on the deceased girl and of failing to follow-up her progress immediately after the operation.

2) The consultant Anaesthetist, X had to pay S.R.15,000 and was sacked from her job, because she had failed to remove all parts of the tube used for the patient's anaesthesia, and did not make sure that the patient was in a satisfactory condition after the operation before sending her back to the ward.

3) Specialist Anaesthetist Dr.X, had to pay S.R.5,000 and was issued with a caution. She had taken the anaesthesia tube out of the patient's mouth and had thrown it on the floor without making sure that all its components were intact. As a result, it was not discovered until it was too late that part of it was still in the patient's throat.

4) Registrar Dr.X had to pay 5,000 and it was recommended that his contract with the Ministry of Health was not extended upon its expiry. He was found to have neglected his duties with regard to the necessary procedure of sufficiently examining and preparing the patient for the operation. He also left the operating room in the middle

of the operation to answer an important phone call, and asked the head of the department to take over, without informing him of what he had done during the time he was in charge of the operation. Further, he had injected the patient with Valium without ascertaining whether she had regained consciousness or was still under anaesthesia.

5) Nurse X, the head of nurses involved in the operation, had to pay S.R.2500 and was given a warning. It was found that she had not raised the alarm quickly enough when she noticed that the patient's condition had deteriorated and had not given first aid. As a result, invaluable time was lost before help arrived and attempts were made to revive the patient.

6) Operation Technician X had to pay S.R.2500 and was given a caution for not counting the cotton swabs which were used in the operation and entering the number in the operation record. This negligence caused confusion among the doctors trying to revive the patient, who thought that the girl may have been suffocating because some swabs had been left in her throat.

7) Nurse X was acquitted, as there was no evidence relating to the case of any negligence on her part.

CHAPTER SIX

PROFILE OF EGYPTIAN DOCTORS IN JEDDAH

This chapter presents the data obtained from in-depth interviews with 52 Egyptian doctors working in the public and private health care services in Jeddah city. The data in this chapter concerns a profile of the respondents. Later chapters are concerned with the doctors' employment in Jeddah, their friendship and social networks in Jeddah, their anchorage to their country of origin, and finally the respondents' families' social life, children's education and other related matters. It must be noted that doctors employed in the public and private health sectors in Jeddah are treated as one group in the analysis throughout this and later chapters. However comparison between the two groups will be made when necessary.

6.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS

6.1.1 AGE AND SEX STRUCTURE

Of the 52 doctors included in the study more than one-quarter of the respondents were female (Table 23). The proportion of female to male in the sample is quite high given the percentage of female foreign doctors to male foreign doctors working in Saudi Arabia. The Ministry of Health Annual Medical Report for 1988 shows that just under (17 %) of foreign doctors working for the Ministry of Health were females, and nearly (19 %) of the overall total of doctors in the Ministry. This proportion is relatively low, considering that the Ministry of Health is trying to provide separate health services for the female population in Saudi Arabia. In the majority of Ministry of Health hospitals, there are usually separate out-and in-patient medical facilities for women. Many primary health care centres also provide secluded out-patient facilities for women. Although where such facilities are provided, they are not necessarily run exclusively by female medical staff.

The provision of separate health facilities for women by the Ministry of Health is the result of a growing demand by the general public in Saudi Arabia. The preference for these facilities stems from the religious standpoint, which prescribes that women should be examined and nursed by

females. This obligation is particularly emphasized when a woman's treatment requires the examination of the private parts of her body.

Various factors may be responsible for the small proportion of female doctors working in hospitals and primary health care centres run by the Ministry of Health, in spite of the religious obligation for women to be examined by doctors of the same sex. One crucial factor is that the government does not usually allow women to come to Saudi Arabia for employment or any other purpose without a Mehrum (a close male relative such as a husband, father, brother, or uncle). Medical personnel are among the very few groups of foreign employees exempted from this rule. These single women, nevertheless, are obliged to live in special halls of residence provided by their place of work, with very strict rules concerning their movements. Some female doctors do not find these conditions very attractive (see Dr.Nejwa's case discussed later).

The overwhelming majority of Egyptian migrant doctors who acted as respondents in this study are comparatively young. Table 23 shows that 51 of the doctors, or (98 %), are between the ages of 29 to 44 years. These results are consistent with other studies of foreign migrant workers in Jeddah; Palestinian migrants in Jeddah (Al-Horob, 1986), Americans in Jeddah (Attiyah, 1983), and semi-skilled Egyptian migrant workers in Jeddah (Khaleil, 1990). The findings of this study also correspond to research on

labour migration to the other oil-rich countries of the Middle East, e.g. Ali et al. (1981) on Bangladeshi migrants, Korale (1986) on Sri Lankan workers, and studies from other parts of the world, such as French (1986) on Filipina domestic workers in Hong Kong.

The findings of this study are, however, inconsistent with the findings of these studies regarding the minimum age of the migrant workers who acted as respondents. These studies found that the majority of 'cross-country' migrants fell with the age range from early-or mid-twenties to mid-or late-thirties. None of the respondents in this study are under 29 years of age. The relatively higher age of the respondents in this study is probably related to the fact that doctors have to spend many years training before qualifying, especially those who go on to specialise. An additional factor is that the Ministry of Health regulations require foreign doctors to have at least two years practicing experience for a G.P., and one year for a specialist, before they are allowed to practice medicine in Saudi Arabia.

Table 23
Distribution of Doctors by Sex and Age.

Age	Male N	%	Female N	%
29 - 32	8	15.3	1	1.9
33 - 36	14	26.9	4	7.7
37 - 40	11	21.1	7	13.4
41 - 44	3	5.7	1	1.9
49 - 52	1	1.9	-	-
Total Responses	38	73.0	14	27.0

6.1.2 RELIGION

The overwhelming majority of the respondents in the sample are Muslims (Table 24). Only 3 doctors follow the Christian faith. These belonging to the Orthodox Church and from the Coptic Christian community in Egypt.

Table 24
Distribution of Respondents by Religion

Religion	N	%
Muslim	49	94.2
Christian	3	5.8
Total Responses	52	100.0

6.1.3 MARITAL STATUS

Table 25 shows that 43 of the respondents (82.7 %) in the sample are married, and 9 (17.3 %) are unmarried. The vast majority of the married doctors are accompanied by their families; only a minority have left their dependants behind in Egypt (see later section on the family).

Highly skilled migrant workers in Saudi Arabia are permitted to bring their families with them, unlike their unskilled and semi-skilled migrant counterparts. The latter are not permitted to bring their dependents to the country because these two groups of migrants, especially the latter, fall into the low paid category. In recent years the Saudi government has introduced new legislation, whereby only those migrants who earn a middle to high income are allowed to bring their families to Saudi Arabia. This action by the government was the result of growing domestic concern over the increasing number of expatriates in the country. The new regulations were designed to reduce the pressure on public services, such as education and health.

Table 25
Distribution of Doctors by Marital Status

Marital status	N	%
Married	43	82.7
Single	9	17.3
Total responses	52	100.0

6.1.4 QUALIFICATIONS AND SPECIALITIES

Almost three-quarters of the respondents are specialists, possessing a higher degree or further qualification in medicine. The majority, or 22 respondents (42.6 %), have a Masters degree, another 4 doctors (7.7 %) have a Diploma (Table 26). Doctors with these types of qualifications are known officially as 'secondary specialists' in Saudi Arabia. The same Table also shows that 8 doctors (17.3 %) possess a Ph.D.. These are officially recognized as 'primary specialists', or consultants. Many of them were previously members of staff at various Egyptian universities. The remaining 14 respondents (27 %) are General Practitioners.

Table 26
Distribution of Doctors by Qualification

Qualifications	N	%
First Degree	14	26.9
Diploma	4	7.7
Master	25	48.1
Ph.D.	9	17.3
Total Responses	52	100.0

The specialists among the respondents in this study cover most of the specialisms to be found in the health services of Saudi Arabia (Table 27). The majority of these specialists work in out-patient clinics, but some working in hospitals have additional in-patient duties, particularly those who specialize in Gynaecology and internal medicine. The former are sometimes required to carry out operations related to delivery cases and other forms of maternity treatment. Three of those specializing in internal medicine worked as registrars.

Table 27
The Distribution of Doctors by Their
Area of Speciality

Speciality	N	%
Internal Medicine	5	9.6
Internal Medicine & Cardiology	2	3.9
Gynaecology & Obstetrics	7	13.4
E.N.T.	2	3.9
Ophthalmology	2	3.9
Paediatrics	4	7.6
General Surgery	2	3.9
Dermatology	5	9.6
Cardiology	1	1.9
Psychiatry	2	3.9
Brain & Nerves	1	1.9
Tropical Medicine	2	3.8
Community Health	1	1.9
Orthopaedic	1	1.9
Radiology	1	1.9
G.P.	14	27.0
Total Responses	52	100.0

6.2 INCOME

The income of Egyptian doctors in Jeddah varies considerably depending on their qualifications, the sector in which they work, and the duration of their stay in the job. In any case, consultants earn the highest income in Jeddah. Of these, the majority receive a salary of more than S.R. 9000 a month, which makes them among the highest paid category of workers among migrants and nationals alike (Table 28).

Table 28
The Doctors' Monthly Income

Doctors' income	Private		Public	
	N	%	N	%
Less than 3051 S.R.	-	-	-	-
3051 - 4500 S.R.	5	9.6	1	1.9
4501 - 5500 S.R.	6	11.6	6	11.6
5501 - 6500 S.R.	5	9.6	11	21.1
6501 - 7500 S.R.	3	5.8	2	3.8
7501 - 8500 S.R.	4	7.8	1	1.9
More than 9000 S.R.	5	9.6	1	1.9
No response	2	3.8	-	-
Total responses	30	57.8	22	42.2

The specialists in the sample fall in the middle bracket of monthly income. Some, however, earned much more than others, depending on their area of specialisation, their skill and the type of work they performed. For example, those working in in-patient facilities, whose duties sometimes require them to carry out or assist in minor operations and to work at weekends, tend to receive higher salaries than those performing only out-patient work. G.P.s are the lowest paid group of doctors. Their income starts at S.R.3500 a month. However, G.P.s working in the private medical sector have greater opportunities than consultants and specialists to earn extra income. This is because some of their work concerns emergency cases, which means that there is the possibility of working at weekends. Further, they also work outside normal working hours, for example, the opportunity conducting home visits and earning extra pay.

However, doctors working in the public health service have an advantage over those working in private medical care, as far as salary is concerned. The Ministry of Health increases the salary of its foreign doctors by 5 % a year. This explains why some G.P.s working for the Ministry of Health, who have been in their job for a long period of time, have a monthly income equal to, or even higher than that of some specialists employed in private medical establishments.

Generally speaking, however, doctors working in private medical care establishments receive higher salaries than their counterparts working for the Ministry of Health. Their monthly salaries are determined by their employers, and thus vary considerably. Furthermore, overall annual and sometimes monthly income, may also vary even between doctors in the same work place, with the same qualifications, a similar length of time on the job, and carrying out nearly or exactly the same duties. Dr.Hani, a specialist aged 29 working in emergency facilities in a private clinic, said that if he or his colleagues earn over S.R.15,000 a month, they receive 5 % of the excess as bonus pay. Dr.Immad, a G.P. working in another private clinic, stated that his employer gives annual bonuses to his employees, depending on the amount of money they make for the clinic in a given year. This practice of encouraging doctors to generate as much money as possible for their place of work seems to be widespread in medical establishments in Jeddah, including hospitals. For example, a Pediatrician working in a large hospital, one of the most sophisticated and modern in the city of Jeddah, stated that the evaluation of doctors' performance in the hospital depends on the amount of money they bring to the hospital and that this determines the size of the annual bonus offered by the management to the doctors.

The majority of the respondents in this study are happy with their salaries, and believe that they are quite "fair" for the amount of work they perform. However, more than 20 % of the respondents are unhappy with the salary they earn each month. Some feel that they are not paid enough for the amount of effort they put into the job. One of these respondents, Dr.Ahmed, an Orthopaedic specialist working in a large private hospital, stated :

"My work is very demanding because I'm the only bone surgeon in the hospital. And because of my speciality, my duties involve working in emergency, carry out surgeries, and following cases up in in-patients. Also I'm on call 24-hours, 7 days a week. Although I'm supposed to work 8 hours a day, more often I end up working more than that. For all of this hard work, I don't get any extra money."

Another respondent, Dr. Di'a, a specialist working in a large specialised public hospital, stated :

"Although my contract specifies that I should work 48 hours a week, sometimes I work more during the week or work at the week-end without any extra pay. Because this is a specialised hospital, we receive too many cases from Jeddah, as well as other towns and villages. Therefore, I think its unfair considering the quantity and quality of work I do."

A G.P., Dr.Mohammed, a colleague of Dr.Di'a working in the same hospital, was also unhappy about his salary and for similar reasons. Moreover, 2 doctors working for the

Ministry of Health were not satisfied with their salary because they obtained their present jobs in Jeddah through 'internal contract', after moving from jobs in the private medical sector. In such cases, the Ministry of Health does not take into account their previous work experience in Saudi Arabia nor in Egypt, as far as salary is concerned. One of these respondents, Dr.Semiha, a Paediatrician, applied for a job in a primary health care centre in Jeddah after working in a private clinic for less than a year. She commented :

"I feel it is unfair that my salary is S.R.2,000 less than that of my colleagues with the same qualifications, simply because I did not get my job contract when I was in Egypt."

Another respondent, Dr.Fatimah, a married Psychiatrist aged 42 employed in a private hospital, earning between S.R.5500 and 6000 a month, began to feel that her salary was not "fair" after she met a Saudi female doctor and realized the difference between her salary and that of the Saudi doctor. She stated :

"My salary appeared to me so inadequate for the work I do, after meeting a Saudi doctor who told me that she is paid S.R.12,000 a month, although she is younger than me and with less experience than mine, only because she is a Saudi citizen."

6.3 PREVIOUS SITUATION IN EGYPT

6.3.1 ORIGIN

The majority of the respondent in the sample, 41 doctors (78.8 %), were born in the urban areas of Egypt. Only 11 respondents (21.2 %), were of rural origin (Table 29). This finding is inconsistent with Khaleil's study (1990) of semi-skilled Egyptian workers in Jeddah, the majority of whom come from rural areas in Egypt. Other studies of Asian migrant workers working in the Middle East have also found that the majority of workers are of rural origins (e.g. Arnold and Shah, 1986; Demery, 1986).

Table 29 also shows that the majority of doctors in the sample, 34 respondents (85.3 %), resided in Cairo and Alexandria, the two major cities of Egypt, before moving to Saudi Arabia. Only 3 respondents (5.8 %) had lived and worked in rural areas before coming to Jeddah. The reason for this appears to be that employers, or the representatives of health establishments in Jeddah, tend to go to Cairo to recruit doctors. This is quite noticeable with regard to the recruitment of doctors for the Ministry of Health and is mainly done through the Health Attache' in the Saudi Arabian Embassy in Cairo. Therefore, it is not surprising that those who live and work in Cairo and Alexandria, which is very close to Cairo, have greater opportunities to secure job contracts abroad than those who live far away from the capital city.

Table 29
Distribution of Doctors by Place
of Birth and Place of Residence

Place of Birth	N	%
Urban Areas	41	78.8
Rural Areas	11	21.2
Total Responses	52	
Place of Residence	N	%
Cairo	23	44.2
Alexandria	11	21.1
Zaqazeeq	4	7.7
Al-Mansourah	3	5.8
Al-Geeza	2	3.8
Shabeen Al-Koom	2	3.8
Other	4	7.8
<hr/> Rural Areas	3	5.8
Total Responses	52	100.0

6.3.2 DATE OF QUALIFYING AS A DOCTOR

Table 30 shows that 39 (74.9 %) of the doctors interviewed first qualified as G.P.s in the early and late 1970s. The same Table also shows that the majority of the respondents who continued their higher education, qualified as specialists in the 1980s. Furthermore, Table 30 shows that 35 (67.3 %) of the respondents obtained their first degree from Alexandria University, Ain-Shams, and Cairo University. Moreover, the majority of the respondents

continued with their higher education at the same university from which they had graduated as G.P.s. Only a few had changed universities in order to continue with their education to become specialists (Table 30).

Table 30
Distribution of Doctors by Year
and Place of Graduation

Year of graduation	B.S.		Diploma		M.A		Ph.D.	
	N	%	N	%	N	%	N	%
Before 1970	3	5.8	-		-	-	-	-
1970 - 74	15	28.9	1	1.9	-	-	1	1.9
1975 - 79	24	46.1	2	3.8	7	13.4	-	-
1980 - 84	10	19.2	1	1.9	10	9.2	5	9.6
1985 - 88	-	-	-	-	13	25.0	3	5.7
Total	52	100.0	4	7.7	30	47.6	9	17.3
University								
Alexandria	13	25.0	-		8	5.4	3	5.7
Cairo	10	19.2	-	-	8	15.4	2	3.8
Ain-Shams	12	23.1	1	1.9	5	9.6	-	-
Al-Zaqazeeq	5	9.6	-	-	5	9.6	3	5.7
AL-Azhar	4	7.7	1	1.9	6	11.5		
Tanta	3	5.8	-	-	3	5.8	1	1.9
Al-Kasr Al-Einy	3	5.8	1	1.9	1	1.9	-	-
Al-Mansourah	2	3.8	-		1	1.9	-	-
Other	-	-	1	1.9	-	-	-	-
Total	52	100.0	4	7.7	37	61.1	9	17.3

6.3.3 PREVIOUS EMPLOYMENT IN EGYPT

More than half of the respondents had jobs in both the public and private health sectors in Egypt (Table 31). These doctors are mostly specialists who worked in official jobs in the public sector during the day, and in their own private surgeries for a few hours in the evenings. More than half of the doctors in the sample owned private surgeries in Egypt before moving to Saudi Arabia. The majority of these doctors closed their surgeries temporarily when they migrated to Saudi Arabia.

Table 31
Distribution of Doctors by Previous
Employment in Egypt

Previous Place of Work	N	%
Public sector	18	34.6
Private sector	3	5.8
Both	31	59.6
Total response	52	100.0

Only 2 respondents sold their surgeries before coming to Jeddah. Both of them did so in the hope that they would be able to buy another surgery in a better location, once they had accumulated enough savings from their employment in Saudi Arabia. One of these doctors, Dr.Suzan, a Gynaelogist aged 37, regretted the sale of her surgery.

She came to Jeddah three years ago and is now convinced that it will cost her a lot of money to buy another surgery when she eventually returns to Egypt, because of the rising prices of property and medical equipment in Egypt in recent years.

4. PREVIOUS EMPLOYMENT IN SAUDI ARABIA AND OTHER COUNTRIES

Only 3 doctors out of the 52 interviewed had worked previously in Saudi Arabia. Dr. Azmi, a 40 year old consultant specialising in brain and nerve illnesses has worked in a private hospital in Jeddah twice before and is currently working in the same place for the third time. He first came to Jeddah in 1984, at the request of the owner of the hospital who knows him personally, to take employment as a visiting doctor. On this occasion he worked for only 4 months and had to return to Egypt in order to finish studying for his PH.D. degree. In 1986, the same employer asked him to work for him again. He came to Jeddah alone, leaving his family in Egypt, as was the case on the first occasion. This time he stayed for 11 months. At the time of the interview Dr. Azmi had gained his Ph.D., and had been working in Jeddah for 8 months. This time accompanied by his family, he intends to stay for 4-5 years.

The second respondent, Dr. Abdullah, a 38 year old married consultant holding a Ph.D. degree in Cardiology, had worked in Egypt as a member of staff at Al-Zagazeeq University Medical School. He first came to Jeddah in 1983, as a visiting doctor and worked for one year in a private hospital. At present, he is working in another private hospital, and at the time of the interview he had been working there for 5 months. Once again, he had initially came to Saudi Arabia on a 3 month visiting visa which was later extended to one year.

The third doctor is Dr. Eibys, a 35 year old married G.P.. He first came to Saudi Arabia in 1984 to work in a private clinic in Khamees-Misheet city, in the south west of the country. He obtained the position through a friend who had initially been offered a job by the owner of the private clinic, but was unable to accept the offer. The friend was already in full-time employment for the Egyptian Ministry of Health. The only way he could have accepted the job would have been to apply for a year's unpaid leave, which would have taken him too long to organize. His friend, Dr. Eibys, although also employed by the Egyptian Ministry of Health, was able to leave his job at any time, because he was employed on a temporary contract. Also, Dr. Eibys was quite willing to move to Saudi Arabia at short notice. Hence, his friend introduced him to the employer and he was eventually accepted for the job. However although his employment contract was meant to last for 2

years, he was dismissed after 18 months and went back to Egypt.

Dr.Eibys, returned to Saudi Arabia in 1986 and has been living in Jeddah ever since. This time it was not his own employment contract which brought him to Saudi Arabia, but that of his wife, who had obtained a contract to work for a private hospital in Jeddah. He came to live with her in Jeddah. Because of his wife's employment Dr.Eibys was given a Muhram (companion) visa, which does not permit the holder to work. However, it is possible for Muhrams to apply for a work permit once they are in the country. In the past, work permits were obtained from Immigration Departments around the country. In recent years, however, the government has tightened the rules governing work permits for foreign subjects living in Saudi Arabia as Muhrams, as well as for the wives of expatriate employees. These days, a work permit for these two categories of people can only be obtained with the consent of the Governor of the region in which the applicant currently resides. For this reason, it was a few months before Dr.Eibys was granted a work permit. After that, it was some months before he found a job in Jeddah. In fact it was not until more than a year after his arrival in Jeddah that he started work.

Another 8 doctors in the sample had worked in other countries before securing employment in Saudi Arabia. Of these, 6 doctors had worked in a number of Arab countries

in the Middle East, namely Kuwait, Iraq, Libya, and Algeria. On average, they had worked in these countries from one to two-and-a-half years in the first half of the 1980s. The exception was one doctor who had worked in Libya for 5 years, from 1975 to 1980.

The remaining 2 doctors had worked in different circumstances. The first, Dr. Mohammed aged 50, a retired Army General and a specialist in internal medicine. In 1963 he worked for a year in North Yemen, during the civil war, with the Egyptian Army. The other doctor, Dr. Immad, a G.P. aged 34, while he was a medical student in the early 1970s. He took a year off to visit and work in England in 1972. He worked in London in an Arab restaurant, first as a "kitchen-help" and later as an assistant cook.

6.5 THE PROCESS OF MOVING

For more than half of the respondents, the decision to migrate to Saudi Arabia was not made in isolation, but was a collective one. Gilbert and Gugler (1982:54) explain that migrants do not contemplate their decision to move on their own, simply because they are members of social groups.

Table 32 shows that for the majority of the respondents other parties were involved in helping the

doctors to make this decision. Spouses, and to a lesser extent, other relatives, were in most cases directly involved in influencing the respondents' decision-making.

This finding is, however, inconsistent with Fergani's study (1988) of Egyptian migrant workers to other Arab countries. He found that the majority of them took the decision to migrate without the involvement of other people. No reason was given by the author as to why that was the case. However, the reason seems to stem from the fact that the majority of his sample were illiterate or had very little education. Most of them had worked in agriculture and construction before migrating, so they had much to gain from working abroad. More importantly, a large proportion of the sample were single, and even those who were married had left their families behind. By contrast, the majority of the respondents in this study are married and most of them are accompanied by their families. Thus, family participation in the decision-making is not surprising.

Table 32 also shows that more than two-thirds of the doctors received encouragement from others, mainly relatives and friends, in the decision to move to Saudi Arabia. Many doctors were particularly encouraged by some of their friends who were working or had been employed in Saudi Arabia.

Table 32
The Decision to Move to Saudi Arabia

Participation of Others in the Decision to Migrate	N	%
Spouse	19	36.5
Relatives and Friends	10	19.2
No one	23	44.3
Total responses	52	100.0
Encouragement of Others		
Spouse	3	5.8
Relatives and Friends	30	57.6
Other	2	3.8
No one	17	32.8
Total Responses	52	100.0
Discouragement by others		
No one	22	42.3
Relatives	23	44.2
Supervisor	4	7.7
Other	3	5.8
Total responses	52	100.0

Fergani (1988) also found that the majority of his sample were encouraged by relatives and friends to move abroad for employment. The reason for this, in his view, was the deterioration of the Egyptian economy in the first half of the 1980s.

However, not all members of respondents' families in this study were supportive of their decision to work abroad. Table 32 shows that 23 doctors (or slightly over 44 %) received some objections to their decision to leave home. Discouragement came mainly from parents, especially

mothers and in-laws. Their objections to their loved ones leaving Egypt were, according to one of the respondents, based on an emotional point of view. Similarly, Fergani (1988:115) found that a large number (48 %) of the migrants' parents, and (21 %) of their spouses, disapproved of their decision to move to other Arab countries for employment. However, their objections centred on the difficulties that they would have to endure during the absence of the migrants.

In the present study, some of the doctors were discouraged from moving to Saudi Arabia by their supervisors. These respondents were registered on Ph.D courses and postponed their studies when they took up the opportunity to work in Saudi Arabia.

Once the doctors had made the decision to move to Saudi Arabia, the majority had to pay only a small sum of money towards making preparations for the move. In most cases their travel expenses were paid for by their employers. The majority paid between E.£.100 to 550, primarily to cover the paper-work necessary and for transport expenses needed to consult the Saudi Embassy in Cairo. Some doctors, however, had to pay extra amounts of money for other reasons. For example, 2 doctors paid around E.£.1500 each to their previous place of work, in order to repay the grant that had financed their Master degrees. This was because they left for Saudi Arabia

before serving the required length of time in their previous place of work after graduation. Another doctor paid a considerable amount of money to an administrator in his previous work place for helping him to get his job in Saudi Arabia. This administrator knew the owner of a private labour recruiting agency, which had a vacancy for a doctor to work in a private clinic in Saudi Arabia. He introduced the doctor to the owner of the agency, whereupon the latter was given the job. Yet another doctor paid E.£.1500 to a private labour recruiting agency to help her to find a job in Saudi Arabia. In addition, she paid for her air-ticket, which her employers did not refund.

These expenses were within the reach of the doctors who had relatively highly paid jobs in Egypt. Low paid workers may find the expenses involved in arranging the trip abroad a difficult hurdle to overcome. Fergani (1988) found that the overwhelming majority of unskilled and semi-skilled Egyptian migrant workers applying for employment abroad in his sample, had to pay an average of E.£.221 to finance preparations for the trip, and many had to pay an average of E.£.363 to other parties who helped them to find employment in other Arab countries.

6.6 REASONS FOR MOVING

Economic reasons were the main motives for the majority of the doctors interviewed (33 respondents) to migrate to Saudi Arabia for employment (Table 33). Another 10 (19.2 %) respondents came to Jeddah to join their spouse. Of these, one of these was a male doctor, the rest were female doctors whose only reason for leaving home was to be with their husband. Of the other respondents, 3 (5.8 %) doctors moved to Jeddah "just for a change". These three respondents are middle-aged consultants and members of staff at medical schools in Egypt. None of them wish to remain in Saudi Arabia for more than a year or so.

The main reason given, a further 4 doctors (7.7 %) is to gain more experience. They liked the idea of working in Saudi Arabia mainly because they were offered employment contracts related to their specialities. Dr.Hind, for example, a consultant specializing in community and tropical medicine, agreed to move to Saudi Arabia simply because it enabled her to work in a hospital specializing in infectious and tropical diseases. Dr.Azah, a hearing specialist, was motivated to take employment in Jeddah it provided the opportunity to work in a large modern private hospital in Jeddah offering advanced equipment for her speciality. The other 2 doctors thought that working in another environment would provide good experience of

dealing with different types of diseases from those found in Egypt.

Table 33
The Main Reason for Moving to Saudi

Reason for Moving	N	%
economic reasons	33	63.5
To join spouse in Jeddah	10	19.2
For a change	3	5.8
To gain more experience	4	7.7
Religious reasons	2	3.8
Total responses	52	100.0

Although Table 33 shows that only 2 (3.8 %) doctors moved to Jeddah on the basis of religious convictions, yet many more respondents gave this as an additional reason for their decision to work abroad. One example of those who were motivated on religious grounds to migrate to Saudi Arabia for employment is Dr.Eibys, a G.P. aged 36. His parents and sisters lived in Jeddah in the mid-1970s. His father was employed there as a teacher, while Dr.Eibys was studying in Egypt at the College of Medicine in Al-Azhar University, a religious orientated university. He explains how strongly he felt about moving to Saudi Arabia:

"My parents would often write to me about the Holy mosque in Mekkah, and the other holy places in Saudi. Even when they came home for the holidays they would talk about these places.

On one occasion they brought me a small bottle of the Holy water of Zamzam, which I kept for three months. All this made me very anxious to see these places for myself, hence I decided to make every effort to find employment in Saudi after my graduation. Therefore, I worked for four years in Egypt after my graduation, as in those days G.P.s were not accepted for employment in Saudi unless they had four years or more of work experience. I even had the chance to work in Libya and Kuwait without the condition of 4 years work experience, with a good financial offer, but I refused in the hope of getting a job in Saudi."

Other studies on foreign migrant workers in Jeddah city have also found that economic reasons were the main motive behind the decision to migrate. For example, Al-Horob (1986) found that the majority (66 %) of his sample of a group of Palestinian migrants in Jeddah took the decision to move to Jeddah for economic reasons. Khaleil (1990) also found that economic reasons were the main factor for the migration of semi-skilled Egyptian workers to Jeddah.

6.7 PREFERENCE FOR EMPLOYMENT IN SAUDI ARABIA OR IN OTHER COUNTRIES

Almost half of the respondents, when asked whether they would have agreed to migrate to a country other than Saudi Arabia, for employment, stated that they were willing to do so only if they were offered employment in one of the Gulf states. However, in Saudi Arabia itself, more than one-third of the respondents stated that they would have

refused to take employment in any place other than Jeddah city. In fact some of these respondents specifically said that their only motivation to move to Saudi Arabia was because the job was in Jeddah. For the majority of female doctors this was because they wanted to live with their husband employed in Jeddah. Other doctors preferred to work in Jeddah because they thought life in the city would be quite similar to that in Egypt. These feelings are clearly evident in some of their comments:

"I was not thinking of coming to work in any part of Saudi other than Jeddah, because I had heard that life in many part of Saudi is quite tough, but in Jeddah it is different, it is a modern city with many places to spend your time in. When I first came to Jeddah I felt as if I had moved from one part of Egypt to another"

"I had worked previously in Jeddah and, from my experience I would say that life in Jeddah is quite similar to that in Egypt, and people here are civilized, contrary to Riyadh city where there are so many bedouins."

"Before moving to Saudi I had heard that life in other places, like Riyadh, is very strict, but social life in Jeddah is similar to that at home. So I did not want to live in a place which is very different from home, in order not to feel homesick."

However, 32 respondents (61 %) were prepared to work in places other than Jeddah. Around half of these respondents were even prepared to work in villages or

remote areas. Most of these doctors work for the Ministry of Health and one of the conditions of their contract, when first given the job, is that they must be prepared to work in any part of Saudi Arabia. These doctors are also relatively young and single, and many of them are G.P.s.

6.8 PRESENT SITUATION IN JEDDAH

6.8.1 LENGTH OF STAY IN JEDDAH

In general, doctors working in hospitals and primary health centres run by the Ministry of Health, stay in Jeddah longer than their counterparts in the private sector. Table 34 shows that the majority of the doctors working in the national health services in this study, have been in Jeddah for more than seven years. One reason for this may be that the Ministry of Health encourages foreign doctors to take long-term employment so they will gain more experience of dealing with health problems in Saudi Arabia. The minimum work contract offered to foreign doctors by the Ministry of Health is for three years. This may be extended by further periods of three years. The overwhelming majority of foreign doctors in the private sector are offered work contracts from one to two years, which may be later extended. This may explain the large

number of doctors working in the private sector who have been living in Jeddah for less than a year.

Khaleil (1990) found that the majority (74.8 %) of semi-skilled Egyptian migrant workers lived in Jeddah between 4 to 8 years. He explained that they tended to stay in Jeddah for relatively long periods in order to accumulate enough savings for their return home.

Table 34
Distribution of Doctors by
Length of Stay in Jeddah

Length of Stay	Private		Public	
	N	%	N	%
Less than a year	16	30.7	2	3.8
1 - 4 years	12	23.0	2	3.8
4 - 7 years	2	3.8	5	9.6
More than 7 years	-	-	13	25.0
Total responses	30		22	

6.8.2 ARRIVAL IN JEDDAH

Most doctors in the sample (32 respondents) initially came to Jeddah on their own (Table 35). Another 10 doctors (19.2 %) travelled to Jeddah with friends, many of whom came to take up employment in the same place of work. Only

5 (9.6 %) doctors came to Saudi Arabia accompanied by their spouses. These spouses were also doctors, and had secured employment in Jeddah before coming to Saudi Arabia (Table 35).

On their arrival in Jeddah, 11 respondents (21.2 %) had not been met at the airport, while the remaining 41 respondents (78.8 %) had been met by various parties. As Table 35 shows, 20 respondents (38.4 %) had been met by representatives from the place of work. These included a general director of the work place, a public relations employee (especially in the case of those coming to work for the Ministry of Health), or Moa'qib (an administrator). The same Table also shows that married female doctors were usually met by their husband who was already working in Jeddah. However, some of the female doctors, who had left their husbands behind and came to Jeddah with a job contract, were met by a representative from their workplace. The regulations in Saudi Arabia do not permit any foreign female employee, under any circumstance, to leave the airport or any other port of entry unless they are met by their husband, employer, or a representative from their place of work. Female migrant workers who are met by friends or relatives, first have to be 'cleared' from immigration by an official from their place of work. This official is required to sign the necessary papers, after which their friends and relatives are able to receive them.

Table 35
Doctors Arrival in Jeddah

Who was with you when you arrived in Jeddah?		
	N	%
No one	32	61.5
Spouse	5	9.6
Children	3	5.8
Friend	10	19.2
Other	2	3.9
Total responses	52	100.0
Who met you at the air port?		
	N	%
No one	11	21.2
Employer	5	9.6
Friends and relatives	12	23.1
Husband	6	11.6
Representative from the work place	18	34.5
Total responses	52	100.0

8.3 ACCOMMODATION

When they first arrived in Jeddah, the majority of the doctors (32 respondents or 61.5%) stayed in accommodation provided by their place of work, particularly those employed in the private sector (Table 36). Those working in the national health services, however, faced some

difficulties in obtaining accommodation. Table 36 shows that 3 respondents (5.8 %), all of whom work for the Ministry of Health, stayed for more than a week in a hotel, which they paid for themselves, before finding permanent accommodation. Some other doctors were provided with accommodation, but this fell short of their expectations. One such case was that of Dr.Ahmed, a Gynaecologist, who came to Saudi in 1980 to work in a Ministry of Health hospital. Upon arrival in Jeddah he was accommodated in an unused ward, which had previously been used to accommodate patients with infectious diseases, in a public hospital different from that in which he was coming to work. This ward was used to accommodate newly arrived foreign doctors. Dr.Ahmed stated:

"I stayed there for 20 days, which were the most difficult 20 days of my life. It was really terrible. The accommodation was extremely poor; it was worse than being in the Army barracks in Egypt. The rooms were especially designed with large windows to allow for direct sunlight for the previously accommodated patients. But this only made matters worse for the doctors who were later accommodated there. The rooms were very hot and humid, especially with the lack of air- conditioning facilities. The accommodation was also a problem for me as it was one and a half hours journey away from my place of work, by public transport. I had to be up in the morning at 5.30 a.m., and even then I was unable to reach work on time (7.30 am). I was often in trouble with the head doctor of my department, as he was unsympathetic to my situation."

Table 36
Doctors Accommodation Upon Arrival
to Jeddah

Accommodation upon arrival	N	%
In accommodation provided by place of work	36	69.2
With friends and relatives	7	13.5
Husband's accommodation	6	11.5
In hotel	3	5.8
Total responses	52	100.0

Married female doctors, who came to Jeddah first as dependents, lived in their husband's accommodation (Table 36). However, 5 married female doctors in the sample came to Saudi Arabia on their own, leaving their husband and children behind. Of these, 2 doctors work for the Ministry of Health. The other 3 work in the private health sector; 2 of these work together in a private hospital. The 2 respondents employed by the Ministry of Health were provided with accommodation upon their arrival in a nurses home provided by their place of work. The 2 who work for the same private hospital were provided with their own private flats. The fifth respondent, Dr.Semiha, a married Paediatrician aged 39, came to Jeddah on her own in 1985, to work in a private health centre. She was provided with accommodation in a room in a flat in the centre. The flat

in which she had lived had three bedrooms. She occupied one, 2 other female doctors another, and 4 nurses the third. She lived in this flat for around three months, until her husband came to live with her in Jeddah. They then moved into a flat of their own.

All Ministry of Health hospitals, throughout the country, provide halls of residence for their foreign female nursing staff and other female health workers, as well as for single foreign female doctors or who come to the country alone. These halls of residence are governed by very strict rules. Female medical staff living in such accommodation are only permitted to leave them to attend to their duties or to go to the city centre for a couple of hours a week, usually at the weekend. They are taken to the city centre by bus and have to return on the bus at a specific time.

These rules are also supposed to apply in the private health establishments, but they are not always observed. As was evident during visits for interviews to private health centres and hospitals. For example, private health centres tend to accommodate their female medical staff on the top floor of the centre, usually the third. One of the private hospitals visited during fieldwork accommodated its female medical staff on the top floor of one of the buildings which provided accommodation for many of the hospital doctors. Exit and entry to such accommodation appeared to be far less strict than in the Ministry of

Health nurses hostels, where security is sometimes provided by the police. These observations were confirmed by a Filipina nurse working in a private health centre and living in a flat with others from the same country, on the top floor of the centre. This nurse said that she and the others in the flat go out shopping almost every day.

Life in a nurses hostel, with movement heavily restricted, can be hard to bear. This was the case for Dr.Nejwa, a 37 year old G.P., married with three children. She had worked in a public hospital since 1982. Initially she had come on her own and was accommodated in a nurses home belonging to the hospital. She remained there for a whole year. She stated:

" I was sharing a room with two Filipina girls. The Matron, a Syrian national, who was in charge of the nurses home, treated me very badly. She put me in a room with the two nurses without even giving me any bed-sheets. However, after complaining to the hospital manager I was given a room of my own. Even so , I was really suffering and felt awful for leaving my husband and children to come and live under such circumstances. In Egypt, I was a very independent person without any restrictions placed on me, whereas when I was living in the nurses home, I was under a lot of restrictions, especially from going out alone. I was extremely unhappy and feeling homesick. I desperately wanted to go back to Egypt. But I was unable to do so as my passport was being kept at my work place, and I was unable to take it back until my annual holiday was due. Therefore, on my holiday I went back to Egypt and decided not to come back unless my husband and children came to live with me in Jeddah. My husband was reluctant to move to Saudi, as he held a very good post which he would have to give up in order to move with me to Jeddah for a lengthy period of time. I suggested that he come for a short while and see if he

would like it in Jeddah. He agreed with the idea, so I came back to Saudi and sorted out the necessary papers for his visa. Eventually he came to Jeddah with the children and found himself a good job. Once we settled down as a family we liked it here and so we decided to stay for a few years."

6.8.4 TYPE OF ACCOMMODATION

The overwhelming majority of doctors in the sample live in flats (Table 37). Only 7 (13.5 %) share a flat with other doctors; these are mainly unmarried doctors working in the private sector. However, most of the married doctors employed in the private sector, who initially came to Saudi Arabia unaccompanied by their dependents, had been also provided with accommodation in shared flats. Once their families joined them in Jeddah, they moved into a separate flat of their own. Most of the doctors in the sample who live in shared flats have a room of their own.

Table 37
The Respondents' Type of Accommodation

Type of accommodation	N	%
Flat	45	86.5
A room in a flat	7	13.5
Total responses	52	100.0

However, the researcher came across 2 doctors sharing a room, and in another case a doctor stated that he had to share a single room with two other doctors. For example, Dr. Mohammed a married G.P., came to Saudi Arabia when he was single and worked in a private hospital. He commented:

"In the beginning there were four of us sharing a three-bedroom flat. After a while it became very crowded in the flat, to the point that there were three doctors sharing one room. Although the management said that it was a temporary arrangement it went on for a long time. I was very disappointed and unhappy about the situation and moved out to stay with some friends."

A accommodation for doctors is provided free of charge, by their employers if they work in the private sector, and by the Ministry of Health in the case of those employed in the national health services. In cases where the employers are unable to provide accommodation, doctors are given a rent allowance instead. While a majority of the doctors employed in the private sector are provided with free accommodation, the majority of those working in the national health services receive rent allowances.

The amount of money paid towards doctors' accommodation differs a great deal between the two sectors. Foreign doctors employed in the Ministry of Health are paid the equivalent of three months salary, while the rent allowance in the private sector varies from one medical

care establishment to another, and depends entirely on the management's judgement.

The majority of the doctors employed in the private sector and provided with free accommodation, live in compounds owned by their employers. These compounds contain residential buildings, two or three stories high, with a large number of flats. They are usually located close to the doctors' work place and exclusively house doctors. Other compounds, however, accommodate both doctors and other employees. The vast majority of accommodation provided by the respondents' places of work is normally furnished, and thought to be generally of a good standard. Only 2 doctors employed in the private sector were given unfurnished residences. However, both were given a furniture allowance.

Most doctors' residences are located quite close to their work place. As a consequence, more than half of the doctors in the sample go to work on foot (Table 38). Since females are not allowed to drive in Saudi Arabia, many female doctors in the sample get to work by obtaining a "lift" from their husband, or use the transport provided by their work place. Those who live nearby go to work on foot. However, walking alone can be risky or may cause problems:

Dr. Suzan, a Gynaecologist, aged 37 working in a private hospital, lives some 300 metres from her place of work. She stated:

"I used to go to work and come back home walking on my own. One morning around 9 a.m. I finished my night shift and was on my way home. A nurse from the hospital was coming to work and a man was walking behind her and suddenly he assaulted her and ran away. I was so scared and did not know what to do-whether to go back to the hospital or carry on going home. The next day I informed the hospital management. After that incident I stopped walking on my own and someone would have to walk me home; sometimes my husband and at other times a porter from the hospital. After a while the same happened to another nurse and to a female doctor. The management, after these incidents asked every female employee in the hospital to be very careful and told married female nurses who live outside the nurses home to ask their husbands to walk them to hospital and pick them up after they finish work. The management also told female doctors to get a lift by hospital transport even if they lived near by."

Table 38
The location of Doctors' Accommodation and
the Means of Getting to Work

Distance of accommodation from place of work	N	%
Near by	28	53.8
Quite near	17	32.7
Quite far	4	7.7
Very far	3	5.8
Total responses	52	100.0
Means of getting to work	N	%
How do you get to work		
On foot	27	52.0
By own car	14	26.9
Transport provided by place of work	5	9.6
By a lift from husband	5	9.6
Other	1	1.9
Total responses	52	100.0

CHAPTER SEVEN

EMPLOYMENT

7.1 SECURING A JOB IN JEDDAH

The Egyptian doctors which comprised the sample secured their employment in Jeddah in various ways. Table 39 shows that there are important differences in the ways that doctors working in the public and private sectors, secured their employment. All those working for the Ministry of Health secured their employment either by 'external contract', whereby they applied for jobs through the Saudi Arabian Medical Attaché in Egypt, or by 'internal contract', in which they found employment by applying to the General Directorate of Health Affairs in Mekkah Province.

The majority of those who secured employment through 'internal contract' first came to Jeddah as dependants, accompanying their husband or wife, and later applied for employment. Other doctors employed in the public sector initially secured employment by 'external contract' and later, for various reasons, moved to another work place.

The overwhelming majority of doctors employed in the private sector secured their jobs through personal channels. Table 39 shows that friends were a major source of help to doctors in securing employment in the private

sector. In most cases, doctors' friends would suggest a friend of theirs to the management when vacancies arose.

Table 39
Securing Employment

Securing the job	N	Private %	N	Public %
With the help of friends	16	30.8	-	-
Through an advert in the papers	4	7.7	-	-
Offered the job	10	19.2	-	-
By applying to the Saudi Medical Attache in Egypt	-	-	13	25.0
Through internal contract	2	3.8	7	13.4
Total responses	32	61.5	20	38.5

Other doctors were helped to secure employment in Jeddah by friends in Egypt. The assistance provided by friends in Egypt is illustrated by some of the doctors' comments:

"My employer needed a Dermatologist, so he contacted a friend of his who is a well known Dermatologist in Alexandria, whom I know personally, to help him to find a Dermatologist to work for him. So he recommended me to my employer and I got the job."

"My employer contacted a friend of his in Egypt to help him to find a doctor to work for him. This person is a friend of mine so he recommended me and I got the job."

"One of my friend's brother, who is a doctor working in Jeddah, knew that my employer needed to recruit two G.P.s, so he helped his brother who is a very close friend of mine, to get the job in Jeddah and he in turn knew that there was a vacancy for another doctor. So he recommended me for the job, and both of us came to work in the same work place."

Table 39 also shows that 10 respondents (19.2 %) employed in the private sector were actually approached by employers or their representatives and offered employment in Jeddah. This group of doctors are highly qualified members of staff at various Egyptian universities and quite well known in their field in Egypt.

These findings concerning the means by which this highly skilled group of Egyptian migrant workers secured their employment differs considerably from the way in which semi-skilled Egyptian migrant workers in Jeddah found their work opportunities. Khalil (1990: 249) found that semi-skilled Egyptians found employment in Jeddah by two main means. He found that 64.4 % secured employment through private employment agencies in Egypt, while 31.8 % of his respondents obtained job contracts with the help of friends and relatives working in Saudi Arabia. These two ways of finding employment abroad were also the main channels by which other Egyptian workers employed in other Arab countries secured their employment (Fergani, 1988: 115).

Most doctors recruited for the public sector had been interviewed before securing employment in Jeddah. The

interview was mainly technical, concerning medical knowledge and experience, and was carried out by a committee from the Ministry of Health.

Unlike their counterparts in the public sector, a considerable number of doctors working in the private sector had not been interviewed before securing employment. These are mostly highly qualified doctors who had been approached by management with an offer of employment in Jeddah, or who were recommended for the job by their friends. Those that had been interviewed were, in many cases, asked general questions about their qualifications and work experience, as well as discussing salary, working hours, accommodation, etc. The interviews were mainly carried out by employers, many of whom were not doctors, or a representative from the work place, usually a doctor. Almost all doctors obtained a written contract for their employment in Saudi Arabia. In most cases the conditions of the contract were fulfilled to the doctors' satisfaction. However, a number of employers in the private sector did not meet all the contractual obligations, as the following examples illustrate.

Dr.Hani, an unmarried Dermatologist, aged 31, employed in a private clinic, reported that:

"My contract stated that I would have a flat of my own. Instead I am sharing a two bedroom flat with another two doctors."

Dr.Abdullah, a cardiologist, aged 38, married with five children, employed in a private hospital, commented:

"In my contract it was specified that my family's travel expenses would be paid for, but after arriving to Jeddah I was told that travel expenses were for me only, which is a violation of the conditions of my contract."

Dr. Ahmed, aged 36, married and employed in a private hospital, stated:

"I was not given a furniture allowance, nor was my family's travel paid for. Also my rent allowance was reduced from S.R.18,000 a year to S.R.14,000 and is 10,000 at the moment."

Another respondent employed in the same private hospital, Dr.Hani, a paediatrician, commented:

"I was supposed to be provided with free accommodation, but instead I was given a rent allowance which was quite adequate in the beginning, amounting to S.R.14,000, but the allowance was reduced to 10,000 and was further cut to 8,000 at the present time."

Violations of contractual conditions may also occur in the public sector. For example, Dr.Hind a consultant, aged 48, employed in a public hospital, stated:

"I was supposed to have furnished accommodation but I was given an unfurnished flat. Also, before coming to Jeddah, I was meant to work in Al-mina hospital, but I was appointed in another hospital instead."

7.2 STARTING EMPLOYMENT IN JEDDAH

More than half of the respondents started their work the day after their arrival in Jeddah table 40. The Table also shows that 9 doctors (17.3 %) who came to Saudi Arabia as dependants started work long after their arrival, ranging from a few months to a number of years. Those who started work within a few months of their arrival in Jeddah did so due to Saudi migration regulations, which prohibit anyone who comes to the country as a dependant from acquiring a job before obtaining a work permit from the Ministry of Interior, which usually takes around two months. In addition, dependants may apply for jobs in Jeddah city only in order to be with their family. They may have been able to obtain employment sooner if they had been prepared to work in other areas. Others had different reasons for not obtaining employment until they had lived in Jeddah for a long time. For example, Dr. Heyat, a Paediatrician, aged 36, with four children, came to Jeddah 10 years ago to live with her husband, who works an accountant in a private construction company. She stated:

"I got married shortly after graduation and came to live with my husband in Jeddah. I did not want to work in the beginning, so I stayed at home for about 4 years. Then I felt I was going to forget medicine, especially because I did not have any work experience in Egypt. So I started looking for a job, but most of the places I applied to for a job wanted a work experience which I did not possess at the time. Therefore, I went back to Egypt to study for a Master degree in Paediatrics, which took me one

and a half years to finish. After that I worked for one year to acquire some work experience and then came back to Jeddah in 1983 and secured employment in a public hospital."

Table 40
Starting the job

Starting the job	N	%
The same day	6	11.5
The next day	27	52.0
In the first week	6	11.5
In the second week	4	7.7
After a few months	9	17.3
Total responses	52	100.0

Although most of the doctors who came to Jeddah as dependants were female, male doctors were also found among this group in the sample of Egyptian migrant doctors in Jeddah. Of these, 2 male doctors were interviewed, and their cases are presented below.

Dr. Mohammed, a G.P. aged 35 and married to a Saudi Arabian doctor. He met his wife while she was studying medicine in Egypt. They married in Egypt and he came to live with his wife in Jeddah. He lived in Jeddah without a job for seven months before securing employment in a public hospital. His move to Saudi Arabia had cost him a great deal of money. He had to rent a flat, and purchase furniture and a car. He also held another wedding

reception in Jeddah for his wife's relatives and friends who were unable to attend the first one in Egypt. He did all this before securing employment in Jeddah.

Dr.Ebiys, a married G.P. aged 36, came to Jeddah in 1986 to live with his wife, Dr. Azah, an E.N.T. specialist aged 33. Dr.Ebiys and their only child came to live with Dr.Azah two and a half months after her arrival. However, Dr.Ebiys remained unemployed for fourteen months, which caused difficulties for the family. As Dr. Azah stated:

"We thought that my husband would find employment within one month or so of his arrival in Jeddah. He and I tried very hard to find a job for him but with no success. It was really hard to see him staying at home with nothing to do. We all suffered for more than a year because of this. It would have been a lot easier if it was me who was staying at home, but you can't imagine how hard it is for a man to be baby-sitting and staying at home most of the time doing nothing. My working hours made it even worse because I work in the morning and in the evening as well. Eventually an Egyptian person working as a representative of a drug company informed me about a vacancy in a private clinic for a G.P. My husband applied to the owner of the clinic and got the job. He has been employed now for a few months but he doesn't like his job at all. He works during the night in emergency from mid-night to 8 a.m. His job is effecting our marriage; we see each other for only a little while every day. I finish work at 9 p.m. while he works at night and sleeps during the day."

On commencement of their jobs most of the doctors were introduced to the medical team and taken on a tour of the various departments to familiarise themselves with the

medical facilities, resources and the work system. Interviews revealed that 5 doctors had undergone some form of training before taking full charge of their job. Of these, 2 were specialists and 3 were G.P.s, working in a private hospital and a private clinic owned by the same individual. These doctors spent some two weeks learning the Saudi dialect and learning how to deal with Saudi patients, under the supervision of a doctor who had spent considerable time in Saudi Arabia. One of these doctors explaining the procedure followed by their employer, commented:

"Our employer doesn't allow us to start working before making sure that we are ready. I was supervised by a colleague for two weeks. In the first few days I was observing him at work, to see how he deals with patients and to get used to Saudi dialect. After a while I examined patients under his observation."

Another doctor specializing in surgery and working as a resident doctor for the same employer, stated:

"I stayed about a week observing other doctors at work in the hospital particularly to learn about the hospital, procedure followed in admitting patients to hospital and discharging them. And after that I started to work on my own."

7.3 WORKING HOURS

Doctors employed in the public sector work fewer days each week than their counterpart in the private sector. They mostly work from Saturday to Wednesday, and only half a day on Thursday, the start of the week-end in Saudi Arabia. Doctors in the private sector usually work from Saturday to Thursday. Nevertheless doctors in both sectors work nearly the same number of hours each week. However, there is a fundamental difference in the arrangement of their working hours, and also between those who work in public hospitals and clinics.

Almost all doctors employed in public hospitals in this study work from 7.30 a.m. to 1.30 p.m., and break for lunch from 1.30 p.m. to 2.30 p.m. Doctors in public clinics usually work from 7.30 a.m. to 1 p.m., and then from 4 p.m. to 7 p.m. Almost all doctors in private medical care establishments work from 9 a.m. to 1 p.m. and later from 5 p.m. to 9 p.m. with the exception of one private hospital where work is from 8.30 a.m. to 1 p.m. and later from 5 p.m. to 9.30 p.m. This arrangement of working hours, in both sectors, is mainly for specialized doctors working in out-patient surgeries. Other doctors working in emergency and in-patient facilities have other working hours. As the great majority of private medical care establishments in Jeddah operate a 24- hour service 7 days

a week, the doctors usually work on shifts arranged by management.

In almost all the private clinics visited during fieldwork, 3 doctors, predominantly G.P.s, work by shifts in emergency through the 24 hours. The shifts change on a weekly basis. The first shift usually runs from 8 a.m. to 4 p.m., the second from 4 p.m. to midnight, and the third from midnight to 8 a.m. Some doctors in public hospitals work shifts which run for a 12-hour period, once or twice a week, others are on 24-hour call twice a month.

Only doctors employed in the private sector, and whose work involves shift-work, have the opportunity to work overtime. This mainly involves working on Fridays or when a colleagues take their annual holiday. Although none of the doctors in the public sector work overtime on normal days, they may earn extra income by working during national holidays, or by working in Mekkah during the Haji (pilgrimage) period.

7.4 PERFORMING THE SAME OR DIFFERENT JOB IN SAUDI ARABIA

20 % of the doctors in the sample carry out exactly the same type of work in Jeddah as they had done in Egypt (Table 41). Another 15 respondents (nearly 29 %) carry out work in Jeddah which is in part the same as that they had done in Egypt. Of these 15, 10 are highly qualified doctors who were members of staff at various Egyptian

universities, and who had held dual work responsibilities in Egypt, e.g. teaching and examining patients. The other 5 doctors, employed in private clinics, work only in out-patient units, whereas in Egypt they had performed both out-patient and in-patient duties.

Finally, 11 of the respondents in the sample perform duties which are completely different from those they had performed in Egypt (Table 41). Of these, 5 are employed in the private sector, working as G.P.s, even though they are qualified specialists. These doctors had accepted employment as G.P.s before coming to Saudi, and therefore are treated by their employers as G.P.s as far salaries are concerned. The other 6 doctors work as G.P.s carrying out emergency duties, whereas in Egypt they were trained as specialists. Most of these doctors had finished the first part of their Masters degree, which is usually the theoretical part, and were preparing for the second part which mainly involves practical work.

Table 41
Doctors' Duties in Jeddah

Doctors' duties	N	%
Exactly the same as in Egypt	20	38.5
Partly = = = = =	15	28.8
Nearly = = = = =	3	5.8
Quite different from that in Egypt	3	5.8
Completely different from that in Egypt	11	21.1
Total responses	52	100.0

Abdul-Mooti's (1984) study of a group of unskilled, semi-skilled, and highly skilled Egyptian migrant workers in Kuwait, found that those who are highly qualified have a better chance of working in jobs similar to those held at home, than those who have few or no qualifications. He found, for example, that only 1 of 5 respondents who used to work as farmers in Egypt worked in a job closely related to what he used to do in Egypt. The other 4 worked as cleaners and watchmen. Among the 5 semi-skilled workers in his sample who had worked in manufacturing jobs in Egypt, 1 found similar employment in Kuwait, while the other 4 worked in the construction and trade sectors. However, even highly skilled Egyptian migrant workers may end up taking jobs which have no relevance to their qualifications. For example, Abdul-Mooti (1984: 73-4) came across a case of a Chemist who had entered Kuwait on a visiting visa (valid for 27 days) and had to find a job during that time to avoid deportation. The young Chemist's attempts to find a job appropriate to his qualifications and skills failed, largely because he had only 2 years experience. However, he found the chance to work as a clerk or supervising a group of labourers 'trapping mice'. He accepted work in the latter job for six months because it gave higher pay than the latter job, although it was hard work. His desperation led him to work in such a job in order to be able to repay his debts, which included the cost of his ticket and other travel expenses.

7.5 DIFFICULTIES WITH THE JOB

Slightly more than a quarter of the respondents reported that they did not face any initial difficulties in taking up employment in Jeddah. However, half of the respondents reported encountering slight difficulties in understanding the dialect of Saudi patients, especially those of Bedouin or rural origin. For a majority of the doctors this was only a temporary problem and was overcome within a few weeks of their arrival and commencement of work. Another temporary difficulty reported by 9 respondents (17.3 %) at the start of their employment was that of familiarising themselves with the commercial names of drugs available in Saudi Arabia. These differ from those available in Egypt, although their scientific names are the same. However, there are other difficulties which Egyptian doctors continue to encounter in their work in Jeddah. For example, 14 respondents (27.0 %) reported that they encounter communication problems with non-Arabic speaking patients. These patients not only cannot speak Arabic adequately they cannot speak any other language known to the doctors, such as English. To deal with such patients, doctors usually use sign language to communicate. Doctors also try to find out the nature of these patients' complaints by using the same technique as they would use when examining little children, that is, to press the suspected sore parts of their bodies while watching the reaction on their faces.

Another difficulty, and one which is of major concern to 10 respondents (20 %) in their present job, is the fear of being in trouble with the Saudi medical laws. These laws provide for severe punishments of doctors who are found responsible for medical malpractice. Most of those at high risk from such accusations are specialists, whose duties involve carrying out, or assisting in, operations. However, doctors working in out-patient units also have to be careful. As Dr.Semiha a Paediatrics aged 39, employed in a public clinic, stated:

"Here we are very scared that something might happen as a result of treating a patient and then we might be held responsible and have to pay compensation. And personally I do not prescribe new drugs in order to be on the safe side. But in Egypt I was very brave in trying new drugs. Sometimes we do not even treat a dangerous case, but we refer it to a hospital."

Some doctors feel that Saudi medical laws and regulations are excessively strict and quite unfair, in that they place full responsibility on the doctors without taking into consideration that complications may occur after operations. As a result, doctors usually try to avoid becoming involved themselves in treating difficult cases. There is always the threat that if anything does happen to a patient and malpractice is suspected it will lead to an inquiry which could take a long time. Those who are under investigation would not be permitted to leave the country until the inquiry was over. The fear of being

punished may often lead doctors to be over-cautious and to try to protect themselves, even if the patient's condition is not particularly serious. For example, Dr.Nejwa a G.P. aged 37, employed in a public hospital, commented:

"One of our colleagues was on duty when a pregnant woman came to the hospital suffering from what she had thought was labour. After examining this patient the doctor told her that she suffered from a false labour and that she was not ready to give birth for maybe a day or so, and she asked her to go home and to come back to the hospital when she was in labour. Instead, the pregnant woman went to a private hospital and was admitted to hospital instantly for a caesarian operation. The woman complained later to the Health Authority, which accused the doctor of misconduct, and the doctor was ordered to pay for the cost of the woman's treatment in the private hospital, which amounted to S.R.10,000. So all of us, particularly when working in emergency, admit patients to hospital even if it is not necessary and their condition is not very serious, in order to be on the safe side, because if we do not admit them to hospital they might go to a private hospital which could take advantage of the situation and then we will be in trouble. This is what happened to our colleague when the private hospital claimed in their report that the woman's condition was very serious and had reached a dangerous point where they had to operate on her instantly."

Dr.Nejwa also claimed that when a patient is admitted for treatment in the in-patient unit, doctors try to be very careful because all those involved in the treatment could be liable for punishment if anything goes wrong.

"In the incubator department a new-borne child died and the cause of death was due to heart failure which the treating doctor did not discover. The child's father complained to the Health Authority. After investigation, the treating doctor was ordered to pay the child's father compensation, and everyone from the medical team which was involved in the child's treatment, and particularly those whose names appeared in the medical report of the patient, was punished. Some of them had their wages suspended for 15 days, some others for 3 days. These things make doctors very scared of writing their names in patients record, especially if the patient's condition is dangerous then everyone would try not to get involved and try to pass the responsibility onto others. For example, the consultant would ask the resident doctor to write his/her name on the patient record. The fear of being investigated by the authorities also discourages doctors from being adventurous in their treatment, which prevent them from learning and gaining more experience."

Dr.Nejwa also reported that medical establishments would even transfer patients who were expected to die to the hospital where she works, in order to avoid investigation by the medical authorities.

An additional problem peculiar to married female doctors with children, is that of coping with the long working hours in Saudi Arabia, compared to those in Egypt.

7.6 DIFFICULTIES WITH SAUDI ARABIAN PATIENTS

Slightly over 25 % of the doctors reported that they have not faced any difficulty in dealing with Saudi patients. However, 7 respondents reported that they feel that their Saudi patients want to get better very fast.

For instance, Dr.Hani, a Dermatologist aged 31, employed in a private clinic, commented:

"Saudi patients are very hard to treat. They want to get better very quickly, so they go to see a doctor and when not feeling better fast they will go to see another one. I often explain to my patients that they should take the prescription for 14 days and should come to see me after one week of taking the prescription for a check up, because skin disease needs a long period of treatment. Also Saudi patients tend to evaluate the doctor by their own experience. For example, if a patient got better fast, he will bring a check up to this doctor, and if not, he would not come back to the same doctor again and would not recommend him to others."

Dr.Semiha, a Paediatrician aged 39, working in a primary health care centre, stated :

"Some mothers feel that their children should get better shortly after examination and they won't wait for the medicine to take affect. They take the prescription in the morning and come back in the evening complaining that the medicine did not work."

Another difficulty which doctors reported as encountering with their Saudi patients is that some do not follow the doctor's orders and do not commit themselves to following the treatment instructions. The doctors felt that this effected their efforts to cure patients. As Dr.Majed, a Cardiologist aged 32, employed in a private clinic, stated:

"Saudi patients want to get better fast, yet they do not co-operate with me to cure them. For instance, I find it very difficult to get the point across to them that diet is a very important part of their treatment, besides medicine. And since people here have got used to a certain type of food, therefore it is very hard to convince them to change their diet. So the treatment doesn't bring the expected results."

Another Dermatologist working in the private health sector, Dr.Jemal, aged 32, commented:

"Some of my patients don't follow the treatment instructions. Some of them, for instance, don't take the full course of their medicine. They will take a little bit of the medicine and then leave it because they are not getting better quickly enough. Others don't continue to take the full course of their prescription after feeling better, although the nature of their illness requires that they should take the full course- for example, those who are diabetic or suffer from high blood pressure."

Dr.Azah, an E.N.T. specialist aged 33, working in a private hospital, reported that it is difficult to persuade some patients to accept her judgement regarding their treatment. She commented:

"Sometimes I ask patients to stop eating or drinking for a couple of hours before starting their treatment. But some of them get very annoyed with me and refuse to do that, thinking that I don't want to work. And because they pay for their treatment they want the

doctors and the hospital to be at their disposal."

However, patients' co-operation with doctors may be achieved through educating and establishing good relationships. Dr.Nejwa, a G.P. aged 39, employed in a primary health care centre, explained:

"Most of the patients who visit this clinic are Bedouin. When I started work in the clinic 4 years ago, these Bedouin didn't listen to my advice, or follow the treatment instructions properly, and their co-operation with me was very low. But now, so many of them have health awareness, because I always lecture them on matters of hygiene, especially how to take care of little children. And also, with time, I have got to know them personally and I know many of them by name, so we have developed mutual trust. Therefore, they respond to all my instructions, unlike in the beginning when there was no personal relationship with them."

An additional problem, which 4 of the respondents encountered in dealing with Saudi patients, was their interference in the doctor's treatment attempting to dictate what treatment they should be given for their illness. The comments of some doctors employed in the private sector, on this difficulty are revealing.

"Some of my patients dictate the type of medicine which they want for their treatment. A typical example of this type of patient is those

who ask to be given injections rather than pills, which sometimes is not possible."

"Some patients who suffer from Asthma would object if I prescribed an inhaler for them and would ask to be given drugs instead."

The interference by Saudi patients in the doctors job is not confined to the private sector only. For example, Dr.Mohammed, a surgeon aged 40, employed in a public hospital, stated:

"Some of the patients would sometimes ask me to prescribe for them a particular type of medicine, saying that they are accustomed to using that particular medicine. It takes time and effort to try to explain to such patients why they aren't given this drug and they should take another instead. Some others would demand to be admitted to hospital for an operation, even though there is no place available in the hospital and their condition isn't so urgent and could wait for a little while. But they always want their demands and wishes to be met instantly."

Dr.Hind, a consultant aged 48, employed in another public hospital, stated:

"People in Saudi Arabia admit themselves to hospital and leave when ever they feel like it. For example, if someone's wife is admitted to hospital and after a day or two she feels a little bit better, her husband would insist that she should be discharged, knowing that he could

always bring her back to the hospital if her condition deteriorated. But such things couldn't happen in Egypt, because it will be explained to the patients that if they leave the hospital by themselves they won't be given a medical report for their work place if they ask for one, and they won't be allowed in the hospital again after leaving without the approval of the treating doctor. But in this hospital it is the opposite; if a patient leaves today, he/she could be admitted the following day."

One further issue Egyptian doctors reported was the difficulties they face in dealing with Bedouin patients: 5 doctors drew particular attention to difficulties in dealing with this group of patients. For example, Dr.I.H., a G.P. aged 40 employed in a private clinic, explained the types of difficulties that doctors may face when treating Bedouin patients:

"Perhaps because Bedouin don't have the experience or the habit of going to the doctor when they were young, they can't explain clearly what their complaints are. When I ask some of them what they feel, they will say, 'I don't know. Examine me, you are the doctor.' "

Another G.P., Dr.Isam, a colleague of Dr.I.H., stated:

"Some of the Bedouin men don't allow me to examine their wives and tell me to ask questions only. Some others will stay very close to me, over-looking my shoulders when I examine their wives, despite the fact that there is always a nurse with me during examination. And they argue with me a lot if I ask them to have some tests."

Dr.Ahmed, a specialist in bone surgery, aged 36, commented:

"Because bedouins depend largely on traditional medicine, particularly in treating broken bones, I find a great difficulty in convincing them to have a plaster put on in the hospital when they need to do so."

Doctors working in the public sector are often required to treat patients who they felt do not need to be treated. For example, 3 doctors in the sample, two of whom are employed in a primary health care centre and the third in a hospital, reported that they "waste their time and effort" with a number of patients who only suffer from minor illnesses. As Dr.Mohammed, a G.P. aged 37, working in a primary health care centre , commented:

"Because the public health service is available free of charge, many people take advantage of that. So many patients visit this clinic, and a large number of them can't be described as patients. Some of them, for example, would only be suffering from exhaustion and only need some rest, yet they think that they ought to be given some medicine."

Doctors working in in-patient units reported that they sometimes encounter difficulties with patients' relatives. These relatives are usually anxious to know everything about the patient's condition, especially when patients are being treated privately. For example, 4 doctors, 3 of whom work in the private sector, reported that they found it

distracting to have to cope with anxious relatives. A typical comment in this respect was:

"Patients' relatives ask questions all the time about the condition of their sick relatives and I have to explain to them the same thing again and again."

Some of the patients' relatives, however, may become impolite and abusive, and may insult the doctor concerned. As in the case of Dr. Fatimah, a Psychiatrist aged 42, employed in a private hospital.

"A Syrian lady was admitted to the Psychiatry department in the hospital. The next day, her son in-law, a Saudi citizen, came to me to ask about her condition. I explained to him why the patient was admitted to the hospital. But he became very angry when I told him that she had to stay in the hospital for a few days. Using very strong language, he demanded that his mother in-law should be discharged from the hospital as quickly as possible, because the patient's family could not afford to pay for her treatment. And he went on saying: 'she is a foreigner like you, trying to survive.' "

Queue-jumping is another nuisance faced by doctors working in the public sector. An important cause of this is that some hospitals and clinics in the public sector are not well organized. This problem, however, does not seem to occur in the private sector, where there is a greater emphasis on good organisation. However, some privately

treated patients are unwilling to wait in the queue, for even a few minutes. As Dr.Mohammed, a specialist in internal medicine and the general director of a private clinic, commented:

"One of the most persistent difficulties all of us have in the clinic is the unwillingness of patients to wait for their turn for 5 minuets before seeing the doctor."

Another serious problem which some doctors find is the prejudice they encounter from some patients because they are foreigners. Of the doctors in the sample, 4 employed in the public sector reported that they have been subjected to racist remarks by some Saudi patients. For example, Dr.Semiha, a Paediatrician aged 39, reported that she gets into trouble with some patients if she tries to put them in order and make them take their turn.

"Some of the patients don't take any notice of the queue and wait for their turn to see me. And they don't like it if I ask them to be in order and they get very angry if a foreign patient gets to see me before them. Some of them insult me verbally if I ask them to be confined to their turn. They will say: 'You work for us' or 'You get paid with our money'. I hear this quite a lot."

Dr.Nihad, a Psychiatrist aged 33, employed in a public hospital, also reported that some Saudi patients show little respect for foreign doctors.

"If you are a foreign doctor then the patients expect you to obey their orders. Once, for example, someone asked me to write him a report to his work place saying that he was ill and he needed to be on sick leave. When I refused to do that he insulted me."

Dr.Diy'a, a Gynaecologist aged 37, employed in a public hospital commented:

"Patients here show no sympathy or respect to foreign doctors. Their attitude is that the government brought us to work for them. Therefore, we ought to be at their disposal. In Egypt, patients come to you because they need your help, so they accept your judgement and listen to your instructions without questioning, whereas here, they always argue with me because of their idea that we are supposed to do whatever they want."

Dr.Nejwa, a G.P. aged 37, describes some of her experiences while working in an out-patient unit in a public hospital, as follows:

"Saudi patients have unusual powers in their relations with doctors compared to those in Egypt. Here they give orders to doctors, shout at them and some of them would throw the medicine back at the doctors if it didn't bring results to their satisfaction. Also they complain about little things to the hospital manager, who would usually take their side and give us a verbal warning. Knowing this, patients threaten doctors that they will complain to the

manager and some would even threaten to complain to the King. Some patients could get very nasty and abusive to foreign doctors and swear at them. One of the things they particularly say to insult Egyptian doctors, which is very common, is 'You Egyptians are beggars- you come here to beg for money'. Once, an officer in his uniform had a big argument with one of my colleagues and he spat on her, and when I came to investigate what the problem was and asked what was wrong, he spat on me as well. In Egypt, doctors are very big-headed, but here, their noses are in the ground."

7.7 PROBLEMS WITH MANAGEMENT

There is a major difference in the management systems followed in the public sector compared to those followed in the private sector. In the public sector, the managing director of a hospital or clinic is the highest authority in the work place. Private health establishments are managed by two main authorities: the owner, who in many cases is not a doctor, and a managing director, who is required to be a doctor, appointed by the employer. This director is responsible for co-ordinating working systems as well as other administrative tasks. In private clinics the director also examines patients, but not necessarily so if working in a hospital.

The managing directors of private health establishments have less power than their employers. The relationship between the general director and employer may be illustrated by reference to the case of Dr. Majed. Dr. Majed, a Cardiologist aged 32, came to Saudi Arabia in 1986 to work in a private clinic in the city of Taif. He

was appointed general director by the owner of the clinic. However, his authority was limited, as the final responsibility for most decisions rested with the owner.

"I was appointed as a general director of the clinic just to comply with the Minister of Health regulations. Therefore, my employer limited my responsibilities to administrative work. I couldn't for instance, issue a decision to punish any of the employees in the clinic because if I decided to punish someone for some valid reasons the owner would cancel that decision, if he had a good relationship with that person, or if he felt that it wasn't necessary to implement the decision. So there was no order in the clinic."

The majority of the doctors in this study do not seem to have had any major difficulties in working with their managers. However, not all of the doctors were so fortunate. One such was, Dr. Mohammed, a G.P. aged 37, who had worked in a primary health care centre since 1986. He came to Saudi Arabia in 1980 on a contract for two years, to work in a private hospital in Jeddah. After one year in that hospital he left and went to work in another private hospital. The reason he gave for this change was that his initial employer paid him only S.R.3000 per month, which is quite a low salary by Saudi standards. As a result, he began looking for another job in Jeddah with better pay, and managed to find work in another private hospital at a salary of S.R.5500. However, his employer refused to give him permission to leave his job, and it

was only when his Saudi in-laws went to talk to the employer that he was able to take employment in the other private hospital. Dr.Mohammed worked there for 5 years, before resigning and taking up employment in a primary health care centre. This was due to a disagreement with his second employer:

"After a couple of years of my work in the second job, the number of private hospitals had increased considerably in Jeddah. As a result we started to receive fewer patients in the hospital. Consequently my salary, and that of other doctors, was reduced. And eventually our employer introduced a new pay system, in which doctors are paid according to how much money each doctor brings to the hospital. So sometimes my salary would be increased or decreased. And because I was married I didn't like the fluctuation of my income and also being pressurised by my employer to bring more money to the hospital. So I decided to leave my job and find work in the public sector, which offers less money than the private sector, but at least doctors aren't obliged to make money for the work place."

The pressure from employers on doctors to bring in more money by exploiting patients is highlighted by the case of Dr.Semiha, a Paediatrician, aged 39, who came to Jeddah more than 2 years ago to work in a private clinic. She worked there for only 5 months, and then resigned to take up employment in the public sector:

"My employer wanted me to request patients to undergo various tests and X-rays, regardless whether their case required such tests or not, in

order to increase the clinic's income. And because my speciality doesn't usually require doing tests, I refused to take advantage of patients. Because of this dispute between me and my employer, I left the job and applied for work in the public sector."

Another doctor was actually "sacked" because his conscience would not allow him to engage in these practices. Dr.Ebiys, a G.P. aged 36, who had worked previously in a private clinic in Khamase-Meshed city, stated:

"After a while in my job, I started to notice that my colleagues brought a lot more money to the clinic than me, by requesting patients to have excessive tests in order to please our employer. And because I did not use to ask my patients to have unnecessary tests, I was in a difficult situation with the employer, who kept asking me as to why I was not making as much money as my colleagues. And he would urge me to do my best to do the same as the others. Eventually I was sacked from the job, because I refused to steal patients' money like the others. After being sacked, my employer refused to pay for my return ticket or to pay me a month's salary, which was specified in my contract. I then took the matter to the Saudi Labour Office which ordered my employer to give me all that I was suppose to have, because he had ended the contract without any valid reason."

Not only do some employers interfere in the day-to-day work of the doctors, they may also dictate their employees' social life. For example, the owner of one particular private clinic in Jeddah has instructed the doctors working for him not to "mix" or make friends with

Saudi nationals. The reason for this, according to Dr.Hani, a G.P. working in the clinic, is that in the past one of the Egyptian doctors in the clinic used to examine patients privately in his home. Dr.Hani stated :

"Some doctors in the building come to our flat pretending that they want see us for a while or asking about something. But in fact they only come to keep an eye on us. And because we are single in the flat they feel free to call at anytime."

Egyptian doctors working in the public sector seem to encounter different problems with their work management than those in the private sector. One such problem is discrimination against foreign doctors in favour of Saudi doctors. Dr.Ahmed, a Gynaecologist, and Dr.Nejwa, a G.P., both working in a public hospital, described the attitude of the previous management of their unit towards foreign doctors as follows: Dr, Ahmed stated:

"There was distinct discrimination between Saudi and foreign doctors, especially with regard to the annual holiday, where Saudi doctors would be able to take their annual holiday anytime they wished, but for us, we would take our holiday not according to our wishes, but whenever the head of the unit decided, which was usually an unsuitable time of the year for us or our families, e.g. during summer, when doctors, especially those with children at school, would be able to travel to Egypt."

Dr.Nejwa stated:

"The previous management used to favour Saudi doctors to work in in-patients while foreign doctors were to work in out-patients, which is the worst place in the hospital, because it is very hard work and doctors don't learn anything from working there. During the many years under that management, foreign doctors were treated as servants."

Discrimination between nationals and Egyptian migrant workers has been reported in many Arab labour-importing countries in the Middle East. Fergani (1988) surveyed a large sample of Egyptian migrants returning home after the completion of job contracts in many Arab countries, including Saudi Arabia. He found that 47 % of the respondents reported that citizens of the host countries are given a lesser work load, 50 % stated that their national counterparts got higher wages, and 39 % stated that the citizens of the host country enjoyed many more privileges.

7.8 THE NEGATIVE EFFECT OF MIGRATION ON DOCTORS' SKILLS AND EXPERIENCE

Of the total of 52 Egyptian doctors in the study, 12 said that their move to Saudi Arabia had adversely effected the development and progress of their medical skills and experience. Of these, 7 doctors felt that their migration

to Saudi Arabia had prevented them from developing the skills and experience needed to become specialists. Most of these were registered on Master courses at universities in Egypt. As well as working in their chosen specialities in different medical establishments under the supervision of senior doctors while in Jeddah they work as G.P.s., performing what they consider to be routine tasks. The other 5 respondents, who are specialists employed in small clinics in Jeddah, felt that their medical experience had been adversely effected due to the fact that their duties are confined to working out-patients, which mainly concerns simple cases. Whereas in Egypt they had worked with both out-patients and in-patients, which meant dealing with more difficult and advanced cases.

However, 20 respondents reported that they had benefited from a medical point of view from working in Saudi Arabia, in some respects, but that there have been some adverse effects on their experience in other respects. Half of these respondents are highly qualified doctors working mainly in out-patient units, while in Egypt they used to teach in Egyptian universities as well as treating patients. According to the other half of this group of doctors, the development of their medical skills and experience had been adversely effected because they only examine a small number of patients with simple complaints daily, compared to their work load in Egypt. The difference between the work load of these doctors in Jeddah

and in Egypt is highlighted in the comment of Dr.Jemal, a Dermatologist aged 32, employed in a private clinic.

"Here I examine no more than 10 cases a day, but in Egypt, especially in the summer, I would see about 100."

7.9 LEARNING AND ACQUIRING NEW MEDICAL SKILLS

Over three-quarters of the respondents felt that they had gained more medical knowledge and experience through their employment in Jeddah. Slightly less than one-quarter felt that their employment had not increased their medical experience, although they said that moving to Saudi Arabia had enriched their personal experience (i.e. living in another society and meeting different people with different customs).

One-quarter of the doctors who felt that they had benefited from a medical point of view, attributed that to dealing with and treating patients of many different nationalities, with different types of diseases not common in Egypt. Another 11 of the doctors interviewed, mainly working in large modern hospitals, felt that they had benefited from using very advanced medical equipment and facilities, which were not available in their previous place of work in Egypt. Another 6 respondents (11.5 %), employed in large hospitals and particularly in in-patient units, felt that they had benefited a great deal from

working alongside, or under the supervision of, highly qualified doctors.

In addition, doctors working in the public sector have the opportunity to develop their medical skills and experience by joining one of the many different training programmes organised by the Ministry of Health for the development of employees' skills. For example, 3 of the doctors in this study had enrolled in a training programme to learn how to work with special equipment for the treatment of sun-stroke and heat exhaustion. They did this in order to join the medical care units provided by the Ministry of Health in Mekkah during the pilgrimage season. Another 2 doctors had attended other training programmes related to their specialities.

Of the other respondents, 3 employed in the public sector said that they had benefited greatly from attending seminars and conferences. As Dr.Semiha, a Paediatrician, aged 39, working in a primary health centre, stated:

"The number of conferences on Paediatrics I attended in Jeddah was much greater than I did at home, as in Egypt the number of conferences is much more than that in Jeddah in general, but on Paediatrics there may be one or two conferences a year."

The other 2 doctors in this group, Dr.Hind and Dr.Rifat also felt that they had learned a great deal from attending many seminars and conferences in Jeddah. Dr.Rifat said

that he had also taken the opportunity to attend an international conference in Riyadh, with his travel expenses paid by the Ministry of Health.

Another 3 doctors reported that their careers' had changed as a result of taking employment in Saudi Arabia, in that they learned, or gained experience in, another speciality. The first of these, Dr.Shireen, aged 36 married with three children, came together to Jeddah in 1980 with her husband, also a doctor, to work in a public hospital. She worked there as a G.P. for two years. In 1982 she moved to Riyadh to study for a Diploma in Paediatrics. She and her husband were transferred to work in Shimasy Hospital in order to be able to attend the course. She studied for one year in King Saud university, after graduation she returned to Jeddah to work as a Paediatrician.

The second, Dr.Nejwa, is a G.P. aged 39, married with 3 children. She and her husband, also a doctor, came to Jeddah more than 8 years ago to work in a public hospital. In Egypt she was the general director of a public clinic, performing the duties of a G.P. duty. In Jeddah, she worked first in a general public hospital in the in-patient unit, where she learned how to check and monitor the conditions of patients admitted. She worked there for 3 months, after which she was transferred to work in a children's and maternity hospital which had just opened. There she worked in children's units for 3 years and

currently works in a primary health care centre as a Paediatrician. Finally, there is Dr.Nejwa a G.P. aged 37, married with 3 children. She first came to Saudi Arabia in 1982. She graduated from Cairo University in 1973. Before coming to Saudi Arabia she had worked in a public hospital in Cairo for 5 years as an assistant internal medicine specialist. During that time she studied for a Master degree in Cardiology. She managed to pass the first part of her course, but failed the second part in 1978. Although she was recruited to work in a public hospital as a G.P., she was appointed to work in a children's out-patient unit as a Paediatrician:

"My present job in Jeddah is a major change in my career, from studying and training to become a Cardiologist to be working now as a Paediatrician which I did not know anything about. When I was interviewed for my job in Saudi Arabia, most of the questions were about Cardiology. My contract was for a job as a G.P., but I was told that there was a possibility for me to work as resident doctor in the Cardiology department in a public hospital. However, after coming to Saudi I was appointed to work in the Paediatrics out-patient department, because the Cardiology department wasn't opened at the time in the hospital that I work in. In fact this, department was opened about 2 years ago, and even then I was not accepted to work there, as the management informed me that they wanted to train Saudi doctors in the department. Instead I was offered a job as a Cardiologist in Mekkah but I refused to leave Jeddah."

In his study of semi-skilled Egyptian migrant workers in Jeddah, Khaleil (1990:282) reported that the majority of his respondents (87.4 %) had gained a great deal of experience from their employment. However, he failed to explain in what way they had gained their work experience, nor did he explain whether they had learned or developed any new skills from their employment in Jeddah.

Evidence from the labour-exporting countries of South-East Asia indicates that temporary migrant workers from this part of the world to the Middle East do not generally learn new skills, nor do they come into contact with new technologies and modes of production that may enhance their experience. Stahl (1986), for example, analysed information collected by the Labour Department in Thailand on Thai workers overseas, and found that 241 respondents out of a sample of 424 migrants working in the Middle East worked in the same occupations that they had undertaken back home. Stahl (1986) assumes that these workers would not have experienced any considerable degree of skill acquisition. Although the sample showed that 156 workers took up jobs which enhanced their skills and experience, Stahl points out that 118 of these were unemployed prior to their migration and were, therefore, placed by the authorities in the category of 'probable skills acquisition'. Stahl also shows that 19 workers were subjected to 'probable skill loss' because they gave up their skilled or professional occupations in Thailand and

worked in unskilled occupations in the Middle East. Finally, Stahl points out that 8 other workers took up new types of employment in the Middle East. While this would have improved their skills, it may have been at the expense of losing the skills acquired in their previous occupations.

Smart et.al, (1986) examined a subsample of nearly 500 Filipino migrant workers in the Middle East, part of a survey of 800 overseas workers conducted by the Institute of Labour and Manpower Studies (ILMS) in the Philippines in 1981. They concluded that Filipino workers in the Middle East do not acquire skills of any significance for Philippine development: 74.6 % of workers had not learned any new work skills and the minority who did so, did not acquire their new skills on the job, as might be expected, but rather as a result of a formal training programme. They further argued that the vast majority of these newly acquired skills were ordinary and could easily have been learned in the Philippines.

CHAPTER EIGHT

FRIENDSHIP AND SOCIAL NETWORK

8.1 MAKING FRIENDS IN JEDDAH

The overwhelming majority of the respondents in this study have friends from Egypt living and working in Jeddah. More than half of the respondents' friends are also doctors, Egyptians and other nationalities. Another 20 respondents (38.4 %) have friends from medical and other professions. Slightly less than half of the respondents made friends when they first arrived in Jeddah by mixing with other Egyptian doctors in their place of work. Another 15 of the doctors interviewed (28.8 %) became reacquainted with people in Jeddah whom they had known back home, and in many cases, with whom they now work.

Most of the female doctors who first came to Saudi as dependants of their husbands initially made friends through neighbourhood contacts, and with wives of their husbands' friends. However, after securing employment in Jeddah, they made their own friends through their place of work. Of the doctors in the sample, 6 respondents (11.5 %) had relatives living and working in Jeddah prior to their migration there.

More than three-quarters of the doctors found it easy to make friends on arrival because of the large number of Egyptian migrant workers in Jeddah, particularly among doctors where Egyptians constitute the largest single foreign group in the city.

Table 42
Making Friends in Jeddah

Making friends	N	%
Through friends and relatives	6	11.5
Mixing with other Egyptians in the work place	29	55.8
Already knew them from Egypt	8	15.4
Through neighbourhood	5	9.6
Through husband	4	7.7
Total responses	52	100.0

Despite the fact that the respondents live and work among a large Egyptian community in Jeddah, in many cases their relationships with each other seem to be rather weak, and many tend to have a limited number of close friends. One reason for this, according to Dr.Nejwa, a married G.P. aged 37 with 3 children, employed in a public hospital, is the lack of time.

"Working for long hours and looking after 3 children, prevent me from getting to know people closely. Therefore, I don't have any close friends in Jeddah and most of those whom I know are colleagues in the workplace, and my relationship with them doesn't exceed being colleagues and there is hardly any contact with them outside the workplace. My family and I feel isolated, and that is particularly hard on the children, who don't have the chance to meet and play with other children."

Another respondent, Dr. Abdul-Hameed, married with 2 children and a Gynaecologist working in a public hospital, also found it hard to maintain contact with his Egyptian friends because of work and family responsibilities. He stated:

"I don't have much time during the week and at the week-end I get very busy with the family and it is really hard for me to keep in close contact with the people I know in Jeddah. For example the wife of one of my close friends gave birth two weeks ago and I still haven't been able to visit them although I bought the present a long time ago."

Shift-work may also prevent doctors from establishing close contact with other people. For example, Dr. Mohammed, a consultant specializing in internal medicine, works in a private hospital emergency unit. He mainly works night shifts and is also required to work during the weekend. Because of his odd working hours, he finds it very

difficult to establish close friendships either with other Egyptian colleagues or with Saudis. He commented:

"When I was in Egypt I worked normal working hours, and I also had many close friends. Therefore I used to have a lot of social engagements and regularly exchange visits with relatives and friends. But here I don't have the time to get to know people, and worse still, those whom I already know from back home and who work with me in the same workplace in Jeddah I don't contact them because they have different working hours and therefore they don't get in touch with me. So me and my wife feel bored and lonely and isolated from the society."

Other doctors, however, have other reasons for not making the effort to establish strong relationships with other Egyptians living and working in Jeddah. For example, Dr.Fetimah, a married female Psychiatrist aged 42, had worked in a large private hospital for just over a month. She came to Jeddah on her own, leaving behind her husband in Egypt. Her husband is an officer in the Egyptian Army and was unable to leave his job to join his wife in Saudi Arabia. Dr.Fetimah lives alone in a flat provided by her employer. Because her husband is not with her and because she has been working in the country for only a short time, she does not know what to expect from people and, therefore, she tries to keep a very low profile as far as making friends in Jeddah is concerned. She stated:

"Personally I don't like to make friends with people until I get to know them very well first. And here I'm trying to be very careful as I'm only new in this place and I don't know what people are like. In a way I feel a bit scared of getting involved with some untrustworthy people."

It appears that some Egyptian doctors working in Saudi are quite suspicious of each other. Dr.Mohammed, a G.P. aged 39, who had worked in a private hospital in Jeddah for more than 4 years, explained why some Egyptian doctors are quite cautious in their relationship with each other. Dr. Mohammed stated:

"In this hospital I noticed that Egyptian doctors are very eager not to lose their jobs; therefore they are very cautious in what they say and how they behave and who they mix with. And since they came to Saudi for the purpose of establishing themselves financially, most of them shut themselves up or keep themselves to themselves. And that is why one's relationships are limited."

Dr.Suzan, a Gynaecologist who has worked in a large private hospital for one year, supports Dr.Mohammed's comments:

"I feel that Egyptian doctors here are scared that someone will take their job. This is maybe because most of them came to Saudi for the money. This could cause envy and mistrust between colleagues. Therefore, I have noticed that cooperation and understanding each other in our place of work, so that we become one team, takes a long time."

These comments are consistent with the remarks made by Ibrahim (1982), who pointed out that when Egyptian migrant workers employed in the oil-rich countries of the Middle East go back to Egypt permanently or for a holiday, they rarely talk about whether they enjoy their work abroad. Rather, they concentrate on describing their competition with other workers in order to have their job contract extended or their conflicts with employees of other nationalities.

The great majority of the doctors (44 respondents or 84.6 %) have Saudi friends in Jeddah. They stated that they get to know mainly them through the workplace, by working with them as colleagues and administrators. This is particularly so in the case of those employed in the public sector. The doctors also made friends with some of their Saudi patients or their relatives, especially when they are successful in curing them (Table 43). A typical comment in this regard was:

"Many patients, when they get better, want to be friends and they will invite me to their houses."

In addition, most female doctors get to know Saudi families through neighbourhood contacts and also through their husbands (Table 43). Dr. Rewhiyah, a married consultant employed in a private hospital, had lived in

Jeddah for less than a month. However, her husband, Dr.Soliman, a consultant aged 40 who had worked in the same hospital for almost a year, had managed to establish good relationships with some of his Saudi patients, who became friends after he had treated them. Dr.Rewhiyah came to know some of these Saudis through her husband. She stated:

"When some of my husband's Saudi friends knew that I had joined him in Jeddah, they came to introduce themselves to me and to ask me around."

Table 43
The Ways in which Doctors Get to Meet Saudi People

Making friends with Saudis	N	%
Colleagues in the same work place	19	36.5
Through Egyptian friends & relatives	6	11.5
As patients & their relatives	14	27.0
As neighbours	4	7.7
Through husband	3	5.8
No response	6	11.5
Total responses	52	100.0

However, doctors' friendships with Saudi people appear to be a rather formal relationships, which may be best described as "people they know" rather than friends. This

is particularly the case for those employed in the public sector, who have many more opportunities because they work with a considerable number of Saudi medical personnel and administrators, than their counter-parts working in the private sector. Typical of many of the doctors' comments is:

"My relationship with the Saudis at the workplace doesn't exceed being colleagues working together; I can't call them friends."

A majority of the respondents who reported that they knew Saudi citizens did not exchange visits with them. Even the very few who do exchange visits with Saudis, do so only on special occasions, such as wedding parties. These also seem to be one-sided visits, in that the doctors and their families are invited by Saudis, but not vice versa.

This formal or low level of close contact between Egyptian doctors and their families and Saudi people occurs for various reasons. Slightly over a quarter of those who have little or no social contact with Saudi nationals, attributed this to being busy with their work and looking after their families. This is more so in the case of married female doctors with children. For example, Dr.Hind, a married female respondent with 3 children, stated:

"I finish work at 5 p.m., go home to prepare something to eat and then help the children with their homework."

Another female respondent, Dr. Azah, a specialist working in a private hospital, described her daily routine. She commented:

"In the morning I make breakfast and do half the cooking for lunch and go to work. After finishing my morning duty at 1 p.m. I go home, prepare lunch, do the washing up, help my son with his homework, and go back to work again at 5 p.m. And when I finish work at 9 p.m. I go home to prepare dinner and do some housework. I have to cook every day as my son doesn't like to eat re-heated food. I'm the dynamo of the house; I have to do everything myself as my husband doesn't help with the housework or help our son with his homework. Therefore, I don't have any time to entertain friends at my house or go to visit them, and any little spare time that I may have in my one day off at the weekend, I would spend with our relatives in Jeddah. In Saudi, time is so precious to me; not like when I was in Egypt, where I used to teach in the University in the morning only and have two days off at the weekends."

Of the doctors in the sample, 9 felt (17.3) that the fact that Saudis have different customs and traditions, especially with regard to social gatherings where women sit separately from men, is a major obstacle to establishing close relationships. As Dr. Hussian, a married specialist aged 37, commented:

"The Saudis are very conservative in their social customs, which are different from ours, therefore we find it difficult to mix with them. For example, in our place of residence there are two families living with us in the same building; one is Saudi and the other is Pakistani. And because the Saudi men and women socialize separately, we exchange visits with the Pakistanis but we have no contact with the Saudis."

However, another respondent, Dr. Abdul-Hameed, a Gynaecologist aged 40, who had worked in a public hospital for 10 years, does not see the segregation between the sexes in Saudi social life as a reason for not socializing with Saudi families. He is personally acquainted with some of his Saudi friends' wives because some of them come to him for examination from time to time. He was, however, very critical of the Saudi customs with regard to the way they treat their guests, where the custom is to prepare a whole lamb for a guest and to invite many other people as well. He found that this practice inhibits Egyptians from mixing with Saudis or maintaining close relationships with them. As Dr. Abdul-Hameed explained:

"Saudi customs are quite different from those in Egypt when it comes to invitations for males. So if Saudi friends invite me and prepare a lamb for me I wouldn't be able to do the same in return because I can't afford to do that."

Some female doctors, however, find the segregation between the sexes according to Saudi social custom

preferable to the Egyptian practice. This was especially the case after they had lived in Saudi Arabia for a considerable number of years. Dr.Heyat, a Paediatrician working in Jeddah for 10 years stated:

"After being in Saudi for a while and having the chance to mix with some Saudi families I found the Saudi ways of social gathering where women sit in a separate place from the men very comfortable. And I myself started to get used to it and actually do it with some of my Egyptian friends when they visit us."

Dr.Semiha, a Paediatrician who has worked in a public clinic for 6 years, also stated:

"I like the fact that Islamic Sheri'a is more implemented here than in Egypt. I like for example the way that women gather separately from men in wedding receptions and also in family visits."

Finally Dr.Hind, a consultant aged 48, employed in a public hospital for 12 years, stated:

"Mixing between sexes in Saudi is very limited in family visits as well as in the outside world, which is a good thing from a religious point of view."

Of the other doctors in the sample, 5 (9.6) said that they believed that their main reason for not forming close

relationships with Saudis, was either because they are unmarried or because they live in Jeddah unaccompanied by their families. Typical of their comments were:

"My wife doesn't live with me in Jeddah and therefore I don't exchange visits with my Saudi friends because home visits require the presence of the wife."

"I don't go to visit my Saudi friends in their homes because I'm single, and I feel if I do that I might make them uncomfortable or embarrass them."

Dr.Issam, an unmarried G.P aged 29, also felt that being single is a major obstacle to establishing close contacts with married Saudis, though it is not so difficult with single people. However, Dr.Majed, an unmarried consultant aged 32, felt that being single made it difficult to make friends with both Saudis and Egyptians living in Saudi. He commented:

"I don't exchange visits with Saudis because they don't allow a foreigner to visit them in their homes until they trust this person very well. Also I'm single and that makes it more difficult to have such visits. Some people, for instance, would ask me to visit them with my wife, so I would say to them, "may be later on", or, "some other time". And I'm quite certain that if they knew that I was single they wouldn't ask me around. People in Saudi are very suspicious of single men. I even had to lie to my land-lord when he asked

whether I was single or married, and I told him that I was married and my wife would join me later, otherwise he would have refused to rent me his property. I also find it very difficult or even impossible to make friends with Saudis as well as married Egyptians because I'm single. Here the first thing people ask you is whether you're married or single and if you say you're single they get very scared of you. For example, even two good friends I used to know in Egypt, where we used to work in the same ward in the same hospital in Egypt, and who were unmarried at the time when I moved to Saudi; some two years ago they got married and they recently moved to Jeddah for employment. After I found out that they are living in Jeddah I tried to contact them so we could get together sometime. But I felt that they weren't very keen on coming to visit me in my place or ask me around to theirs. Instead, one of them came to see me in my workplace, or would talk to me on the phone sometimes. And I think that the only explanation for their cold reaction in contacting me is because they had got married while I'm still single. This kind of behaviour doesn't happen in Egypt because you could visit your friends whether you're single or married."

These findings, which suggest that a majority of the Egyptian doctors in the sample have little or no close contact with Saudi people, is consistent with Al-Moosa and McLachlan's (1985) findings in their study of a sample of Egyptian migrant workers in Kuwait. They concluded that these migrants rarely mix with Kuwaiti or other Arab nationals living in Kuwait. Nevertheless, they found that the Egyptian migrant workers were very helpful to each other and have close social relationships within their own community. In Jeddah, however, Khaleil (1990) found that the vast majority of his sample of semi-skilled Egyptian

workers had established friendships with Saudi people. They had got to know these Saudis mostly through their place of work, which had brought them into direct contact with the general public.

Although Khaleil used the term 'close friendly relationship' to describe the kind of contacts between Saudi nationals and Egyptian semi-skilled workers in Jeddah, some of his data contradict this picture. One may observe from his data that these relationships were rather more superficial than indicated. For example, the data shows that only a minority of his respondents regularly exchanged home visits with Saudi people. In addition, the overwhelming majority (84 %) of the married respondents in his sample very rarely visited other Saudi families, and those that did visit Saudi families did so mainly on special occasions. Moreover, the lack of strong contacts between these respondents and Saudi nationals in their social life is revealed by the fact that only 1 out of the 500 respondents had learned Kearum and Bellott; two popular and widely played games which Saudis commonly play at their social gatherings.

Furthermore, Al-Salim, and Tahir (n/d) conducted a study of foreign migrant workers in 5 Arab Gulf countries: Kuwait, Bahrain, Qatar, United Arab Emirates, and Saudi Arabia. They selected a sample of nearly 23,000 respondents consisting of citizens, officials, and foreign workers. The researchers assessed the degree and type of

contact between the citizens and foreign workers in these countries and found a general lack of close contact between the two parties. They found that the respondents' main reason for avoiding close relationships with foreign nationals residing in their countries was the difference between their own customs and habits and those of the expatriates.

8.2 SPENDING SPARE TIME

All the married respondents spend most of their spare time with their families (Table 44). They are obliged to do so because it is quite difficult for the family to go outside the home on their own. This is mainly because women are not allowed to drive in Saudi. Another reason is that many doctors and their families do not have a strong social network in Jeddah. This is evidenced by the fact that only a minority of the respondents and their families visit friends and relatives in Jeddah in their spare time (see below). Hence many doctors feel that they are more responsible for their families in Jeddah than when they were living in Egypt. Dr.Mejdi, a 35 year old married G.P. who has one child, for example, stated:

"When I'm not at work I have to spend all my spare time with my wife, because she can't go outside the house on her own, whereas in

Egypt she could go to her parents or visit some friends and relatives, and I would be able to have some time to myself. So I used to do many things in my spare time, such as playing sports, or going out with some of my friends."

Dr. I.H., a G.P. aged 40, married with two children, working in a private clinic, also commented:

"Here my family rely on me totally in their movements, so I find it difficult to have some time for myself to practice my hobbies as I used to do when I was in Egypt. Back home, for example, my wife was able to take the children out or visit her relatives or go shopping, and I would be able to go out with some friends or get together with some of them and play music, which I really miss so much."

The majority of single doctors spend most of their spare time with friends, usually flat-mates who are in most cases other Egyptian doctors working in the same medical establishment (Table 44).

Table 44
Response to : ~~Whom~~ Do You Spend Most of Your Spare Time with in Jeddah ?

Spending Spare Time	N	%
With family	36	69.2
With Egyptian friends	9	17.3
With relatives	3	5.8
On my own	4	7.7
Total responses	52	100.0

The majority of the respondents had little spare time during week days. Some of them just go shopping others spend a quiet evening at home watching T.V. or video. Most female doctors have the housework to do, and those with children of school age help their children with their homework.

The majority of the doctors spend their spare time, which is usually their day off, in a similar way. Most go window-shopping in major shopping complexes as well as doing their shopping, usually in the early evening and later spend some time in Al-Hemrra, the sea-side area in Jeddah (Table 45). A typical comment on the way that married doctors with children spend their spare time in Jeddah was:

"At the weekend we go around the shopping centre, do the shopping, and take the children to the fairs in Al-Hemrra."

Table 45
Leisure Time Activities of Doctors
on the Weekend

Spending Leisure Time on Weekend	N	%
Visit friends and relatives	8	15.4
Go shopping	11	21.1
Go window shopping & Al-Hemrra area	33	63.5
Total responses	52	100.0

Shopping in Jeddah is considered by some doctors to be a pleasant experience and a nice way of spending spare time in the city. Jeddah is the largest commercial city in Saudi and has a large number of modern shopping centres selling a variety of regional as well as international goods and commodities. These shopping centres are located in different parts of the city and attract a large number of the indigenous, as well as expatriate, population particularly at weekends. For example Dr.Hussian, a married consultant aged 33, explained how going shopping in Jeddah is in itself a way of spending spare time:

"Stores in Jeddah are in a compound, so you find most of the things you need in one place, and that makes shopping in Saudi very easy and enjoyable. So the shopping is done as well as having a nice time. Shopping isn't tiring and frustrating as in Egypt where you have to go to so many different places to do the shopping."

Table 45 shows that only 8 respondents (15.4) visited friends and relatives at weekends. This is because for most doctors, weekends are their only opportunity to take their families, and particularly their children, on outings for pleasure. Those who have relatives and close friends in Jeddah sometimes arrange to meet them in Al-Hemrra area. Only occasionally do some doctors and their families join with other Egyptian families for a weekend at Ubhor (a popular sea-side resort about 35 Km outside Jeddah).

Weekends, however, are a problem for some doctors because they do not know how to pass the time. Dr.Ahmed, a single G.P. aged 30, who had been working in a private clinic for eighteen months, commented:

"I have a lot of spare time which is a big problem for me because I don't know what to do or where to go, as there aren't many places to go to in Jeddah. So when I'm not working I get very bored, especially on my day off. This couldn't happen in Egypt, because if you want to go out, there is always some place to go to. Here I spend most of my spare time watching T.V. and Video."

Dr.Majed, an unmarried specialist aged 33, had recently moved from Taif to Jeddah. He reported that he feels very bored when not working, contrary to his experience in Taif. He stated:

"Spending my time in Jeddah is a big problem for me, because I don't have many friends and also because I don't have a car to go out. When I was in Taif I didn't have this problem because I had so many friends and the city was quite small, so it was easy to go around on foot, unlike Jeddah, which is a big city where it is very difficult to go any place without a car. I feel so bored in Jeddah and occasionally I go to Taif to see my friends."

Another popular activity, for doctors who are very religious is to spend their day off visiting the holy mosques in Mekkah or Medinah. Of the respondents who are

very religious 7 (13.5 %) reported that they go to Mekkah fairly often, which is 70 Km from Jeddah, and only occasionally to Medinah which is about 450 Km from Jeddah. Their reason for visiting these two holy cities is either to perform Umra or simply to pray in the holy mosques.

The great majority of the doctors had been to these two holy cities at one time or another during their stay in Saudi Arabia, in order to perform Umra or Haji (Table 45). Only 8 respondents have not been to Mekkah. Of these, 3 were Christian and the rest had only recently arrived in Jeddah. Apart from performing religious duties in these two holy cities, just over one-third of the doctors had visited other places in Saudi Arabia. Another 8 (15.3 %) of the respondents had been to Taif city, the summer capital of Saudi Arabia about 170 Km from Jeddah. The majority of these doctors work in the public sector, and have been to Taif for a holiday during national holidays. Another 11 (21.1 %) doctors had travelled to different parts of the country, namely Riyadh, Al-Qassaim, Abha, Khamees-Misheat, Al-Dumam, Bel-Jorashi, and Al-Konfidah, mainly to visit their relatives.

In his study of semi-skilled Egyptian migrant workers in Jeddah, Khaleil (1990) found that going to the local cafe was the most popular spare time activity, particularly on their day off. The cafe was not only a place where these workers could meet their friends and enjoy drinking tea and smoking Sheishuh (traditional smoke), but many also

used it as an address at which to meet newly-arrived workers with news and messages from relatives and friends back home. The cafe was also used to secure extra work outside their normal job hours. In addition, Khaleil found that a majority of the respondents went to Al-Hemrra at the weekend. Unlike the majority of the respondents in this study, he found that the majority of his sample only occasionally went down town and to shopping centres in Jeddah.

The way in which the doctors and their families spend their leisure time in Jeddah is quite different from the way they spent their leisure time in Egypt. Slightly more than half of the respondents used to spend much of their leisure time socializing with close friends and relatives. Another 22 (42.3 %) respondents had spent their leisure time in a variety of places which are not available in Jeddah, such as private clubs, cinemas, and theatres.

An overwhelming majority of the female doctors in the sample were able to spend their spare time more freely when they were living in Egypt than in Saudi Arabia. Typical of their comments were:

"In Egypt I was able to go out on my own for shopping or to visit friends and relatives. But in Jeddah it is almost impossible to go out without my husband, and since he is quite busy with his work I don't go out very often."

"Egypt is an open society where I used to drive my own car and go out in my spare time to wherever and whenever I wanted."

"At home it was possible for me to go out without my husband; therefore in my spare time I used to visit some of my friends or go out with them, whereas in Saudi it is difficult to go out without being accompanied by a man."

"In Egypt I had the freedom to go out on my own and was not so dependent on my husband to take me out. Therefore, I use to play a lot of out-door sports and visit friends."

"In Egypt I was a member of a private club, so in my spare time I would take the children out to the club or visit friends and relatives; but in Jeddah my children and I are dependent on my husband in our movements."

Among the respondents, 7 doctors (13.4 %) reported that they did not have much free time while living and working in Egypt, but they enjoyed more free time in Saudi Arabia. Dr.Abdul-Hameed, a married Gynaecologist aged 40, employed in a public hospital, stated:

"At home one is obliged to be engaged in visits and social engagements at the expense of having time for personal hobbies such as playing sport regularly. But in Saudi I don't have any social obligation so I'm able to benefit from my spare time by playing sport regularly to keep fit."

Dr.Nebeel, a 40 year old specialist working in a public hospital, also used his spare time in Jeddah constructively; he is able to prepare and study for a Ph.D degree in Gynaecology in Egypt while working in Saudi. Dr.Nebeel, has been registered as a Ph.D student in Al-Azhar University since 1985, and is carrying out his research in Saudi. He commented:

"In Egypt my spare time was usually wasted in something worthless, particularly socializing with friends. But here I spend my spare time in conducting my Ph.D research."

CHAPTER NINE

ANCHORAGE TO HOME

9.1 TIES WITH HOME

All the Egyptian doctors in this study reported that they maintain regular communication and very close ties with relatives and friends in Egypt. The most popular means of keeping in touch with relatives at "home" is by telephone, and to a lesser extent by letter. All the respondents regularly make phone calls to relatives, whereas just over one-third occasionally write letters. The majority of the respondents keep in touch with friends in Egypt, mainly by letters. However, many admit to writing to their friends in Egypt less often than they had done when they first moved to Saudi Arabia.

An important factor accounting for why all the respondents in this study made regular phone calls to relatives, and in some cases to their friends, in Egypt, seems to be the fact that they can readily afford such calls. Moreover, telephone facilities are widely available in Saudi Arabia. Those who do not have such facilities in their homes are able to make phone calls from their place of work at almost the same cost as calls made on private telephone lines.

In contrast, Khaleil (1990) found that the majority of his sample of semi-skilled Egyptian migrant workers in Jeddah communicated with people in Egypt by letter, and only a minority used telephone facilities. This may have been because a substantial number of his respondents came from rural areas in Egypt which may not have had telecommunications facilities. Another factor may have been the fact that this group of migrant workers earned far less than highly skilled migrants such as doctors. Fergani (1988) similarly, found that more than 80 % of his sample of Egyptian migrant workers, the majority of whom were unskilled and semi-skilled labourers, in rich Arab countries, maintained contact with their families back "home" through letters, either sent by the post or entrusted to acquaintances returning to Egypt. In a study of Palestinian migrants in Jeddah, Al-Horob (1986) found that 73 % of the respondents, the majority of whom were highly qualified, maintained close contacts with relatives and friends in their country of origin. Only 16 % of these respondents used telephones for this purpose. Their main method of maintaining close contact with relatives was by regularly sending them money, and, to a lesser extent, by dispatching letters.

The doctors in this study also maintain their ties with Egypt by closely following news and events in various ways. The most important source of up to date information and news of "home" is Egyptian television, which can be

seen in Jeddah city and surrounding areas for many months in the year, particularly during Spring and Summer. It became possible to receive Egyptian television transmissions in Jeddah in the early 1980s, due to the expansion of Egyptian television transmissions to cover the areas which Egypt reclaimed from Israel after the signing of the Camp David peace treaty. Saudi television is also considered by many doctors to be quite useful in keeping them and their families informed of important news concerning Egypt. Moreover, Saudi television frequently shows many Egyptian programmes, e.g. drama series, films, plays and musicals.

Newspapers, mainly Egyptian but also Saudi Arabian, constitute another significant source of information for the doctors. Many Egyptian newspapers and magazines are widely available in Jeddah. The majority of the doctors said that they regularly read Egyptian papers, particularly "Al-Ahram", which is one of the most widely-distributed newspapers in Egypt as well as abroad. There are three main Egyptian daily newspapers to be found in Jeddah, namely "Al-Ahram", "Al-Akhbar", and "Al-Weffd". These newspapers have become widely available in Jeddah in recent years and quite recent editions can be obtained from newsagents, as well as mini supermarkets. Many doctors also read Saudi newspapers, the most popular being "Al-Sharq Al-Awsatt", which mainly covers regional news about the Arab world, and to a lesser extent "Okaz".

These findings are inconsistent with Khaleil's (1990) study of semi-skilled Egyptians workers in Jeddah. He found that most of his respondents followed "home news" through radio, (76 % of the workers) and only rarely through television, (24 %) followed events in Egypt through newspapers and magazines. One explanation for this finding might be the fact that this group work in semi-skilled occupations where it is possible for them to listen to radio while carrying out their duties.

In a study of Egyptian migrant workers in Kuwait, Abdul-Mooti (1984) found that 28 % of his respondents, most of whom were unskilled and semi-skilled workers did not keep up with news and events in Egypt. However, he found that all the professionals and highly skilled workers in his sample kept in touch with news and events at home. Nevertheless, Fergani (1988) found that 47 % of Egyptians working in Arab countries in the Middle East, including Saudi Arabia, did not regularly follow news about Egypt. He also found that 24 % of those who returned permanently to Egypt had never followed events taking place there during their absence.

Another source of news available to the respondents in this study are acquaintances who return to Jeddah after spending their holiday in Egypt and those who come to perform Haji or Umra. As Dr. Abdullah, a Cardiologist aged 38, employed in a private hospital, explained :

"There is a large number of Egyptians in Jeddah, so there is always someone who has just come back from home and will bring us the latest news from Egypt."

News and information about events and developments in Egypt are a frequent topic of conversation among work colleagues. For example, Dr.Hussian, a consultant working in a large private hospital, commented:

"During meals in the hospital canteen I usually hear news about Egypt from my Egyptian colleagues."

The Egyptian doctors in the sample also keep reasonably well informed about circumstances and events in Egypt by visiting home quite regularly. Table 46 shows that more than two-thirds of the respondents visit home once every year, and that some visit Egypt twice a year.

Table 46
Frequency of Doctors' Visits to Egypt

Go to Egypt	N	%
Never	10	19.3
Once a year	36	69.2
Twice a year	6	11.5
Total responses	52	100.0

A majority of the doctors employed in the public sector visit in Egypt for more than a month on their annual holiday. These doctors are entitled to 45 days holiday annually, as well as free return tickets to Egypt for themselves and their families. In contrast, doctors employed in the private sector are entitled to 30 days paid holiday annually in addition to a free return ticket. Their families do not usually get free travel. However, all the respondents who worked as consultants, as well as most of the specialists, employed in private hospitals are given free return tickets for their families. These doctors are able to take further unpaid holidays if they wish. Doctors employed in the public sector visit Egypt more than once a year by dividing their annual holiday between two periods. In such cases, they pay their own travel expenses on the second visit.

Doctors' spouses, if not working in Saudi Arabia, usually visit Egypt two to three times each year. The feelings of boredom and loneliness experienced by the doctors' wives in Jeddah is the main reason why they visit Egypt quite regularly for holidays. This is particularly the case for those who used to work in Egypt. Almost half of the respondents' families who had lived with their spouse in Jeddah for a year or more, travel to Egypt twice a year. The families of the other respondents visit home once each year. Dr. Mohammed's wife, for example, finds life in Jeddah very boring compared to that in Egypt. In Egypt

she worked as a computer programmer for many years in a research institute. She spends most of her time in Jeddah in the house. Her husband commented:

"My wife feels very bored and lonely. She can't go out on her own, and being busy myself means that she ends up staying in the house most of the time. I rarely take her out during the week, because I stay at work until 9 p.m., and then it is too late to go out. Also, on my day off, there are not many places to take her to where she could enjoy herself. Because of that and the fact that she hasn't got many friends in Jeddah, she gets very bored. Therefore, she travels to Egypt every 4 or 5 months for a holiday."

Most of the doctors' wives who have children of pre-school age, or those who have no children, and do not work in Jeddah, tend to stay in Egypt for as long as possible when they visit for holidays. Some of them return to Egypt a month or two before their husbands join them there on their annual holiday. And some delay their return until a month or two after their husband has returned to Saudi Arabia.

A majority of the doctors' families who reside permanently in Egypt visited their spouses in Saudi Arabia twice a year. Those with children at schools usually visit during mid-term for about 2 weeks and in the Summer vacation for about 3 months.

9.2 REMITTANCES AND INVESTMENT IN EGYPT

Almost two-thirds of the respondents reported that they kept their savings in Egyptian banks (Table 47). Of the other respondents, 6 (11.5 %) kept their savings in Saudi banks. In most cases, these savings are used or transferred when the doctors visit Egypt for their annual holiday. Another 5 (9.6 %) respondents reported that they send some of their income to their bank in Egypt and keep some in a Saudi bank account (table 47).

Table 47
Doctors' Response to : Where do you
save your money ?

Saving money	N	%
In Egyptian banks	34	65.4
In Saudi banks	6	11.5
In both	5	9.6
Other	3	5.7
No response	4	7.8
Total responses	52	100.0

A majority of the doctors (43 respondents or 82.7 %) said that they remit money home through official channels (i.e. banks) in Saudi Arabia. The remaining 9 respondents (17.3 %) said that they remit money to Egypt by personal means; mainly by taking it with them when visit Egypt on

their annual holidays, or by sending it with their wives, and relatives, or friends. These findings are consistent with Fergani's (1988) findings on the way Egyptian migrant workers, returning home after their work contracts in other Arab countries in the Middle East had expired, remitted their money to Egypt. The majority of his respondents (61 %) sent their remittances to Egypt through official channels, while the rest (39 %) did so through relatives or friends who worked with them.

Doctors' savings, in most cases, are sent to Egypt to be invested temporarily in banks until the doctors eventually return home. When they return home they may transfer their money to other types of investments (see below). However, 7 (13.5 %) respondents felt very sensitive about keeping their money in saving accounts in commercial banks and receiving interest. This sensitivity arises from the fact that Islam prohibits its followers from accepting money generated from interest. These doctors are investing their savings, while still working in Saudi Arabia, either by buying shares in mainly Islamic-orientated Egyptian companies or by putting their savings in Islamic banks in Egypt, of which the most popular is Faisal Islamic Bank. Moawad (1987) argues that religious factors which make some people in Egypt save and invest in Islamic banks and Islamic investment companies, results from the influence of migrant workers and returnees on the religious behaviour patterns in Egypt.

Another 11 (21.1 %) respondents said that they had invested their savings in various projects in Egypt as long-term investments. A majority of these doctors are those who have worked in Saudi Arabia for several years. One such respondent is Dr.Mohammed, a surgeon aged 40, who has been employed in a public hospital for almost 10 years. He and some of his friends had established a food factory in Cairo few years ago. Dr.Heyat, a married Paediatrician aged 37, who had worked in a public hospital for the last 5 years, and her husband, who works in Jeddah, as an accountant in a bank, are building a private hospital in Egypt. Another female respondent, Dr.Dorayah, a G.P. aged 31, employed in a public clinic, is also joining forces with her husband in a partnership enterprise in Egypt. They are engaged in the construction of a number of residential buildings in their home city of Al-Menssourah. Their future plans include the construction of a building to contain a pharmacy, which her husband who is a pharmacist could manage, and a private surgery.

Another 3 (5.7 %) respondents reported that they have invested some of their income from their employment in Jeddah in establishing private business enterprises operating in Egypt. Of the other respondents, 4 (7.7 %) doctors have purchased private surgeries, and another 3 (5.7 %) have purchased new flats for their accommodation when they eventually return permanently to Egypt. Those who have invested their savings in businesses and other

projects in Egypt reported that they have authorized some of their relatives and friends, who in some cases are the respondents' partners, to look after their interest while they are away.

Not all doctors, however, have managed to save money from their employment in Jeddah. Of these respondents, 4 (7.7) had worked in Saudi Arabia for less than six months. These doctors were unable to accumulate significant savings in such a relatively short period of employment, particularly when they have financial commitments. For example, Dr.Mohammed, a married specialist aged 42, had worked in a public hospital in Jeddah for some 4 months. He moved to Jeddah on his own, temporarily leaving his wife and two children in Egypt until he settled in Saudi Arabia. Because his place of work did not provide him with free furnished accommodation he has spent most of his income on setting up a new home for his family when they eventually join him. He has also regularly sent part of his income to his wife. This was also the case with Dr.Moneer, a 36 years old married specialist employed in a public hospital. Dr.Moneer lived in Jeddah alone for 4 months before being joined by his family. He said that renting and furnishing accommodation in Jeddah as well as sending his wife money had consumed most of his income.

Living and supporting a family in Jeddah with the intention of settling down permanently can be very costly. For example, Dr.Mohammed, a G.P. aged 37, is married to a

Saudi women and has 3 children. He has lived in Jeddah for 8 years, and intends to settle permanently in Saudi Arabia. He stated:

"I spend most of my income on my family, because I want them to live very comfortably. This might have been different if I was to live in Saudi temporarily, because then I would only provide my family with the necessary things rather than anything they desire."

Visits home for holidays can consume a large proportion of doctors' savings. Dr. Suzan, a married Gynaecologist aged 37, who has worked in Jeddah for 2 years, commented:

"I haven't managed to make any real savings, because every time I visit Egypt I spend most of the money I have on buying presents for my relatives and friends."

However, a majority of the respondents said that they are planning to use their savings to make investments when they eventually return home. Most of those who are already investing their savings in projects in Egypt said that they will try to complete them. Buying a flat to be used as a private surgery was the main investment target which a majority the doctors sought to achieve. Those who owned surgeries before migrating to Saudi Arabia said that they

intended to modernise and develop them by purchasing new medical equipment.

Only 5 (9.6) of the respondents reported that they intended to invest their savings in establishing a private business with no connection to their profession. One explanation for the small number of those interested in non-medical business enterprises was expressed by one of the doctors:

"I will only invest my money in something that I know much about (i.e. medicine)."

Clearly, this group of highly qualified migrants tend to invest their savings in what they see as viable enterprises. This finding is consistent with other studies on highly qualified Egyptian migrants in the Middle East. Mohi-Eldin and Omer (1980), for example, in their study of Egyptian university staff in Middle Eastern Arab countries, found that slightly less than half of the respondents invested their savings in projects with the prospect of good income, while the other half invested their savings in villas or residential flats. Abdul-Mooti (1984), in a study of Egyptian migrant workers in Kuwait, found that the majority of the highly qualified respondents in his sample invested their savings in business enterprises, buying bank bond certificates and keeping their money in saving accounts.

However, studies of unskilled and semi-skilled Egyptian migrant workers in the oil-rich Arab countries of the Middle East, show that such workers tend to spend or consume most of their income. For example, Mohi-Eldin (1980) in a study of a group of Egyptian construction migrant workers in the Middle East found that 78 % spent their income on durable goods. Al-Deib and others (1984) studied a group of Egyptian migrant farm workers in the rich Arab countries. The study showed that 35 % of the respondents spent most of their income on durable goods, another 20 % purchased construction land or built houses, and another 28 % repaid debts. Only 4 % invested their money in farm land and farm equipment.

Abdul-Mooti (1984) also found that migrant farming workers were the least likely of all respondents in his sample to invest their money in a way that would generate income. In addition, Fergani (1988) studied the spending patterns of a group of Egyptian migrant workers returning home permanently, the majority of whom were unskilled and semi-skilled workers. He found that more than a quarter of the respondents' savings were used to purchase durable goods, 25 % were kept in saving accounts and of bond certificates, while just over 24 % were invested in building land and already constructed buildings. Fergani found that only about 6 % of this group of returnees had invested money accumulated during their migration in 'direct productive purposes'. It was particularly

noticeable that industrial projects had not attracted these respondents' savings.

9.3 RETURNING HOME

Egyptian doctors have a great sense of loyalty to their country. A majority of them (30 respondents or 57.6 %) said that they would not consider remaining in Saudi Arabia permanently, even if they were given the opportunity to do so (Table 48). However, the same Table also shows that 34.6 % of respondents said that they would like to settle in Saudi Arabia permanently if they were given the opportunity. Of these respondents, 4 (7.7 %) said that they would require one main condition in order for them to consider permanently living in Saudi Arabia: to be assured of continued employment with a good income.

Table 48
Doctors' Preference for Settling in Saudi
Arabia if Given the Opportunity

Choice of Settlement	N	%
Agree to Settle in Saudi Arabia	18	34.6
Refuse the offer	30	57.7
Don't know	4	7.7
Total responses	52	100.0

Although most of the doctors are aware that securing permission to settle in Saudi Arabia permanently is rather difficult, yet some of them would love to stay in the country for as long as possible. For example, one female respondent felt that she and her family could settle in Saudi Arabia without any incentives. Dr.Nejwa, a G.P aged 39, who had been employed in Jeddah for almost 9 years, stated:

" If I was given the opportunity I would stay in Saudi Arabia even without a job"

Dr.Abdul-Hameed, is a married specialist aged 40, employed in a public hospital for 9 years, prior to which he had worked in a private company in Jeddah for a year. Dr.Abdul-Hameed commented :

"I would love to stay in my job in Jeddah until they kick me out of the country."

Dr.Nebeel, a married Gynaecologist aged 40, had worked in a public hospital for 5 years, stated:

"I had the intention of going back to Egypt 3 years ago, but I have got used to my work and life in Jeddah to an extent which has made me feel that I have become part of this country."

Finally, Dr.Ebiys, a married G.P., expressed a wish to remain in Jeddah for the longest time possible, mainly because of his religious convictions. He commented:

"I wish to stay near the holy places for as long as possible, because I just can't get enough of visiting and seeing these places."

Nonetheless, Table 49 shows that a majority of the doctors (40 respondents or 77 %) intend to return to Egypt when their employment contract expires. A few said that they are planning to go to other countries, mainly to Europe to obtain a higher degree in medicine.

Table 49
Doctors' Destination when Their Employment
Contract in Saudi Arabia Expires

Destinations	N	%
Egypt	40	77.0
Another country	5	9.6
Don't know	7	13.4
Total responses	52	100.0

Most of those who intend to return to Egypt reported that they will actually go back to the same area in which they were living before migrating to Saudi Arabia. An

important exception here is Dr. Hussain, a married specialist aged 33, who has been employed in a private hospital for just under a year. Dr.Hussain plans to go to the small country town of Al-Arrysh and settle there to lead a quiet life away from the over-crowding in Cairo. Dr.Hussain hopes to work in Saudi Arabia for at least 5 years in order to accumulate enough money to help him carry on with his plans.

The great majority of the respondents will also go back to their previous jobs when they return permanently to Egypt. This is because the overwhelming majority of the doctors in the sample are on "work leave" from their previous place of work in Egypt. Doctors are usually permitted to have initially one year unpaid leave which may be extended further up to a maximum of 10 years. However, spouses who are doctors working in Saudi Arabia, and who came as dependants, do not have any time limit placed on their stay in Saudi Arabia imposed by their place of work in Egypt. They are permitted to remain in Saudi Arabia for as long as their husband or wife remains in employment there. Nevertheless, some doctors have a limited or a specific time period in which they must return to their previous job. In this study 4 (7.7 %) respondents fell into this group of doctors, 2 (3.8 %) of whom have actually resigned from their place of work in Egypt in order to stay for a longer time in Saudi Arabia. The first is Dr.Hind, a consultant specialising in general medicine and

community health. She came to Jeddah on 4 years "work leave" from Cairo University, where she worked as a member of staff in the College of Medicine. After her "work leave" expired, Dr.Hind resigned from her position in the university and decided to remain in her job in Saudi for a longer period of time. She has worked in a public hospital Jeddah for 12 years. The second is Dr.Abdul-Hameed, who was also on a 4 years "work leave" before coming to Saudi Arabia. He resigned from his previous position in Egypt in order to remain in Saudi Arabia for as long as he possibly can. To date, he has been working in Jeddah for 10 years.

Slightly less than half of the doctors in the study said that they intended to settle permanently in Egypt when they eventually return home. However, over 20 % of the respondents said that they would not mind travelling abroad again for employment if the opportunity arose. Almost half of these doctors had been in Jeddah for only a short period of time. The rest of this group of doctors said that they would not mind migrating again for employment but only to Saudi Arabia. These are mainly those who have lived in Jeddah for a few years.

9.4 DIFFICULTIES FACING RETURNEES

Only 7 (13.5 %) of the doctors felt that neither they nor their families would experience any problems in re-adjusting to life in Egypt and that their temporary migration to Saudi Arabia would not effect them in any way (Table 50). However, the Table shows that an overwhelming majority of the respondents felt that they and their families would face a whole range of difficult problems when they returned permanently to Egypt. The most common problem that concern the respondents is that of coping with the low standard of living in Egypt after getting used to the high standard of living in Saudi Arabia (Table 50). The respondents also anticipated that they will need to re-adjust to the problems of daily life in Egypt after being in Saudi Arabia where they have got used to an easy and comfortable life. In particular, they anticipate that they will have difficulty adjusting to the noise, over-crowding, heavy traffic (particularly for those who live in Cairo), problems of transport, and rising prices.

Similar results were found by Fergani (1988) among a large sample of Egyptian migrant workers returning to Egypt at the end of their work contract from major Arab labour-importing countries. He found that economic problems such as rising prices and low wages, as well as the general problems of housing, overcrowding, and transport, were

among the most common difficulties that faced these returnees in Egypt.

Ibrahim (1982) also confirms that Egyptian returnees from the rich Arab countries of the Middle East face the problem of re-adjusting to the circumstances they had left behind in Egypt before moving abroad, in terms of their salaries and consumption patterns. He notes that although it is far easier for people to adapt to a higher standard of living, it will never be easy to adjust to a basic standard of living. He concludes that it is very difficult, in most instances, for an Egyptian returnee to live on his 'tiny' salary in Egypt after living abroad for a few years where he has become accustomed to extravagant spending. What usually happens is that the returnee draws on his savings until they are almost exhausted and he is then forced to seek another work opportunity abroad.

Of the doctors in this study, 9 (17.3 %), who had worked in their private surgeries before moving to Saudi Arabia, said that they expected to encounter problems in finding clients again on their return to Egypt (Table 50). Dr. Abdullah, a married Cardiologist, for example, has had first-hand experience of this problem. He had worked in Jeddah for one year, in 1986. After returning to Egypt, he reported that it took about three months to build up the business for his private surgery to the level it had been before moving to Saudi Arabia.

Table 50
Difficulties Expected by Doctors
upon their Return to Egypt

Type of difficulties	N	%
None	7	13.5
Coping with low standard of living and problems of life in Egypt	29	55.8
Winning clients again	9	17.3
Children's education	6	11.5
Other	1	1.9
Total responses	52	100.0

In addition, some doctors felt that they have missed promotion opportunities because of their long period of employment in Saudi Arabia. As a result, they would be in a lower occupational status when they rejoin their previous workplace compared to their colleagues who had not migrated abroad for employment.

A major concern for many of the married doctors with children of school age, is the fear that their children might face educational difficulties when they return to Egypt. They anticipate that problems may arise because of differences between the Egyptian and Saudi Arabian education curricula. Dr. Abdulah, a married Cardiologist with 5 children, felt that moving his children from one school to another with different rules and regulations, as well as different curricula, might confuse them and that

they would definitely need some time to adjust to the situation.

Dr.Semiha is a Paediatrician aged 39, married with 3 children of school age, working in a public clinic. Her family had lived with her in Jeddah for more than two years. She also expected that her children would face problems with their education when they returned to Egypt permanently because they would have to cope with a different curriculum. This will be difficult for Dr.Semiha's children, firstly, because they are not registered in Egyptian schools while living in Jeddah. Therefore they are unable to study the Egyptian curriculum and go home in the Summer to sit final examinations in their former schools, as some other doctors' children in the sample do (see below). A second difficulty is that primary school in Egypt of 5 years duration, while in Saudi Arabia it is for 6 years. This means that 2 of her children will be a year behind other Egyptian pupils in their age group if they stay in Saudi Arabia for a long time. This was indeed the case with her eldest son. Dr.Semiha, therefore intends to return to Egypt in a couple of years, before her two children, who are in the first years of elementary school reach the fifth year. She stated:

"My oldest son joined school in Saudi in the fifth year of primary school and had to study for another year before going to elementary school which means that he is one year behind his friends in Egypt. I don't want that to happen to my other two children. I'm only going to stay in

Saudi for another two years, just in time for my oldest son to finish elementary school, because I want him to start in another educational level (i.e. secondary school), when we go back permanently to Egypt."

Dr.Hind, a married consultant with 3 children, daughters aged 19 and 17 and a 6 year old son, has worked in a public hospital for 12 years. She first came to Jeddah in 1976 and lived alone for 3 years before her husband and the children joined her. Her family remained in Egypt for all that time because her eldest daughter was in her first year in elementary school. Dr.Hind wanted her to complete the three year period of elementary school in Egypt before coming to Saudi Arabia to start her first year in secondary school. Dr.Hind's eldest daughter graduated from school and returned to Egypt to study at Cairo University. However, she was not able to join any of the top colleges because of her low grades. The reason being that the Educational Evaluation Office in Egypt had lowered her grades. Dr.Hind stated:

"The educational evaluation office is a big problem for Egyptians working abroad because they tend to give students a lower grade than they deserve. My oldest daughter, for example, scored 92 % in her final secondary school examination, but they only evaluated that to about 70%, because they consider the standard of Saudi secondary school to be lower than that in Egypt. Therefore, I had to send my daughter to the American University in Cairo where she joined the medicine college privately at a cost of \$6000 a year:

However, some of the doctors who sent their children to private schools in Jeddah felt that their children's education would probably be adversely affected when they return permanently to Egypt. They felt that the educational standard of private schools in Saudi Arabia were high compared to those in Egypt. Among those respondents who expressed this view was Dr.Azah, a married specialist aged 33, employed in a private hospital. She has a 6 year old son, who was in his first year of elementary education in a private school in Jeddah. Dr.Azah, commented:

"My son receives a lot of attention and is very well looked after by his teachers. His progress is monitored very regularly and he receives help accordingly and I'm sure he would miss that when we go back to Egypt for good, as he will receive little attention from teachers there, because of the large number of students in Egyptian schools."

Dr.Nejwa, a G.P. aged 39 and the mother 3 children, also felt that her children's education would be adversely affected when they eventually return to Egypt. This is mainly because she intends to enrol her children in public schools which have very little emphasis on the English language, whereas in Jeddah they attend private schools which teach pupils a great deal of English.

Finally, Dr. I.H., a G.P. aged 40 and employed in a private clinic, believes that his children will lose the

high educational standards they have attained in Jeddah when they are transferred to Egyptian schools. Dr. I.H. has a son aged 12 and a daughter aged 9. His son studies in the British Embassy school in Jeddah, where he is taught by native English speaking teachers. Dr. I.H. sees this as a great opportunity for his son to learn English properly. His daughter is also attends a private school following the Saudi curriculum, but most subjects are taught in English, mainly by native English teachers, an advantage which is not widely available in Egyptian schools.

Nevertheless, a few respondents do not anticipate that their children will have any problems when they return permanently to Egypt, mainly because they are taught the Egyptian curriculum in addition to their formal education in Saudi schools. These children are registered in schools in Egypt where they have to sit their final examinations during the summer vacation.

9.5 ITEMS TO TAKE WHEN RETURNING HOME

On their return permanently to Egypt, a majority of the respondents reported that they will take with them a whole range of electrical and manufactured goods purchased in Jeddah. Tape-recorders, video machine, television sets, washing machines, refrigerators, and ovens, are the most

popular items. In addition, female doctors reported that they will be taking back kitchen equipment, such as china sets, food processing equipment, etc. Another 8 (15.4 %) respondents said that they intended to take a new car with them on their permanent return to Egypt. Some doctors also said that they planned to take non-electrical appliances and durable goods, such as decorative materials and other luxuries such as curtains, crystals, clothes, gold, computer games, rugs, and paintings. This tendency among highly skilled migrant workers to take decorative and luxury items back to Egypt from Saudi Arabia was also noticed by Abdul-Mooti (1984) in his research on a group of Egyptian migrant workers in Kuwait. He found that highly qualified Egyptian migrants tended to bring back to Egypt items quite similar to the luxury items mentioned above.

Among the respondents, 7 (13.5 %) doctors had already taken some or most of the durable equipment and other manufactured goods they required back home. They had taken these goods during their visits to Egypt on their annual holidays. The majority of these doctors are those who have been working in Saudi Arabia for more than 6 years. For example, Dr. Heyat, a married pediatrician, who has worked in Jeddah for 10 years, stated:

"I took all the things that I need for our use in Egypt, such as a fridge, washing machine, a T.V. set, as well as most kitchen equipment. In fact we take most of our stuff from Saudi and that include things like clothes, curtains, bed

sheets, and so on and so forth. We even took a new car from Saudi Arabia some years ago."

Most of the doctors who had already taken items back to Egypt, tend to take a few things with them whenever they visit home for a holiday. However, one respondent, Dr.Ahmed, a married Gynaecologist who had worked in Jeddah for more than 8 years, actually took all of his requirements, in terms of major household appliances as well as a new car, back to Egypt in his first year of employment in Saudi.

Nonetheless, more than one-sixth of the respondents do not intend to take any household electrical appliances back to Egypt. According to many of these doctors this is because of the high customs duties that they have to pay on such goods. Others reported that they already possessed all or most of durable goods and electrical appliances they needed, before moving to Saudi Arabia. Another reason given by the doctors is that it is possible to buy many different types of imported durable goods from the duty free market in Port-Said in Egypt. According to many of this group of doctors, those goods can be purchased at a similar price or even cheaper than in Saudi Arabia, especially when one adds the cost of cargo and customs which have increased substantially in recent years.

CHAPTER TEN

THE FAMILY

10.1 LIVING APART OR TOGETHER IN JEDDAH

Although 43 (82.7 %) of the doctors in the sample are married, some live on their own in Jeddah. Of the 43 married doctors, 10 had left their families behind in Egypt. Some of these respondents did so because they did not wish to disturb their children's education. For example, Dr. Mahmood, a married Ophthalmologist with 3 children of whom 2 are at schools in Egypt, left his wife and children in Egypt. By the time his employment contract and travel arrangements had been finalized his children had already started the school year. Dr. Mahmood stated:

"When I was coming to Jeddah, my children had already started school. And because I intend to stay in my job in Jeddah for no more than a year and a half, I thought that there was no point in bringing the family over, which may affect my children's education."

Among the respondents, 3 doctors (5.7 %) said that they had left their families in Egypt simply because their children attended private schools, which are much cheaper than enrolling them in similar schools in Saudi Arabia. Dr.

Ahmed, a married specialist with 3 children whom 2, aged 8 and 6, are at private schools in Egypt. Dr.Ahmed has worked in a private hospital in Jeddah for more than 3 years and intends to remain in his job for another few years. Dr. Ahmed explained the reason for leaving his family behind:

"Two of my children are studying in foreign private school in Egypt. To enrol them in a similar school in Jeddah would cost me S.R.15,000 each, which is a lot of money."

Dr. Mahmood, a married Dermatologist aged 47, employed in a private clinic, has lived in Jeddah on his own for a year and a half. He has 3 children, all of whom attend private schools in Egypt. He said that the only reason he left his family behind was because he could not afford to send all of his children to private schools in Jeddah. Another 3 (5.7 %) respondents said that they had left their families behind not only because their children attended private schools in Egypt, but also because their wives are pursuing a career in Egypt.

Another 3 (5.7 %) respondents said that they lived on their own in Jeddah, because their spouses are in full-time employment in Egypt. Of these respondents, Dr.Mohammed, a Gynecologist aged 39, and Dr. Ahmed, an E.N.T specialist aged 31, are both married with no children. Both of their wives work in Egypt as tutors in different schools of

medicine where they are also studying for M.A. degrees. The third doctor, Dr. Fatimah, is a 42 year old psychiatrist. She is married to an Army engineer officer who was unable to leave his job in order to join his wife in Jeddah.

10.2 FAMILY ARRIVAL IN JEDDAH

Only 3 (5.7 %) of the respondents whose families live with them in Jeddah, were accompanied by their families when they first arrived. These respondents work for the Ministry of Health, and both they and their wives, also doctors, came on employment contracts. However, in the vast majority of cases, the respondents' families joined them in Jeddah between 1 to 5 months after their arrival. The reason respondents did not move to Saudi Arabia accompanied by their families is that the regulations specify that those who have employment contracts cannot apply for residence visas for their families until after they have arrived in Saudi Arabia. However, in practice most of the respondents needed this period of time in order to sort out their accommodation before receiving their families. On the whole, the doctors reported that they had not encountered any difficulties in bringing their families to Jeddah. There were, however, two exceptions. Dr. Abdulah, a married consultant with 5 children, came to Jeddah on his own, first

as a visiting doctor. A few weeks after his arrival the management of his place of work provided him with a normal work visa. In recent years it has become increasingly difficult for foreign migrants, like Dr. Abdulah, to apply for a residence visa for their dependants. Although his family was granted a residence permit in less than 6 months, Dr. Abdulah thought that the procedure took longer than it should have done.

The second case was that of Dr. Semiha, a married Paediatrician with 3 children. She first came to Jeddah on her own in 1985, to work in a private health centre. Before coming to Jeddah she was given strong assurances by the management of the clinic that her family would be able to join her in Jeddah almost immediately. However, after a while it became apparent that these assurances had little validity and had falsely raised her hopes. Dr.Semiha commented:

"I only agreed to come to Jeddah because I was told before I signed the job contract when I was in Egypt that it would only take a few weeks to get my husband's residence visa and those of my children sorted out. After arriving in Jeddah, months passed by and the family still had not been given their entry visas. I thought of leaving the job then and going back home. As a last resort, however, I went myself to the Ministry of Interior branch in Jeddah and submitted a personal request to the head of the Ministry branch for residence visas for my family. My plea was accepted and my husband and children came soon afterwards."

A study of another group of Arab migrant workers in Jeddah showed that bringing dependants over to Saudi Arabia, in recent years, could be a very lengthy process. Al-Horob's (1986) study of a group of Palestinian temporary migrants in Jeddah found that 68 % of those who came in the early 1970s had arrived together with their families. Of this group of early migrants 22 % had brought their dependants to live with them within less than a year of their arrival. This was apparently because the rules concerning the entry of migrants' families were quite relaxed. However, by the end of the 1970s the government had introduced tougher regulations regarding the entry of migrant workers' families, and even stronger measures for particular groups of migrants who tend to settle permanently, such as the Palestinians. Al-Horob also found that recent Palestinian migrants in Jeddah (e.g. those who came to Saudi Arabia in the early 1980s) had found it very difficult to bring their dependants over. More than half of the recent migrants in his sample had taken 3 or more years to bring their families to Saudi Arabia, while another 28 % had taken from 1 to 3 years to secure residence permission for their dependants. Only 20 % had managed to bring their dependants to Jeddah in less than a year.

10.3 CHILDREN

The overwhelming majority of the married doctors in the sample had children (Table 51). Almost half of these children are of pre-school age, while the other half are at school. Table 51 also shows that the average size of the doctors' families is quite small by Saudi standards, where people tend to have a large number of children. As shown in Table 51, only 4 (7.7 %) respondents have more than 3 children, while the majority have 1 to 3 children. In recent years Egypt has launched a massive family planning campaign in order to reduce its ever-increasing population. Consequently, Egyptians in general, and particularly those living in urban areas, tend to have smaller families than their Saudi counterparts.

Table 51
Distribution of Married Doctors According
to the Number of Children

N.of children	N	%
No children	7	13.5
1 - 3	32	61.5
4 - 6	4	7.7
No responses	9	17.3
Total response	52	100.0

Not all of the doctors' children live with both their parents in Jeddah. Some live with their mothers or with relatives in Egypt, mainly because of their education. Six of the doctors' children live in Egypt in order to pursue their studies. Their parents did not want their children's education to be interrupted or affected in any way by moving to Saudi Arabia. These are mostly the children of doctors who said that they did not intend to stay in Saudi Arabia for a very long period of time, and who thought that it would be more appropriate to move to Jeddah unaccompanied by their families. Other doctors said that they had left their children at home mainly because their wives were in full time employment in Egypt. The vast majority of those who had left their families behind were employed in the private sector. Most of these doctors work on 1 to 2 year contracts, and do not have any assurances that their contracts will be extended further. By contrast, the majority of those employed in the public sector lived with their families in Jeddah.

Other respondents said that they simply could not afford to send their children to private schools in Jeddah and that they preferred to leave them at home, where they were already in private schools. For example, Dr. Saadi, is a married Ophthalmologist aged 43 with 4 children. He left his family behind because 3 of his children were attending private school, and because his wife works as a pharmacist in Egypt. Another respondent, Dr. Mahmood, a Dermatologist

aged 46, is married with 3 children all attending private schools in Egypt. He has worked in Jeddah for a year and a half and intends to remain for another 3 years. He said that his children's education was the only reason he did not bring his family to Jeddah. He wants them to be educated in private schools, which in Saudi Arabia would cost him a substantial amount of money. Another respondent, Dr. Ahmed, a surgeon aged 36, is married with 3 children, of whom 2 attend a private school in Egypt. He has worked in Jeddah for more than 3 years and hopes to continue working in Saudi Arabia for quite a long time. Nevertheless said that he decided not to bring his family to Jeddah because of the cost of sending his children to a private school.

Some doctors, however, have left or sent some of their children back home, while others remain with them in Jeddah. Dr. Abdulah, for example, a Cardiologist aged 38, is married with 5 children of whom 3 are of school age. He said that as he only came to work in Jeddah for a year, he left 2 of his children (aged 10 and 9) with their grandmother in Egypt, because both were in the final stages of elementary school. He brought his third child (aged 7) and his other 2 pre-school aged children to Saudi Arabia. His 7-year old son attends a private school in Jeddah.

Other doctors sent their children back home after they had lived with them in Jeddah for some time. For example, Dr. Hind, is a married specialist who has worked in a public hospital for 12 years. She has 3 children, 2 teenage girls

and a 6-year old son. Her eldest daughter completed high school in Saudi Arabia and was sent home to study at an Egyptian university primarily because she was unable to obtain a place in King Abdul-Aziz University in Jeddah. Another respondent, Dr.Heyat, sent 3 of her 4 children back to Egypt after they had lived with her in Jeddah for several years.

Dr.Heyat is a married Paediatrician aged 36, who came to Saudi Arabia in 1978 together with her husband, who was working in Jeddah as an accountant in a private company. She later secured employment in a primary health care centre. She was only recently married when she came to Saudi Arabia. She now has 4 children, 2 boys (aged 11 and 9) and 2 daughters (aged 6 and 2). When her eldest son reached school age, he was enrolled in a private school in Jeddah, where he remained for 3 years. During this time, her second son reached school age and was sent to the same school. Dr.Heyat said that she found it increasingly difficult to afford the school fees for her sons, especially since one of her daughters was approaching school age. At the end of the 1986 school year she withdrew her 2 sons from their private school and tried to enrol them in a public school. However, there were no vacancies and she was asked to wait. Some of her Egyptian friends informed her that it has become difficult to enrol children in Saudi public schools. As a consequence, she decided to send her 2 sons, and later the eldest daughter, back to Egypt, where they are

looked after by their grandmother and where they attend a public school.

10.4 CHILDREN'S EDUCATION IN SAUDI ARABIA

The Saudi government makes certain educational provisions available for the children of migrants of Arab origin living in the country. In theory, primary education is available with no limitations, to all Arab children. This, however, is not always the case in practice. Especially in recent years it has become increasingly difficult for foreign nationals to enrol their children in all levels of the Saudi educational system. These provisions are thought to be of a discriminatory nature (Al-Said, 1987). Some groups of Arab migrant workers' children have more access to public education than others. Al-Said (1987:102-3) identified three groups of Arab workers' children who have access to public education: 1) children of temporary migrant workers are enrolled in public schools on the basis of a specific quota fixed by the Ministry of Education as follows: 15 and 10 per cent of the total number of pupils in the intermediate and secondary levels respectively at any given school; 2) those children whose parents are granted permanent residence in the kingdom; 3) since 1979 children from North Yemen and Gulf countries have

been treated equally with their Saudi counterparts in terms of unrestricted access to public schools and universities. In recent years the government has granted Palestinian children unlimited access to public schools. This, however, may not continue to be the case for Palestinian or Yemeni children as a result of the Gulf crisis.

Of the 16 (30.7 %) respondents who had children of school age, 9 (17.3 %) send their children to private schools in Jeddah. Most of these respondents said that they did so because they believed that private schools provided much better education than public schools, particularly with respect to the English language. In addition, the children of these respondents had attended private schools in Egypt and their parents want them to maintain the same standard of education. Some of those whose children started their education in Saudi Arabia said that they intended to enrol them in private schools when they eventually go back home. They therefore wanted their children to get used to this type of schooling while residing in Jeddah. However, 2 of the respondents said that they preferred to send their children to private schools in Jeddah because they feared that they may be subjected to bullying by other children because of the fact that they are foreigners. One of these respondents is Dr. Azah, a married specialist with one son aged 6 and a half years. She sent her son to a private school for this particular reason, as well as additional considerations. She stated:

"Some of my colleagues who have been in Jeddah for some time told me that private schools in Saudi Arabia are far better than public ones in both social and educational respects. Also my son is only little as well as being a foreigner, I thought that he would be happy in a private school. In addition to this I'm very busy with my work and would not be able to help him with his studies, and I know that he would get a lot of help in a private school."

Another respondent, Dr. I.H., a married G.P. aged 40 with 2 children, a daughter and son aged 8 and 6 and a half years respectively. His two children attend private schools primarily because they are Christians. He said that he had enrolled his children in the British school in Jeddah so that they would have the opportunity to mix with children of the same faith. Dr. I.H commented:

"I would have loved to send my children to public schools, if only to save the enormous school fees I'm paying for their private education. But of course it is very hard to find them a place in government schools because of their religion. I also could not enrol them in private Saudi schools as they would mix with children who have a different faith and different way of life. They would also be taught by teachers with a different religion. Surely this would affect my children one way or another in the long run. Therefore, I had no other choice but to send the children to Western schools which is costing me a lot of money. The idea of sending my family back to Egypt crosses my mind every year, but I have not been able to do so because I can't stay here without them. It is very important for children to have a father around for guidance. Although I'm very happy with my work in Jeddah, the children's education would be the only reason

which would force me to go back home. I think that working abroad is appropriate only for those who have recently got married or have no children."

Another 5 respondents in the sample have enrolled some of their children in private schools and some in public schools. Some of these doctors had enrolled their children first in private schools, and after a number of years had transferred them to public institutions. An example is Dr. Najwa, a G.P. aged 39, married with 3 children: 2 daughters aged 12 and 9, and a 6 year old son. She and her husband have worked in Saudi Arabia for more than 8 years. When her eldest daughter reached school age, she was sent to a private school. Three years later, when the second daughter was ready to go to school, Dr. Nejwa felt that it would be too costly to pay for both daughters in private school. As a consequence, they were, transferred to a public school. However, when her son reached school age, he was enrolled in a private school. She said that this was because of the fear that he might be subjected to some problems with other children. In her view, private schools pay more attention to the behaviour of pupils.

Dr. Semiha is a married Paediatrician aged 39 with 3 children: 2 sons aged 12 and 8, and a daughter aged 9. She had worked in Jeddah for 28 months. When she was in Egypt her children attended private schools. When they arrived in Jeddah she sent them to private schools, because she wanted

them to carry on learning English. However, when her eldest son finished primary school she enrolled him in a public school because she could not afford the high fees of private elementary schools.

Dr. Hind, a married consultant with 3 children, a 6 year-old son and 2 teenaged daughters, has worked for the Ministry of Health for 12 years. Her daughters attended private schools until they finished elementary level and were then transferred to schools in the public sector. Her son, however, attends a private school. Dr. Hind stated:

"My children usually go to private schools until they finish elementary level, whereby they would learn English language and then I transfer them to public schools. At present only my six year old son is in private school."

Finally, there is Dr. Fatimah, a married consultant aged 40, with 3 children, 2 daughters aged 14 and 10 and a 7 year old son. Since their arrival in Jeddah 4 years ago, her daughters have attended a public school, but when her son reached school age, he was sent to a private school.

A additional reason why Egyptian doctors send their children to private schools in Jeddah is that it has become increasingly difficult for foreign children to be accepted in Saudi public schools. These schools give preference to Saudi pupils, and to the children of other groups of foreign nationals living in Saudi Arabia (e.g. Yemeni, Palestinian,

and those whose parents have permanent residence visas). The difficulties arising from such a situation usually confront doctors with school age children upon their arrival in Jeddah, and also when the children move from one level of education to another, e.g. from primary to elementary level. In such cases, the doctors' children are usually put on a waiting list and eventually admitted to the school of their choice if and when there is a vacancy. Otherwise, the doctors seek admission for their children to another school at a greater distance than the one of their choice. If they do not succeed, they are forced either to send their children to private schools or to send them back home, as shown in the earlier case of Dr. Heyat.

10.5 DIFFICULTIES FACED BY DOCTORS' CHILDREN IN SAUDI SCHOOLS

A majority of the doctors' children began their education in Saudi Arabia. Hence, they seem to cope quite well with their studies, although their teachers' accent may cause problems. For example, Dr. Azah, a specialist aged 33, with one son aged 6 who was in his first year of school in Saudi Arabia, commented:

"My son's teacher was from Jordan and my son had some difficulties in understanding his accent in the first couple of months, but later he got used to it and is coping fine in school."

However, those children who had attended schools in Egypt before moving to Saudi Arabia faced some difficulties in Saudi schools. The respondents reported that some found difficulties in religious classes because Saudi education puts a great deal of emphasis on religious subjects, particularly in primary school, unlike Egyptian schools. Dr. Semiha is a Paediatrician aged 39 with 3 sons aged 12, 10, and 8. The two eldest had attended school in Egypt before moving to Saudi Arabia with their mother, while the youngest began his education in Saudi Arabia. She stated:

"My oldest son found it very difficult to cope with religious subjects in his Saudi school, since he came to Saudi and began in the fifth year of elementary school, which has a great deal more of religious subjects than in Egypt. He found reciting the Koran with Tajweed particularly difficult, but his father and I helped him to overcome this difficulty as we both memorised some chapters of the Koran. The other two younger children didn't face any difficulty in school as the oldest of the two was in the second year of elementary school when he joined school in Jeddah, and the youngest started his first year of education in Jeddah."

Dr. Fetimah, is a consultant with 3 children aged 7, 10, and 14, the eldest of whom had attended schools in Egypt before moving to Jeddah where they attend public schools. She also believes that religious subjects in Saudi schools

are far more advanced than in Egypt. Although she is convinced that religious education is beneficial to her children, she said that her children found some difficulties in coping with these classes in the beginning. Dr Fetimah's children also found mathematics classes hard to follow in the beginning. Their difficulties stemmed from the fact that the curriculum in Saudi schools has been changed in recent years, and 'modern mathematics' has been introduced at all education levels. Her children had not come across these methods in Egypt.

Another respondent, Dr. Semiha, reported that her children had been subjected to bullying by other children at their school in the early months, simply because they were foreigners. Dr.Semiha commented:

"Some of the children at school were picking on my children because they were strangers. But before long my children started to make friends and started to be good at their studies, which made them liked by others."

10.6 SPOUSE

Only 2 of the respondents in this study came to Saudi Arabia with a Mehrum visa, as the companion of their wives. This type of visa is granted to the husbands of foreign female employees in certain jobs which pay above the minimum salary which entitles male or female workers to bring their husbands or dependants to live with them in Saudi Arabia. Those who come to Saudi Arabia as Mehrums are not allowed to seek employment until they obtain a work permit, which may take up to a few months. This rule also applies to females who come to Saudi Arabia as dependants.

The 2 respondents who came to Jeddah as Mehrums, Dr.Ebiys and Dr.Mohammed, are both G.P.s. It took more than a year for Dr.Ebiys to find employment in Jeddah, while Dr.Mohammed was unemployed for almost 7 months (see Chapter Seven).

The vast majority of the respondents' spouses worked in Egypt before coming to Saudi, or are still working there. The wives of 9 respondents had not worked in Egypt. Of those spouses who had worked, or are working, in Egypt, 15 were doctors and 17 were engaged in various skilled and professional occupations, mainly as engineers, lawyers, teachers, accountants, computer programmers, and pharmacists.

Only 5 out of 17 of the respondents' wives work in Jeddah, 4 of them are qualified doctors. The remaining 12,

most of whom had worked previously in Egypt, are full-time house wives. The majority of these wives had not worked in the medical or teaching professions. They have less chance of obtaining employment in Jeddah because female employment in Saudi Arabia is limited to teaching and medical occupations. For this reason some of the doctors' wives remained in Egypt to continue their employment.

Three female respondents in the sample had initially come to Jeddah on their own and later were joined by their husbands, who came as Mehrams. Dr.Hind's husband worked in Egypt as the head of the military court. He came to Jeddah in 1979 with his wife and stayed for about 8 months, searching for employment. Eventually he found employment as a legal consultant in a firm of solicitors. He secured this position with the help of an Egyptian patient who worked in the firm and had been treated by Dr.Hind. This patient informed Dr.Hind that his employer was looking for a legal consultant and arranged for her husband to have an appointment with his boss, as a result of which he was accepted for the job.

The second case is that of Dr.Semiha's husband, an engineer working for the General Directorate of Health Affairs in Jeddah. Dr.Semiha described the difficulties experienced by her husband before securing his job in Jeddah. These stemmed from the fact that he came to Saudi

Arabia early in 1983, when the regulations for allowing dependants or Mehrams to acquire employment were tightened:

"My husband joined me in Jeddah one year after my arrival in the county. I came to know that it was very easy for him to find a job in Jeddah because of his qualifications. The only real obstacle for his employment in Jeddah was the fact that he came to the country with a Mehrum visa. We tried to change his visa to a normal residence one, so he would be eligible to apply for employment in Jeddah. But about 4 months passed after following normal procedure to change his visa and nothing happened. I therefore went myself to see the Governor of Mekkah province, prince Majed Ibn Abdul-Aziz, who kindly issued me with an order to the head of the Immigration Department in Jeddah to grant my husband a work permit. A few weeks later, my husband obtained a work permit, and shortly afterwards he was in full employment in Jeddah.

Dr.Seni's husband was more fortunate than the preceding two cases. He managed to obtain a work permit and employment in a short period of time because he and his wife had good personal contacts with people in high positions in Jeddah. In Egypt Dr.Semiha's husband had worked as a lecturer in the Faculty of Engineering of Cairo University, at present he works in a non-academic position in King Abdul-Aziz University in Jeddah.

10.7 DIFFICULTIES FACED BY DOCTORS' FAMILIES UPON THEIR ARRIVAL IN JEDDAH.

Of the 34 married respondents in the sample who live with their families in Jeddah, 5 (9.6 %) said that their families did not have any difficulties in adjusting to life in their new environment. However, a majority of the respondents said that their wives found it very hard to cope with the fact that it is very difficult to go out unaccompanied by their husband when they first came to live in Jeddah. Most of them still find it hard to come to terms with the restriction on their movements, even after being in the country for quite a long time. The case of one female respondent provides an insight into what it is like for doctors' wives living in Jeddah. Dr. Heyat, is a Paediatrician aged 36, came to Saudi Arabia in 1978, who stayed at home for 4 years and then obtained a job. She described her feelings about staying at home without a job, as follows:

"I felt as if I was in prison and I still have that feeling now, even after starting work, because I can't go outside the house on my own whenever I want."

Similar feelings were also expressed by Dr. Fatimah, a married Psychiatrist living on her own in Jeddah. She has been employed in a private hospital for less than 2 months. Dr. Fatimah stated:

"Movements of women in Saudi Arabia are very restricted. I feel as if I'm in a prison. I have to depend on someone to take me out. If it wasn't for the help of an Egyptian doctor working in the same hospital whom I knew from back home, it would have been very hard for me to get something simple done, like shopping. I needed an alarm clock the other day and I had to ask him to take me down to the city centre. I feel very embarrassed to ask him to take me places, but I just can't help it."

Feeling lonely and "home-sick" was also a common difficulty which most of the respondents' families had faced in the beginning of their residency in Jeddah. These feelings were made worse because most of the doctors work long hours, particularly those who work in the private sector. Another difficulty that some doctors wives have to adjust to upon their arrival to Saudi Arabia, is wearing Abayah, a black garment worn over one's clothes. Although wearing Abayah is not compulsory by Saudi law for foreign women, yet Saudi tradition places a strong emphasis on the wearing of modest clothes, represented by wearing Abayah. Foreign women employed in Saudi Arabia are advised by their employers to wear modest clothes and to wear the Saudi Abayah. Nevertheless, foreign women accompanying their husbands in Saudi can choose whether or not to wear the Abayah.

Of all the respondents' wives, 22 wear the Abayah when they go outside the house. These women do not consider wearing the Abayah as Hijab, in accordance with the Islamic

way of dressing, which involves not only wearing modest clothes, but also covering the hair, and they did not do wear it in Egypt. Their main reasons for wearing the Abayah, according to their husbands' statements, are to follow Saudi customs, to show respect and not to look abnormal. Nevertheless, another 15 of the respondents' wives wear Islamic Hijab; most of them used to wear it before coming to Saudi Arabia. However, some of them never wore Hijab when they were in Egypt and started to wear it for the first time in their lives after coming to Saudi Arabia, and more particularly after they performed Hajj. For example, Dr.Ahmed, a specialist aged 36, commented:

"My wife never wore Hijab when we were in Egypt, although she intended to wear Hijab one day, but after we moved to Saudi and performed Hajj, she decided to wear it and she even got used to wearing Abayah and wishes that it was possible for her and other people to wear it in Egypt."

Dr.Immad's wife, had a more personal reason for her decision to wear the Hijab. Her husband a G.P. aged 34, stated :

"My wife did not use to wear Hijab in Egypt and after moving to Saudi she used only to wear Abayah, but 6 months ago my wife's mother died so she started to be very particular about religious practices and decided to wear the Islamic Hijab."

All but one of the female doctors interviewed were wearing Hijab. Most of them had worn it from an early age. However, 3 female respondents started wearing Hijab after moving to Saudi Arabia. One of these is Dr.Nejwa, a married G.P. aged 39. She had never worn Hijab when in Egypt, but started to wear it after performing Haji. The second respondent, Dr.Nejwa, is a married G.P. aged 37. She began wearing Hijab after living in Saudi Arabia for a short time, where she began to seriously observe religious practices. Finally, Dr.Shireen, a married Paediatrician aged 36, began wearing Hijab shortly before moving to Saudi. She commented:

"I wore Hijab when I was preparing myself to move to Saudi. I had the desire to wear Hijab when I was in Egypt. But moving to Saudi encouraged me and I took the decision with full conviction and with faith and I shall keep on wearing it when I return back home."

10.8 DOCTORS' FAMILIES' FRIENDSHIP AND SOCIAL NETWORKS

Of the 52 doctors interviewed, 25 % said that their wives tend to visit other Egyptian families more often than their husbands (Table 52). This is because most of the doctors' wives do not work in Jeddah and therefore have the time for socializing. These visits are mainly to other

Egyptians living in the same residential building and are usually the families of Egyptian doctors who work together. Mixing with the same people, however, can become boring. For example, Dr.Mohammed, a married consultant aged 38, employed in a private hospital, reported that his wife became bored with mixing with the same people in the same building all the time.

Table 52
Doctors' Families' Social Contacts with
other Egyptian Families in Jeddah

Visiting Other Egyptian Families	N	%
Quite often	13	25.0
Sometimes	9	17.3
Very rarely	5	9.6
No visits	7	13.5
No response	18	34.6
Total responses	52	100.0

However, Table 52 shows that a considerable number of doctors' wives do not socialize very often with other Egyptians families, and then only on special occasions, despite the fact that many live either nearby or in the same building. This Table also shows that another 7 (13.4 %) of the doctors' families do not have any Egyptian friends in

Jeddah, and 5 (9.6 %) of these confine their social visits to relatives living in Jeddah.

Slightly more than half of the respondents said that their families had also become acquainted with Saudi families. These contacts were mainly established through their spouse, and to a lesser extent through the neighbourhood. However, those who reported that they were acquainted with Saudi families said that they had very little contact with them. They very rarely exchange visits with each other, mainly on special occasions, such as wedding parties. These visits appear to be one-sided, in that they overwhelmingly involve visits by Egyptian families to Saudis.

The respondents reported that most of their children, who were old enough, had Saudi friends. The children had formed these friendships through school and the neighbourhood. A majority of the respondents said that they allowed their children to play with their Saudi and Egyptian friends, but only if they lived in the same residential building. The children usually meet and play together in the back-yard or on the roof.

Hardly any of the respondents who have children of school age allow them to play with other children outside their residential building. For example, Dr.Semiha commented:

"I don't permit my children to go out on their own; they have to be under my supervision all the time."

Other doctors said that they felt it was dangerous to let their children go out to play with other children because of the heavy traffic and the impression that Saudi people drive very fast. For example, Dr. Abdulah, a married Cardiologist with 5 children, 4 of whom are at school, stated:

"I don't allow my children to play outside because there are so many cars around our residence, and I feel that it isn't safe for them to play outside."

Another respondent, Dr. Azah, a married specialist, has a 6 year-old son who had been allowed to play with other children outside the house in Egypt. In Jeddah, however, he is not permitted to do so. His mother commented:

"People in Jeddah drive so fast and I don't feel that it is safe for my son to play in the street."

Another reason respondents gave for not allowing their children to go out on their own is the fear that they may be abducted by strangers. Dr. Nejwa, a married female G.P. with 3 children, of whom 2 are of school age, stated:

"I don't let my children go out on their own, because we hear a lot of stories of children being abducted. We hear such stories from our friends and the media as well."

Doctors who have daughters are more anxious about their safety if they are allowed to go out on their own. Dr.Mohammed, is a married specialist with 3 children, 2 daughters (aged 7 and 4) and a baby boy. He said that he does not allow his children to play outside the house because he believes girls are in greater danger of being kidnapped than boys. Dr.Fatimah, is a married consultant with 3 children, a 7-year old son and 2 daughters (aged 10 and 14). Dr.Fatimah and her family have lived in Jeddah for 4 years, yet she feels it is not safe for the children to go out alone. She commented:

"When we were in Egypt my children used to go out to meet and play with their friends from the neighbourhood. But here I don't think it is wise to allow them to do that. I don't even let my oldest daughter to go down to the nearby shops, which is a normal thing to do in Egypt."

Another female respondent, Dr.Nejwa, who has lived in Jeddah for 6 years, does not like her children to mix with Saudi children. She said that this was because she thinks that some Saudi children have not been brought up "properly"

and that they use bad language and talk about things which they are not supposed to know at their age.

The majority of doctors reported that they felt that most of all their families miss their relatives and friends. Some respondents said that being away from relatives and friends had been particularly difficult for the children, because they did not have other children to play with. The respondents also reported that their wives missed being able to go out on their own while living in Jeddah. As Dr. Die'a, a specialist, employed in a public hospital since 1983, commented:

"My wife has the feeling of being imprisoned in the house, despite the fact that she has been living with me in Jeddah for five years. She feels that way because she only goes out at the week-end when I'm around. She doesn't leave home even when she needs to buy something for the family, and would rather wait until I get back from work. She used to go out quite often back home. Even at night she used to go cinema or theatre with her sisters."

Of the 52 respondents, 5 (9.6 %) reported that their wives greatly miss their jobs back home. The fact that they were in full time employment in Egypt has added to the feelings of boredom which they experience in Jeddah. Dr. Hani, a Paediatrician aged 35, described the way his wife feels about being a full-time housewife in Jeddah:

"My wife was working as a secretary in a hospital in Egypt. My wife and I were members of a private club in Egypt where we used to spend our spare time engaging in the club's sporting and social activities. Also I took my wife out to the cinema and theatre. Here she feels so bored as she has too much time and doesn't know what to do. Even the shopping is my responsibility as she can't go out alone."

The feelings of boredom and loneliness experienced by doctors' wives in Jeddah is the main reason why they go back to Egypt quite regularly for holidays. This is particularly noticeable among those who used to work in Egypt. Almost half of the respondent's families who had lived in Jeddah for a year or more, travel to Egypt twice a year. The other respondents' families go home once every year. Dr.Mohammed's wife, for example, finds life in Jeddah very boring compared to that in Egypt. She worked in Egypt for many years, as a computer programmer in a research institute. While living in Jeddah she spends most of her time in the house. Her husband commented:

"My wife feels very bored and lonely. She can't go out on her own, and being busy myself, means that she ends up staying in the house most of the time. I rarely take her out during the week, because I stay at work until 9 p.m., and then it is too late to go out. Also on my day off there are not many places to take her to, where she can enjoy herself. Because of that and the fact that she hasn't got many friends in Jeddah, she gets very bored. Therefore, she travels to Egypt every 4 or 5 months for a holiday."

It is not surprising then, that most of the doctors' wives who either have no children or have pre-school age children and who do not work in Jeddah tend to stay in Egypt for as long as possible when they return for a holiday. Some tend to return a month or two before their husbands join them on their annual holiday, and some delay their return until a month or two after the husband has returned to Saudi Arabia. A the majority of the doctors' families who reside permanently in Egypt come to visit their spouses twice a year. Those who have children at school, usually come during mid-term for about 2 weeks, and in the Summer vacation for about 3 months.

CHAPTER ELEVEN

CONCLUSIONS

This study has been concerned to investigate and describe the way a group of 52 temporary migrant Egyptian doctors and their families have reacted and adapted to working and living in Jeddah city. More specifically, the collection and analysis of data based on fieldwork focused on (a) the factors and processes involved in the doctors' decision to migrate to Saudi Arabia, (b) their experiences of working and living in Jeddah, (c) the way they and their families have experienced and adapted to life in Jeddah, and (d) their plans for the future. Given the size of the sample and the methodology employed in this study, the findings can in no way be seen as representative of all Egyptian doctors working and living in Jeddah or in Saudi Arabia. Nevertheless, the findings pertaining to this particular group of doctors and their families are important in their own right, and in the way they provide formerly unavailable data on, and insights into, a group of migrant workers that have hitherto been neglected by researchers in Saudi Arabia. This chapter begins by summarising and discussing the main findings of the study in relation to the existing literature on migration. After considering the methodological issues arising from this

study, the chapter concludes by outlining discussing a number of areas for further research.

Basic socio-economic data on each of the 52 migrant Egyptian doctors working and living in Jeddah was collected and analysed. The findings showed that the majority of the doctors in the sample were relatively young married males, accompanied by their families, who had come from urban areas in Egypt. In specific terms: (1) 51 (98 %) respondents were between the ages of 29 to 44 years; (2) 43 (82.7 %) of the doctors were married; (3) of the 43 married doctors, 10 (19.2 %) had left their families behind in Egypt; (4) 14 (27.0 %) of the respondents were married females, all but one of whom were accompanied by their husbands who were also employed in Jeddah.

Many studies on migration in developing countries have found that rural-urban migrants are predominantly young adults (e.g. Caldwell, 1969; Byerlee, 1974). As far as the actual age of the respondents is concerned, the findings of this study are at variance with those of other studies. Many studies of migrant workers in Jeddah in particular, and in other major labour-importing countries of the Middle East in general, report that 'cross-country' migrants are predominantly between 20 and 35 years of age (e.g. Al-Horob, 1986; Ali et al., 1981; Koraler, 1986, Arnold and Shah, 1986). In contrast, the youngest respondent in this study was 29 years of age and the majority were in their mid-30's to early-40's. The

difference in age structure between this group of respondents and those in other studies is not difficult to explain. Firstly, Egyptian medical students must complete a seven year course before qualifying as doctors. Secondly, Saudi health authorities require a minimum of two years work experience before granting a work permit. Taken together, these two factors are responsible for the age structure of the respondents in this study, and for their relatively late entry into the Saudi medical labour market.

The overwhelming majority of the doctors in the sample had migrated to Saudi Arabia in order to undertake temporary employment primarily for economic reasons. These included the prospect of higher salaries, to enjoy the high standard of living in Saudi Arabia, the opportunity to accumulate savings which could be invested in projects on their return to Egypt in order to improve their livelihood. Unmarried doctors were motivated to migrate to work in Jeddah in order to accumulate savings to help them purchase private accommodation in Egypt and to finance their proposed marriages. However, some doctors had more personal reasons for leaving Egypt and for working temporarily in Saudi Arabia. These included a desire to gain more medical experience, the adventurous prospect of living abroad, the benefits to be gained from living and working in a new environment, and for religious reasons. The opportunity to work and live near the holy places of Mekkah and Medinah was also an additional motive among many

of the doctors who came to Saudi Arabia primarily for economic reasons. Islam requires its followers to perform Pilgrimage at least once in their lifetime and considerable importance is attached to the high rewards promised to those who perform Umra. The opportunity to make frequent visits to the holy places was seen by many respondents as one of the most important advantages of working in Saudi Arabia, and in Jeddah in particular.

In the majority of cases (29 or 55.7 % respondents) the decision to migrate was part of a collective process involving spouses, family members, friends and acquaintances. Spouses and other close relatives were directly involved in the decision-making process. Although the rest of the sample (23 or 44.3 % respondents) reported that they had taken the actual decision to migrate by themselves they admitted that family members and close friends were indirectly involved in the decision-making process. It is not surprising, therefore, a majority of the doctors (35 respondents or 67.2 %) said that they had been encouraged to move abroad for employment by friends and relatives, some of whom had themselves worked in Saudi Arabia in the past. These findings conform with studies of rural-urban migration which have also found that when people decide to migrate, they do not make their decision in isolation. The decision to move is frequently collective, involving members of the extended kinship group (e.g. Wilkie, 1968; Caldwell, 1969).

With regard to the process by which the doctors secured employment in Jeddah, the study found a major difference between those working for the Ministry of Health and those employed in the private medical sector. The majority of the doctors working in Ministry of Health run establishments were recruited in association with the Medical Attaché in the Saudi Embassy in Egypt. A few of these doctors secured their employment in Jeddah by applying directly to the General Directorate of Health Affairs in Jeddah, either after moving from jobs in the private medical sector or after joining their spouses and later deciding to obtain employment. On the other hand, most of the doctors working in private medical establishments had secured employment through the help of a friend already working in Jeddah, or had been directly approached and offered employment by their employer or his representative. This finding indicates that employers in the private medical sector prefer to contract doctors who are recommended by other doctors already in their employ or by people they know in Egypt. In this way, employers seek to save themselves the time and expense of searching for trustworthy and suitable employees, which may be difficult, considering that many employers have no medical background.

In this regard, the process by which this group of highly skilled migrant workers secured employment in Jeddah differs significantly from that of their unskilled and semi-skilled counterparts. Khaleil's (1990) study of

unskilled and semi-skilled migrant workers in Jeddah found that the vast majority secured employment through private labour recruiting agencies in Egypt. Fergani (1988) studied the same categories of Egyptian migrant workers recruited to Saudi Arabia and other Gulf countries, and came to the same finding. Nagi (1986) also points out that the recruitment of South Asian migrant workers to countries in the Gulf region has been mainly through private agencies operating in most South Asian countries. For Nagi, this is one of the factors responsible for the huge increase in the utilization of workers from these countries by employers in the Gulf States.

Another major difference between those doctors working in hospitals and primary health care centres run by the Ministry of Health and those working in private medical establishments, was the duration of their stay in Jeddah. It was found that a majority of those employed in the public sector had been in their jobs for more than seven years, while the vast majority of those in the private sector had worked and lived in the city for periods of between less than a year to 4 years. The duration of the work contract offered by the Ministry of Health to the foreign doctors it employs is an important factor which accounts for the relatively long periods of time that some of the Egyptian doctors in this study remain in the country.

By contrast, those working in private medical establishments are usually given initial employment contracts for one to two years. Their contracts, in most cases, are then extended annually, if their employers still require their services. These doctors are, therefore, unable to plan to stay in the country for more than a year ahead. In fact a large number of these doctors did not have a clear idea of how long they could remain in their job in Jeddah, even though many expressed a desire to work in Saudi Arabia for a few more years. However, their counterparts working for the Ministry of Health know, when they sign their contract, that it will last for three years. They know exactly when their contract will come to an end and are able, therefore, to plan in advance whether to return to Egypt or to apply for an extension of their employment contract for another period of three years.

Not all the doctors working in Jeddah were performing similar duties to those they had undertaken in their previous jobs in Egypt. Over 25 % of the sample were performing duties which were only partly comparable with those they had performed in Egypt, while just over 21 % were involved in carrying out duties which were quite unlike those for which they had been trained (see Chapter Seven). Among this group of respondents, the vast majority felt that their employment in Saudi Arabia had not enhanced their medical experience in the same way that

would have been the case if they had remained in their previous jobs in Egypt. In fact, many said that their medical skills had been adversely affected as a result of working in Jeddah, where they were only involved in performing routine duties. Other respondents in the sample considered that their migration to Saudi Arabia for employment was beneficial as far as gaining new experience and developing medical skills were concerned. However, there were others (38.5 %) who believed that, although their job in Jeddah had enhanced their experience in some areas of medical practice, they had also experienced some 'de-skilling' in other areas. These doctors found examining patients from many different countries a very useful experience. Yet because they were, for the most part, only working in out-patient units, they had little opportunity to follow up and be involved in the progress of their patients.

In the interviews a majority of the doctors reported that they had encountered some initial difficulties when they began work in Jeddah. The most common initial difficulty reported was that of understanding the Saudi dialect, which contains phrases and expressions which are very different from the Egyptian Arabic dialect. However, most of these respondents reported that they overcame this problem after a few weeks. Nonetheless, slightly over 25 % of the doctors experienced continuing difficulty in communicating with non-Arabic speaking patients who had not

learned Arabic well enough to express themselves. The respondents who reported on this problem were mainly doctors working in medical establishments located in areas where many non-Arab migrant workers reside. The doctors' difficulties in treating such patients are particularly great where they speak neither Arabic nor English.

The Egyptian doctors also reported that they experienced a number of different kinds of difficulties with regard to their treatment and their relationships with Saudi patients. Some of the doctors found that while Saudi patients wanted to be cured or to regain their health as quickly as possible, they often ignored the doctor's orders and advice. Some doctors reported that Saudi patients tended to interfere directly in the way doctors reached decisions about diagnosis and treatment, and attempted to dictate their own treatment in line with what they thought was best for them. Most of the doctors who had experienced such behaviour from Saudi patients were employed in the private medical sector. In such a context patients may perhaps feel more entitled to dictate the type of treatment and prescription they feel is suitable since they pay for their treatment. However, similar behaviour was also reported by doctors working in public health establishments (see Chapter Seven).

A more serious problem reported by a number of respondents, working in both public and private medical care establishments, was the prejudice they encountered

from some Saudi patients. Of the respondents in the sample, 5 (9.6 %) said that they had often been subjected to 'racist' remarks and to verbal abuse from patients or their relatives. Shouting at doctors, being impolite and giving them orders are common behaviour among some Saudi patients in their relationships with Egyptian doctors. In addition, the doctors said that they are frequently reminded that it is 'the money' which had brought them to work in Saudi Arabia. This prejudice displayed by some Saudis seemed to stem from an attitude, particularly among those patients seeking treatment in the public health services, that foreigner doctors do not 'deserve' to be shown any respect because the government had brought them to Saudi Arabia to be at the disposal of patients. While patients paying for their treatment seem to feel that they have the right to show either respect or disrespect to those who are paid for their "services". In this regard, Saudi Patients seem to be taking advantage of the vulnerability of foreign doctors, who are employed to offer their services to the general public with a minimum numbers of complaints made against them by patients. A high number of complaints made by patients would certainly jeopardize the chances of any foreign doctor being able to renew his or her contract. This is very clearly evident in the private medical sector, where a doctor's success depends primarily on the number of patients or 'customers' they bring to the establishment with the least number of

complaints made against them. Doctors, therefore, are very anxious to satisfy their patients' demands or orders, and to avoid conflict with them. Even if this means that they have to ignore the verbal abuse and impolite behaviour of some of their patients, and accept this behaviour as one of the hazards of working in a foreign country.

With regard to the doctors' relationships with the managements of their respective workplaces, the study found a significant difference between those employed in the public sector and those employed in private medical care establishments. While doctors in the public sector are considered as government employees and bound by the regulations and laws of the Ministry of Health, their counterparts in the private medical sector are directly controlled by their Kefeel (employers) who have unrestricted powers over their employees and who have absolute authority in regulating and administering their enterprises as they see fit.

Apart from the Saudi Labour Office there is no government body which provides foreign migrant workers in Saudi Arabia with any real protection from the misuse of their Kefeel's powers. The main duty of the Saudi Labour Office is to resolve disputes between workers and their Kefeel with regard to violations of the terms set out in their employment contracts, regarding such matters as wages, accommodation, etc. . Even then, migrant workers do

not have any access to legal aid or to legal representation during the hearing of their case, which means that the hearing is essentially their word against that of their employers. Consequently, foreign migrant workers in the private sector in Saudi Arabia are effectively at the mercy of their Kefeel, who are able to change and introduce new conditions and terms to their employees' contract when their initial contract expires. The employee has only two real choices: to accept the changes or to leave the country.

Moreover, the Kefeel have the power to 'sack' or dismiss any of their employees without any apparent reason. In such cases, the Saudi Labour Office has no authority to reinstate those who have been dismissed. The only measure which the Labour Office can take is to require that the 'sacked' worker is paid a month's salary and provided with the fare to return to his country of origin. This, however, may explain why the majority of the doctors working in private medical establishments in this study had come to Jeddah on one-year extendable contracts. Clearly, migrant workers employed in the private medical sector have nothing to gain, and much to lose, from creating conflict with their employers by submitting a complaint about them to the Saudi Labour Office. Thus, while the study found that some doctors reported that their Kefeel had not fulfilled all the conditions specified in their contracts, none of the doctors had taken any action.

An equally serious issue, about which many doctors expressed great anxiety and apprehension, concerns the legal framework and the procedures followed by the Saudi health authorities regarding both suspected and proven cases of medical malpractice and medical negligence. The fears, anxiety and apprehension expressed by doctors with reference to such laws and procedures are well justified. There is no trade union, or any kind of formal or informal association, which could provide doctors and other medical personnel with assistance and protection should they find themselves the subject of investigation by the health authorities. The doctors' anxiety and apprehension is increased by the knowledge that when a case of medical malpractice or negligence is proven, Diyah (compensation) must be paid, not only by the person or persons directly responsible but also by those not directly responsible for the incident. Case 1/408, presented in Chapter Five, showed that the whole medical team involved in operating on a patient, including nurses and other personnel, may will be included in any investigation into a case of suspected medical malpractice or negligence. Such investigations may take more than a year to reach a conclusion. During this time, foreign medical personnel whose names appear in the investigation are not permitted, under any circumstances, to leave the country. These laws and procedures mean that those doctors whose duties place them in 'high risk' groups are extremely fearful of becoming involved in such an

ordeal. The doctors whose duties place them in 'high risk' groups include surgeons, resident doctors, those involved in carrying out or assisting in operations, and those with certain responsibilities in in-patient units, such as gynaecologists.

An important part of this study has been devoted to an investigation of the different kinds of difficulties faced by Egyptian doctors and the conditions in which they work in Saudi Arabia. While this focus is directly linked to studying the doctors' experiences of working and living in Jeddah, it has a wider relevance. The working conditions and difficulties encountered by such migrant workers have received little specific attention from scholars or policy-makers. Identifying the major areas of difficulties with which foreign doctors are faced in their employment would seem to be a necessary prerequisite to any efforts designed to create a better working environment for them. Such efforts are needed if health policy-makers and administrators are to obtain the maximum benefit from the expertise and services of these migrants, which must be the ultimate goal of bringing them to Saudi Arabia. The preceding discussion has highlighted a range of difficulties, of varying degrees of significance and seriousness, faced by Egyptian doctors working in Jeddah which need to be brought to the attention of policy-makers and administrators. In this respect, the findings of this study suggest that there are good grounds for arguing that

the Kefeel system must undergo an extensive revision, and that serious steps must be taken to give doctors and other medical personnel working in private medical care establishments protection and assistance to counter the unrestricted powers of their employers.

As far as the respondents' social networks in Jeddah were concerned, the study found, somewhat surprisingly, that although the doctors had formed extensive network of social relationships with other Egyptians, they had formed very few close personal relationships with those networks. A large proportion of the respondents in the sample worked alongside many Egyptian medical personnel, and most lived in residential buildings largely occupied by Egyptian doctors from the same workplace. However, the patterns of social relationships and social interaction that existed between the respondents and their Egyptian colleagues and the wider Egyptian community in Jeddah tended to be shallow or superficial. When asked the question, "How did you first make friends with other Egyptians in Jeddah ?", many respondents objected to the use of the word "friends". They insisted on referring to those with whom they worked and with whom they came into direct contact as "acquaintances" or "colleagues". A number went on to explain that they believed the word "friend" has a deeper meaning and implication, and cannot be used casually. Only a minority of the respondents in the study had formed close social relationships with other Egyptians in Jeddah. In

most cases these involved their relatives who also worked and lived in Jeddah, or friends they had known in Egypt before migrating.

However, the doctors' wives who were not employed had formed stronger social relationships with other Egyptian house-wives living in the same residential building. Their frequent visits and 'close-knit' contacts arose from the fact that they had little to do during the daytime, and from the sheer close proximity of their accommodation. Although a large number of the respondents in the study lived in compounds mainly occupied by other Egyptian doctors from the same workplace, it should be noted that this accommodation was provided by the workplace and was not of their own choosing. In fact, those who had been required to find accommodation for themselves chose it mainly for its proximity to their place of work, rather than its proximity to other Egyptians. The majority of the doctors' wives had worked in Egypt where they were free to go out on their own to do their shopping or visit friends and relatives. They found life in Jeddah rather dull. For this reason, many of the doctors' wives, if they were not working in Jeddah and had pre-school children, took the opportunity to travel to Egypt for holidays at least once a year.

These findings are inconsistent with the general findings in most studies of migration, that migrants tend to form close personal social relationships with those who

come from the same place of origin. For example, French (1986) concluded that Filipina migrants in Hong Kong formed a strong social network that reproduced their own Philippine society in the place of destination. Attiyah (1983) also found that temporary American migrants in Jeddah lived in close proximity to other Americans and Europeans in the city.

This study has found that extensive and 'loose-knit' social networks were characteristic of the patterns of social relationships that existed between the respondents and other Egyptians who worked and lived in Jeddah at the time. The social relationships which formed the links in these networks were overwhelmingly superficial or 'shallow', rather than being of a close or deeply personal nature. In order to account for these findings, and to explain why they are inconsistent with those of earlier studies of other groups of migrant workers, it is necessary to consider the effect of a number of different factors and the way these factors impinged on and reinforced each other in the daily lives of the respondents and their families.

Firstly, the doctors come to Jeddah as individuals or as members of very small family units, rather than as members of teams or large group as is normally the case among unskilled and semi-skilled migrant workers. Secondly, the uncertainties surrounding precisely how long the doctors would remain in employment in Saudi Arabia were not conducive to the establishment of 'close-knit'

networks and deep social relationships with their countrymen. In particular, the private medical sector tends to employ doctors on a short term basis, sometimes for only a few weeks or months at a time, which makes it difficult for them to establish close or long-lasting friendships. Thirdly, the doctors were very self-conscious concerning their career prospects and professional status. The competition between doctors working in the same establishment for status and for extensions of their employment contracts created an underlying feeling of uneasiness in their dealings with each other, both at work and outside. Fourthly, the doctors worked long and awkward hours, leaving them with little spare time during the week. Married male doctors had strong family commitments to fulfill in their spare time, particularly because their wives were unable to go out on their own. Even such simple functions as shopping had to be done by, or in the company of, husbands. The restrictions on the movements of women outside the home obliged the doctors to spend any spare time they had with their wives and families. Married female doctors were constrained from forming and maintaining close personal relationships and 'high density' social networks with other Egyptians in Jeddah because they also had to attend to their household responsibilities and care for their children, and because their movements outside the home were restricted by local culture. Unmarried doctors, and those who although married did not

have their families with them in Saudi Arabia, had less extensive social networks and relationships than their married counterparts. Such doctors tended to keep very busy by working extra hours, particularly at the weekends. Fifthly, the sheer size of Jeddah and the inadequacy of public transport makes frequent contact with acquaintances and friends living in different parts of the city quite difficult, particularly for those who do not own cars. Sixthly, there is a lack of formal or informal meeting places, such as private social and sporting clubs, where doctors would have the opportunity to meet and interact with those who have similar background and interests, or to engage in shared and activities. Finally, the respondents did not attach great importance to maintaining their Egyptian identity by cultivating 'close-knit' networks and deep social relationships with other Egyptians in Jeddah. Instead, they sought to maintain their Egyptian identity by carefully cultivating their existing networks and relationships with relatives and friends at home in Egypt, and by keeping up with news of events taken place there.

The vast majority of the respondents (44 or 84.6 %) reported that they had become acquainted with a number of Saudis citizens. They said that they got to know them primarily through their place of work, as colleagues or patients. Of the married doctors, around half of the respondents reported that their wives had become acquainted with Saudi families. These contacts had been mainly

established through their husbands, and to a lesser extent through neighbourhood encounters. However, the respondents had established only superficial and 'shallow' relationships with Saudis outside the workplace. Similarly, the doctors' wives had a very low level of social interaction with their Saudi neighbours, beyond the exchange of a few friendly words when they met on the staircase. Very few doctors and their families exchanged home visits with Saudis. Such visits were extremely rare and almost entirely one-sided, in that the respondents and their families were invited by Saudis, but did not return the invitations, or take the initiative in inviting Saudis into their homes.

These findings are supported by those of Al-Ghamdi (1985), who investigated the attitudes of a sample of Saudi nationals of different socioeconomic backgrounds in Jeddah to the presence of foreign migrant workers in Saudi Arabia. He found that the majority of his sample viewed the presence of expatriate workers in Saudi Arabia in very negative terms.

There are several reasons why Egyptian doctors and their families exhibit such a low level of social interaction and social contact with Saudis, and why the relationships involved tend to be largely superficial and very formal in nature. Clearly, all of the factors already discussed regarding the networks and relationships between the respondents and other Egyptians in Jeddah are also in

operation in this context. More specifically, the formal nature of the relationships and the low level of close contact between Egyptian doctors, their families and Saudis arises directly from the differences between Saudi customs and social practices and those of the Egyptians. Of particular importance here are the strict Saudi customs in relation to social gatherings and family visits, where women gather separately from men. In addition, Saudis are quite well known for 'distancing' themselves from foreign nationals working and living in the country. A number of doctors in the sample reported that although they were eager to make friends and establish contacts with Saudis, they felt that the latter "keep themselves to themselves" and that Saudis were not keen to make friends with foreigners. Indeed, the majority of people with whom the doctors interact outside the workplace are themselves foreign migrant workers, e.g. shopkeepers, taxi drivers, porters, etc. The lack of direct informal interaction between the doctors and Saudis outside the workplace prevented the respondents from developing a deeper understanding of the Saudi way of life and of thinking. Thus, the doctors felt hampered in forming relationships by their lack of knowledge about how to approach and communicate with Saudis. Indirectly the respondents must also have been influenced by the prejudice and impoliteness they encountered with some of their Saudi patients. In addition, some of the doctors who work in poor or low-

middle class areas of Jeddah come into frequent contact with Beduins, many of whom are uneducated and may behave in an uncivil manner. This may reinforce the doctors' lack of close contact with the local population. In fact, several of the doctors said that they had found it much easier to make the acquaintance of, and establish social relationships with, people from other nationalities rather than Saudis.

Although the lack of social contact between the doctors, their families and Saudi citizens is to a large extent due to differences between Saudi and Egyptian customs and way of life, it is necessary to emphasise that Saudi and Egyptians share many similar customs and traditions. After all, Egyptians and Saudis follow the same religion, speak the same language, and share a common history. These similarities highlight the fact that there are no fundamental ethnic differences between the respondents, their families and the host society. Unlike many other studies of migration, this study found no evidence to indicate that there was a major socio-cultural clash between this group of migrant workers and the rest of Saudi Arabian society, and certainly no major socio-cultural clash that would make social adjustment and daily life exceptionally problematic for the doctors and their families.

For the most part, the respondents in this study kept their savings in banks in Egypt, awaiting their return when

their employment contracts came to an end. Unlike unskilled and semi-skilled migrant workers, only a few doctors sent remittances back home to support their families and in some cases to pay for their children's education. This can be explained by the fact that the majority of the married respondents in the sample lived together with their families in Jeddah. However, 11 (21.1 %) of the respondents had worked in Saudi Arabia for long enough to accumulate sufficient savings to be able to invest them in various ways in Egypt. Some had invested their savings in business enterprises, some had purchased their own private surgeries, and a number had purchased flats in which they planned to live when they returned home permanently. A majority of those who had not already begun to invest their savings while working in Jeddah expressed the intention of doing so when they eventually returned to Egypt. Most planned to purchase private surgeries, and those who already owned surgeries intended to use their savings to modernize and develop them. Moreover, several doctors said that they intended to use their savings to establish a private business. These findings show quite clearly that this group of highly qualified migrant workers used or intended to use their savings to invest in income generating projects. By contrast, studies of unskilled and semi-skilled Egyptian migrant workers in the rich Arab countries of the Middle East (e.g. Mohi-Eldin, 1980; Al-Deib et.al., 1984, Abdul-Mooti, 1984; and Fergani, 1988)

show that such migrant workers invest most of their savings in non-productive or non-income generating projects (see Chapter Nine).

As noted earlier, the doctors in the study worked long and awkward hours with little spare time during the week. At weekends the married doctors tended to spend almost all of their time with their families. In the absence of entertainment facilities and interesting places in which to pass the time, the doctors usually spent their spare time in shopping and in taking their families to the seaside area (Al-Hammra). The unmarried doctors, and those who had left their families in Egypt, worked as many extra hours as was possible. They spent much of their spare time in domestic chores. The doctors' wives who were not in employment in Jeddah found life in the city very boring. The respondents said that their wives found life in Jeddah dull because women are not permitted to drive and are unable to go out unless escorted by their husbands. Because of their boredom, a majority of the respondents' wives who had no children to care for or whose children were of pre-school age travelled to Egypt for a long holiday at least twice a year.

The doctors and their families in Jeddah maintained close contacts with Egypt. Not only did they maintain strong communication links with relatives and friends in Egypt, they also frequently visited home. These findings corresponded with those from studies on rural-urban

migration (e.g Al-Nassar, 1990) and on international labour migration (e.g French, 1986; Al-Horob, 1986; Fergani, 1988). The doctors were able to make frequent visits home because of the proximity of Jeddah and Egypt, and because of the free annual travel allowance given to the doctors, and in many cases their families as well. The respondents and their families were well informed about events and news in Egypt through Egyptian newspapers and television programmes.

A majority of the respondents in the study said that they hoped to return to Egypt, when their employment contracts in Jeddah eventually expired, and rejoin the establishment where they had worked prior to migrating to Saudi Arabia. Almost all of the respondents anticipated that they would encounter some difficulties upon their eventual return home. Many said that they would experience difficulties in re-adjusting to the lower standard of living, and the problems of overcrowding and traffic congestion in Egypt. This was particularly the case for those respondents who intended to return to reside in one of Egypt's major cities. With reference to these issues, all of the respondents pointed out that Saudi Arabia has one of the highest standards of living in the Arab World. A number of doctors expressed anxiety about the personal hardships that they may experience when they return to settle permanently in Egypt. For example, some of those

who had closed their private surgeries during their migration abroad, expected to have to work very hard to build up their practice again. Other doctors, who had worked or hoped to work in Jeddah for a long period, were concerned that their employment in Saudi Arabia would adversely affect their promotion prospects in Egypt, e.g. that they would "fall behind" their colleagues, in terms of career prospects and status, who had remained in Egypt.

There has been little, if any, research on the dependants of labour migrants in Saudi Arabia in particular, and the labour-importing countries of the Middle East in general. This study has sought to partly fill this gap by collecting and providing basic descriptive data on the social life and perceptions of Egyptian doctors and their families living in Jeddah, as well as on impact of migration on their children's educational progress.

Although doctors are among the few groups of migrant workers who are permitted to bring their families with them to Saudi Arabia, not all the married respondents in the sample lived together with their families in Jeddah. Of the 43 married respondents, 10 had left their families behind in Egypt. They had done so because their wives were full time employment in Egypt, or because they were unwilling to disrupt their children's education, or in the belief that it was quite expensive to enrol children in private schools in Jeddah.

A majority of the respondents who had children of school age sent some or all of them to private schools in Jeddah. Some of the respondents had enrolled their children in private schools in Jeddah because they wanted them to have the best possible available education, while others had been forced to do so because they had found it difficult to find a place for their children in Jeddah's public schools. Those respondents who had moved more recently to Saudi Arabia had experienced more difficulties in finding places for their children in public schools. One explanation for this is that the Saudi government in recent years has placed limits on the number of foreign children admitted to public schools. Preference for these places is given to children whose parents have permanent resident permits in Jeddah, and to the children of Yemeni and Palestinian parents. However, it seems safe to assume that Egyptian migrants will find it less difficult in future to gain admittance for their children to public schools as a result of the Gulf War and the subsequent rift in government relations between Yemen and Saudi Arabia. This rift has already led to the permanent repatriation of a large number of Yemeni migrants and their families (see Chapter Three).

The respondents reported that for the most part their children had not encountered any major difficulties in adapting to and coping with their studies in Saudi schools, even though the curriculum followed differed from that

taught in Egypt. The explanation for this finding seems directly attributable to the fact that most of the children had either not begun their education until their arrival in Jeddah or had come to Saudi Arabia when they were very young and had been enrolled in Saudi schools in the early stages of their education. This explanation is supported by the further finding that the children who were reported as having had difficulties when they began their schooling in Jeddah were those who were at a more advanced stage in their studies. The difficulties reported centred on lessons in religion and mathematics, and were not of a particularly serious or long-standing nature.

The discussion so far has concentrated on drawing out the similarities and some of the difference between the findings of this study and those of other studies on migration. For example, with regard to the socio-demographic characteristics of the migrant workers, their motives for migration, the collective nature of the process involved in the decision to migrate, the ties they maintain with their place of origin, etc. However, the findings of this study differ in a number of important respects from the findings of other studies on migration.

A very large number of studies have stressed that kin and friends play an important role in the whole process of migration, where the existence of relatives, friends and fellow countrymen at the place of destination is a crucial factor in the way migrants adjust to their new environment.

These studies have shown that, on their arrival, migrants rely almost entirely on their relatives, friends and fellow countrymen for assistance, friendship and social interaction, rather than upon individuals from the host society (e.g. Stromberg et. al., 1974; Kemper, 1977). Although the respondents in this study soon made the acquaintance of, and formed relationships with, other Egyptians working in the same establishment, the majority confined their contacts with other Egyptians to the workplace. Further, the respondents considered these relationships to be little more than working relationships with "colleagues", rather than the basis for developing more personal relationships or "friendships". However, some of the respondents had relatives, or friends they had known in Egypt, working and living in Jeddah. In such cases, these relatives or friends became the focus of the respondents' patterns of social relationships and forms of social interaction.

A number of studies have found that migrants involved in the actual process of moving have been provided with a great deal of direct and practical assistance by their kin and friends, including those who are left behind (e.g. Choldin, 1973) and those who have previously migrated to the same place of destination (e.g. Abu-Lughod, 1961; Tienda, 1980). Such assistance and support may be provided long after the migrants have reached their place of destination. Migrants are usually met upon their arrival

and provided with accommodation (e.g. Stromberg, et. al., 1974), some may also receive financial support, and all are provided with information about the host society (e.g. Choldin, 1973; Al-Nassar, 1990). In this study, however, there was not a single case where the doctors' move to Jeddah had been directly facilitated, in terms of financial support and assistance with paying for the expenses of their journey, by kin or friends in Egypt or Saudi Arabia. Only a very small number of the respondents had been met on their arrival by kin and friends already living in Jeddah. The overwhelming majority of doctors had been met on arrival by their employers or a representative from the workplace. A further contrast with the findings of other studies is that virtually all of the doctors in the sample had found and be assigned accommodation by their place of work before they arrived.

It is worthwhile noting at this point in the discussion, that the pattern of cross-country migration characteristic of Egyptian doctors working and living in Saudi Arabia stands in sharp contrast to many of the patterns associated with rural-urban migration in developing countries. There is no evidence in this study of seasonal, circular or other forms of migration where migrants move from rural locations to small towns and then to major urban centres in a series of steps (Abu-Lughod, 1961; Choldin, 1973). The pattern of cross-country

migration characteristic of Egyptian doctors in this study is much more highly structured than that reported for rural-urban migration, and invariably involved migration from one major urban centre in Egypt to another in Saudi Arabia.

The findings of this study also reveal further points of similarity and contrast between this group of highly skilled Egyptian migrants working in Jeddah and other groups of unskilled and semi-skilled migrant workers working in Saudi Arabia and other Arab labour-importing countries of the Middle East. The study found that the doctors were relatively older than their unskilled and semi-skilled counterparts when they first entered the Saudi labour market. This was because of the lengthy education and practical experience required of doctors. The doctors expressed the intention of taking back a whole range of electrical and other manufactured goods from Jeddah for use in Egypt. In this, they were similar to Egyptian unskilled and semi-skilled migrant workers employed in the rich Arab countries of the Middle East. However, there is a differences in that unskilled and semi-skilled migrant workers have not usually been able to possess such durable goods before migrating abroad, while the doctors had already purchased many such household appliances before moving to Saudi Arabia. It is, therefore, extremely likely that the doctors intended to take back additional

appliances or, perhaps, to replace their old appliances with better quality and more up-to-date models. They also differed from their unskilled and semi-skilled counterparts in that they were more likely to take back such luxury items as curtains, crystal, china, etc.

Another significant similarity between the Egyptian doctors and manual and semi-skilled migrants working in Saudi Arabia is that none of them have the privilege of being members of a trade union or any other organization which may protect their rights. In this respect, their situation is similar to that of migrants who are working in the majority of the major labour-importing countries in the Arab World. The exception here is Kuwait, which permits long-term foreign migrant workers to become members of trade union organizations. Furthermore, highly skilled, semi-skilled, and unskilled foreign workers are all, if working in the private sector, controlled by their Kafeel, who has unrestricted legal powers over their employees. This is also the case in all other Arab Gulf countries.

However, among the differences between this group of highly skilled migrants and other, unskilled and semi-skilled migrants working in Saudi Arabia, is that the former are allowed to bring their families with them because of their high income. Another difference is that these highly skilled migrants did not have an informal meeting places in Jeddah, unlike their counterparts among manual and semi-skilled workers who take full advantage of

the large number of traditional cafes, particularly in the old and undeveloped part of the city where a large number of foreign migrant workers are to be found. Khaleil (1990), for instance, pointed out the importance which cafes play for Egyptian semi-skilled workers in Jeddah. As well as a venue for spending spare time with friends, they are used to obtain information about jobs and other important matters. Traditional cafes found in Saudi Arabia's cities often are not considered "respectable places", and therefore highly skilled migrants try to distance themselves from such places. Another major difference between Egyptian doctors and other migrant groups in Jeddah is that the nature of their work may involve them directly or indirectly in an incident in which a patient loses his or her life, or is caused permanent disability as a result of medical negligence or suspected negligence, which may lead to a lengthy public enquiry. As mentioned earlier, the risk of getting involved in such a case was a major concern to those doctors whose work involved carrying out or assisting with operations. The severity of Saudi health laws and regulations in dealing with cases of medical negligence and suspected malpractice imposes considerable and continuing strain on the doctors. The fact that the health authorities prevent the travel of all foreign health personnel involved in a suspected case of medical negligence, until the investigation is over, is

particularly worrying for the respondents, as it is for all of those employed in the health services.

The way in which this group of highly skilled migrants secured employment in Jeddah, is an additional difference between them and their unskilled and semi-skilled counterparts. The vast majority of unskilled and semi-skilled migrant workers find employment through private labour recruiting agencies in Egypt. As is shown in Khaleil's (1990) study of this group of migrants in Jeddah, and Fergani's (1988) study of unskilled and semi-skilled Egyptian migrant workers recruited to Saudi Arabia and other Gulf countries. Nagi (1986) also points out that the recruitment of South Asian migrant workers to countries in the Gulf region has been mainly through private agencies operating in most South Asian countries. These private agencies constitute one of the important reasons for the huge increase in the utilization of workers from such countries by employers in the Gulf States (see Chapter Three).

With regard to the development of the Saudi health services, the study has shown that a rapid expansion of health care and medical facilities has taken place in recent years. The study also shows that the delivery of health services in Saudi Arabia is heavily dependent on expatriate health personnel from other Arab countries, Europe, the United States, the Indian sub-continent, and

the Far East. As a result of the rapid expansion and the presence of large numbers of expatriate medical personnel health and medical care services have been extended to rural and remote areas all over the country. The majority of foreign doctors working in Saudi Arabia are of Arabic origin. This is not surprising given their ability to communicate with Saudi patients in their mother tongue. In addition, Arab doctors share the broad socio-cultural background of the host society, which is invaluable in diagnosing and treating patients.

The concern of private medical care establishments in Saudi Arabia to attract clients who normally used national health services, has prompted them to employ a large number of specialists and highly qualified consultants, even in small private clinics (see Chapter Four). Moreover, the competition between the private medical establishments themselves serves to intensify the demand for the more experienced and highly qualified doctors. Given that Egyptian doctors are the largest single group of foreign doctors working in Saudi Arabia, one can conclude that this situation may in the long term adversely affect the availability of medical personnel with such skills in Egypt.

According to Ibrahim (1982), the Egyptian labour market has suffered from shortages of construction workers as a result of the increasing demand from Arab countries since the early 1970s. In Egypt the consequence has been

to pushed the wages of workers in this occupation category to very high levels. He also argues that since the majority of Egyptian workers migrate to obtain employment abroad mainly to acquire a higher income, a large number of them accept jobs which require lower levels of skills than those they have acquired in Egypt. Ibrahim (1982:136) rightly suggests that this may have adverse effects on the migrants themselves, and may in the long run have a disastrous impact on the interest of Egypt, and of the Arab World as a whole. Although this study has shown quite clearly that a substantial number of Egyptian doctors working in Jeddah have increased their medical knowledge and experience, and that some have also learned new skills, it remains to be seen whether these doctors will be able to employ those skills and experiences upon their return to Egypt.

An important concern of this study was to investigate the validity of the widespread feeling among many people in Saudi Arabia that some of the private health establishments tend to financially exploit patients by increasing their bills with unnecessary tests and X-rays. The study confirmed that instances of exploitation certainly do occur in small private health centres as well as in large and quite well known hospitals. The case of Dr.Abiys, presented in Chapter Seven, who was dismissed from his job in a private clinic simply because he had failed to

generate sufficient income for his employer, provided clear evidence of the extent to which some Kefeel will go in order to increase the income of their enterprises. Two other doctors, described in the same chapter, had left their previous jobs in the private medical sector and applied for jobs in the public health service in order to escape the constant pressure by their employer to order their patients to undergo various tests and X-rays.

The study also found that some employers encourage doctors in their employ to increase workplace income indirectly, by paying a bonus to those who manage to generate a substantial amount of cash. The researcher noticed, while interviewing respondents in a number of private medical establishments, that when patients came to see a doctor they were given a receipt, of which there were three copies: one was kept in reception, the second was given to the treating doctor, and the third was for the patient. The researcher also noticed that in some private medical establishments the form given to patients, when they were referred to a laboratory to undergo tests or an X-ray, showed the name of the treating doctor. The researcher came to understand that in this way a doctor could document and account to the management for the number of cases he or she had treated in a given time, in consideration of the bonus which they might receive. This suggests that those doctors who bring in more money to their place of work stand a better chance of keeping their

jobs than others. In many of the private medical care establishments visited by the researcher during fieldwork, it appeared that the management evaluated the performance of doctors on the amount of money generated for the workplace, rather than any other criterion.

It has not been the intention of this part of the discussion to reach any major generalisations concerning international labour migration. Nor has the intention been to reach any major generalisations concerning the experiences of all Egyptian doctors and their families living and working in Saudi Arabia. The significance of this study in relation to the existing literature on migration in general, and that which deals with labour migration to Saudi Arabia and in the Middle East, is that it has endeavoured to provide a detailed account of a group of highly skilled and highly qualified migrant workers who seem to have escaped the attention of researchers. In summarising the main findings of the study, the discussion has inevitably led to a consideration of studies of other groups of migrant workers. Accordingly, the intention of this part of the discussion has been to draw out the points of similarity and contrast with the findings of other studies in order to place the findings of this particular study in a wider context. The empirical issues arising from the findings of this study, viewed in relation to the findings of studies on other groups of migrant workers,

obviously raise a set of questions for further research. These will be addressed later in this chapter.

METHODOLOGICAL CONSIDERATIONS AND FURTHER RESEARCH

The actual methodology employed in any empirical sociological study is almost always the end-result of a series of decisions and compromises made during fieldwork and which are reflected in the collection and analysis of the data. These decisions and compromises arise from the tension between the main purposes of the study, the ideal methodology needed to fulfill these purposes, and the methodology that can be realistically employed given the time and resources available and the overall situation in the field (Heguye, 1988: 196). As Bulmer and Warwick (1983) point out, these tensions are particularly great for researchers working in developing countries. In this respect, the methodology employed in this study was no exception. However, the methodology employed was effectively justified (a) by the overall concerns which guided the research work, (b) by my own knowledge of the research setting and the respondents, and (c) by the lack of research on highly skilled migrant workers in Saudi Arabia, the Middle East and in the literature on migration in general.

The overall concern of the fieldwork was to collect both quantitative and qualitative data on a sample of Egyptian doctors and their families working and living in Jeddah. At the very beginning of the study was decided that a major part of the fieldwork would focus on the perceptions and experiences of the respondents and their families, rather than simply on their socio-demographic characteristics. A list of simple questions was used in the early stages to guide the organisation and planning of the fieldwork: Who exactly are these highly skilled and highly qualified migrant workers ?, Why did they decide to leave their jobs in Egypt and pursue a career in another country ?, What were the implications of their move for their medical skills and experience? How were their families affected by moving to Jeddah ?. On the basis of such questions a structured interview schedule was drawn up, tested and modified, and then used as the main source of fieldwork data. The interviews were carried out in as an informal and relax manner as possible. It was clear from the outset that selecting a representative sample of Egyptian doctors to interview would constitute a major problem. This was conformed in the early stages of fieldwork. As a consequence, the decision was taken to utilize the interview schedules within a snowball or rolling sampling approach. While this could in no way compensate for the small size and lack of representativeness of the sample, it did permit the

researcher to include in the sample as wide a variety of Egyptian doctors and medical establishments as time and resources allowed. Another major part of the fieldwork concerned the collection of data on the structure and organisation of Saudi health and medical services, covering both the public and the private sector.

The absence of published official statistics, or publicly available official lists and registers, regarding foreign migrants and their dependants working and living in Saudi Arabia made it impossible to draw any kind of random, let alone representative, sample of Egyptian doctors in Jeddah. Obviously a large-scale census-type survey of Egyptian doctors working in Jeddah would have provided a more adequate sampling frame from which a random, though still not truly representative, sample might have been drawn. However, the researcher had neither the time nor the resources to conduct such a preliminary survey. Therefore a non-random, purposive sample of doctors was selected for inclusion in the study by means of a snowball or rolling sampling approach.

The great disadvantage of employing such an approach is that the sample, and hence the findings, may be unrepresentative. However, the absence of official statistics, lists and registers regarding Egyptian doctors working in Jeddah, means that there is no reliable means available to check on precisely how representative the doctors in the sample are. This is a problem that

regularly confronts researchers working in developing countries (see Casley and Lury, 1981; Bulmer and Warwick, 1983). In this regard, Pons (1988) points out that a great deal of valuable and important research can be carried out on specific groups in developing countries notwithstanding the problem of their representativeness. Given the size of the sample and the methodology employed in this study, the findings cannot be taken as representative of all Egyptian doctors working in Jeddah. Nor can the range of public and private medical services available in Jeddah be taken as representative of other urban centres in Saudi Arabia. Throughout the discussion care has been taken to stress the point that the findings of this study pertain only to the doctors in the sample, and that great care must be taken in applying these findings to the wider population of doctors working in Jeddah or in Saudi Arabia as a whole.

As discussed in Chapter one, the snowball sampling approach served the purposes of this study in a number of important ways. Among the major benefits of this approach was that it helped to reduce the level of suspicion and mistrust among respondents. Had not such an approach been followed, the researcher might well have been seen as an official, or a collaborator, from the General Directorate of Health Affairs in Jeddah or the Ministry of Health. The fact that the researcher was personally introduced to almost all of the respondents by a colleague or a close friend clearly made them more willing to be interviewed,

and increased the probability of obtaining high quality data.

Of the many limitations of this study, one is particularly important. The researcher was unable, with the exception of two cases, to interview the doctors' spouses or children, as had originally been planned. It became necessary to rely on the doctors themselves, acting as respondents, to answer the questions on the interview schedule concerning members of their family. A further limitation of the study, not already referred to in earlier discussions, was that it did not include Egyptian doctors running single-handed private surgeries in Jeddah, nor did it include Egyptian doctors working in private companies or military establishments. This was not simply the result of an oversight, it was not possible to include such doctors because of time and resource constraints. There are no detailed available records containing the names, addresses and nationalities of doctors running single-handed private surgeries in Jeddah. In order to conduct interviews with Egyptian doctors working in military establishments, it would have been necessary to obtain permission from the Ministry of Defence, the National Guard, and the Ministry of the Interior.

Within the limits imposed by time, resources, the absence of either official or academic relevant background data, and the constraints operating in the research setting, the methodology employed proved reasonably

successful in servicing the main aims and purposes of the study. The collection and analysis of both quantitative and qualitative data provided a more complex view of the position and experiences of the doctors and their families than that which could have been obtained by focusing strictly on either quantitative or qualitative data. The combination of informal interviewing procedures, organised around an interview schedule, and a snowball sampling approach, based on introductions and referrals between respondents, provided data, examples and insights that could not have been adequately obtained in any other manner.

Although the main aims and purposes of the study were achieved reasonably successfully, the study itself should be seen as constituting a baseline or foundation on which to carry out further research. In order to supplement and substantiate the findings of this study there is clearly a need for further and even more detailed research on this group of 52 doctors and their families, perhaps based on case-studies together with a more highly structured form of social network analysis. For example, the findings suggest that more research is required on the doctors' migration and recruitment patterns in relation to their employment contracts and working conditions (including their difficulties with patients and managements), on the doctors' workplace relationships and social networks in relation to their family relationships and their

dependants' social networks (including their ties with Egypt and their relationships with other Egyptians working and living in Jeddah), and on the doctors' and their dependants' relationships with Saudi colleagues and families.

With respect to this group of 52 doctors and their families, further research could well be undertaken to investigate the impact of their experiences as migrant workers in Saudi Arabia on their lives when they eventually return permanently to Egypt. The ways in which doctors and their families re-adjust to life in Egypt after experiencing the high standard of living in Jeddah, and the way they re-establish their careers and social networks in Egypt after years of working and living abroad, require investigation. Research on doctors who have returned after working abroad would provide a clearer picture of whether or not the new medical skills and experience some acquired in Saudi Arabia are utilized in their work in Egypt. Such research would also reveal how they go about re-establishing and building their careers. This is a topic of considerable importance because their years of foreign work experience are not taken into account in Egypt for the purposes of promotion.

In addition, there is clearly a need for more extensive research, along the lines of this study, on other groups of Egyptian doctors and their families working and living in Jeddah and elsewhere in Saudi Arabia. Research

on other groups of Egyptian doctors and their families in other parts of Saudi Arabia, particularly those in villages and remote areas, would be particularly interesting and relevant. Similarly there is scope for research on groups of other Arab and non-Arab doctors and their families working and living in different parts of Saudi Arabia. The latter group present a particularly interesting topic for research. Research of this kind could then provide the basis for more extensive, large-scale surveys, perhaps based on questionnaires, designed to systematically compare the working and living conditions of different groups of foreign doctors and their families in different parts of Saudi Arabia.

This study has also highlighted the need for more research on Saudi Arabian health and medical service. The development, structure and operation of Saudi Arabian health and medical services obviously constitutes a crucially important and relevant area for research for scholars from many different disciplines. The importance and relevance of such research extends far beyond the boundaries of this study. However, in terms of this study and its findings, two areas for further research can be noted. Firstly, there is a need for research which is concerned to compare the type and quality of health and medical care provided in the public and private sectors. Secondly, there is a need for research which compares the socio-economic characteristics of the users of different

kinds of health and medical facilities in the public and private sectors.

A great more empirical research on all aspects of international labour migration is needed in Saudi Arabia. Among the huge number of foreign workers there are a large number of highly skilled and highly qualified foreign migrant workers, such as doctors, engineers, nurses, academics and teachers. Although this study has looked in some detail at a small sample of Egyptian doctors and their families working and living in Jeddah, its findings can be readily used as the basis for comparative research on other groups of highly skilled and highly qualified migrant workers. Such comparative research would focus on their socio-demographic characteristics, their recruitment and working conditions, their workplace difficulties and coping with Saudi bureaucracy, their relationships with other migrant workers and Saudis, and the problems they encounter with their managements and their kefeel.

Similarly, there is a great need for more research on rural-urban and inter-urban migration in Saudi Arabia. Such research is needed in order to establish the points of similarity and contrast between migrants involved in internal migration and those involved in international labour migration, e.g. their socio-economic characteristics, reasons for migrating, mechanisms for securing employment, and social networks, etc. Research of this kind would be to analyse the way internal migrants

react and adapt to working and living in new urban environments and provide clear points of comparison with cross-country migrants. Extensive research of this kind is also needed in order to identify the extent to which rural-urban and inter-urban migration, in relation to international migration, have contributed to urban growth in Saudi Arabia's major cities. The lack of existing research on rural-urban, inter-urban and international migration means that, at the moment, it is extremely hazardous to draw any conclusions about the impact of the huge influx of foreign migrant workers on culture and way of life of Saudi Arabians, or about the consequences of international labour migration on urbanisation in Saudi Arabia.

With regard to the theoretical framework that could be employed as a foundation for all of this research, a combination of the 'historical structuralist' and the 'system approach' approaches seems most appropriate in the current circumstances. The 'historical structuralist' approach provides many of the essential conceptual linkages whereby different facets of rural-urban, inter-urban and international migration can be integrated in an analysis of capitalist development. However, this approach has difficulties in recognising that different social, economic, political and cultural structures produce important international, national, regional and local

variations in patterns of migration and in the lives and experiences of different groups of migrants. Further, notwithstanding the ideological overtones of the 'historical structuralist' approach, it contains little methodological guidance for empirical research work. In contrast, the 'system approach', while agreeing in many respects with the underlying principles of the 'historical structuralist' approach, contains few real theoretical insights but provides clear methodological guidance for empirical research work. The 'system approach' emphasises that all of the components within any migration process are inter-related, and a change in the nature of any single component can have an effect on all of the others. Unlike other models for the study of migration, which concern themselves mainly with the volume of migration and the migrants' reasons for moving, the 'system approach' directs the researcher's attention beyond these issues, towards describing and analysing the implications of the process of migration for the migrants themselves and their families who may accompany them or be left behind, as well as the consequences of migration for both the sending and the receiving areas.

It is, however, neither feasible nor viable to attempt to move from a rather small-scale study, such as the one reported on here, to an elaborate and wide-ranging discussion of the advantages and disadvantages of different theories and models of migration, and of international

labour migration in particular. Consequently, it was never the intention of the researcher to attempt to assess or apply any of these theories or models in the context of this study. Part of the difficulty lies in the fact that the findings of this study pertain to only a small group of highly qualified and highly skilled migrant workers and their families in Jeddah. The findings cannot be generalised with any great degree of confidence to cover the working conditions and living experiences of all Egyptian doctors, or all other groups of foreign doctors, let alone all other groups of highly skilled foreign workers in Jeddah or in Saudi Arabia as a whole. However, part of the difficulty also lies in the fact that there is a desperate shortage of empirical research on rural-urban, inter-urban and international labour migration, particularly with regard to groups of highly skilled and highly qualified migrant workers, in Saudi Arabia and in the Middle East as a whole.

In order to fill this gap a 'basket' of studies needs to be undertaken which focus on the working and living conditions of a wide range of different groups of highly skilled and highly qualified migrant workers and their dependants, and on a wide range of other types of migrant workers in Saudi Arabia and in the other major labour-importing countries of the Middle East. Such studies should not focus simply on the volume, direction and socio-demographic characteristics of different groups of migrant

workers, but should encompass their recruitment and working conditions, the difficulties they encounter in their jobs, the problems they experience with managements and employers, their friendship and social networks, and the problems of re-adjustment facing returnees. It is hoped that this study will stimulate interest in all aspects of migration in Saudi Arabia, and particularly in further research on groups of highly skilled and highly qualified migrant workers and their families.

APPENDIX I
THE INTERVIEW SCHEDULE

CASE NO.	RESPONDENT'S NAME	NAME OF PLACE OF WORK	LOCATION
....

Type of Place of Work:

Private Hospital
Public Hospital
Private Clinic
Public Clinic

SECTION ONE:

SOCIAL BACKGROUND

1. AGE:

Under 29 Years
29 - 32 Years
33 - 36 Years
37 - 40 Years
41 - 44 Years
49 - 52 Years
Over 52 Years

2. What is your place of birth ?

3. SEX:

Male Female

4. MARITAL STATUS:

Single
Married

Engaged	.....
Divorced	.....
Widowed	.....

5. RELIGION:

Moslem Christian

6. EDUCATIONAL BACKGROUND:

First degree	.....
Diploma	.....
Master	.....
Ph.D	.....

7. If you have a higher degree, what is your specialty ?

Internal Medicine	.....
Internal Medicine & Cardiology	.....
Gynaecology & Obstetrics	.....
E.N.T.	.....
Ophthalmology	.....
Paediatrics	.....
General Surgery	.....
Dermatology	.....
Cardiology	.....
Psychiatry	.....
Brain & Nerves	.....
Other - specify	.....

8. From which university did you graduate ?

Alexandria Uni.	.....
Cairo Uni.	.....
Ain-Shams Uni.	.....
Al-Zaqazeeq Uni.	.....
AL-Azhar Uni.	.....
Tanta Uni.	.....
Al-Kasr Al-Einy Uni.	.....
Al-Mansoura Uni.	.....
Other - specify	.....

9. When was that ?

10. How long have you lived in Jeddah ?

Less than one year	.....
1 - 3 Years	.....
4 - 6 Years	.....
7 - 9 Years	.....
More than 9 Years	.....

11. What is your monthly income ?

Less than 3501 S.R.	.....
3501 - 4500 S.R.	.....
4501 - 5500 S.R.	.....
5501 - 6500 S.R.	.....
6501 - 7500 S.R.	.....
7501 - 8500 S.R.	.....
More than 9000 S.R.	.....

SECTION TWO:

MOVING TO SAUDI ARABIA

12. Where were you living before moving to Saudi ?

Cairo	.....
Alexandria	.....
Al- Zaqazeeq	.....
Al-Mansourah	.....
Al-Geeza	.....
Shabeen Al-Koom	.....
Other - specify	.....

13. What was/were your main reason/s for moving to Saudi ?

Economic reasons	.....
Religious reasons	.....
For a change	.....
To join husband/wife in Jeddah	.....
To gain more experience	.....
Other - specify	.....

14. Did anyone helped you in taking the decision to

move to Saudi ?

Yes No

15. If yes, who helped you ?

16. Did anyone encourage you to move to Saudi ?

Yes No

17. If yes, who encouraged you ?

18. Did anyone discourage you from moving to Saudi ?

Yes No

19. If yes, who discouraged you, and why ?

20. How much did it cost you to move to Saudi ?

21. What was the money spent on ?

22. Have you worked in Saudi before ?

Yes No

23. If yes, when, where, and for how long ?

24. Have you worked in another country other than Saudi ?

Yes No

25. If yes, when, where, and for how long ?

26. Would you have agreed to migrate for employment to
another country other than Saudi ?

Yes No

27. If no, why ?

28. In Saudi, would you have agreed to work in another place other than Jeddah ?

Yes No

29. If yes, would you have agreed to work in a village or remote area ?

Yes No

30. Did anyone meet you at the airport when you arrived in Saudi ?

Yes No

31. Who was/were with you when you arrived ?

32. Where did stay when you arrived in Jeddah ?

33. Do you still live in the same place ?

Yes No

34. What type of accommodation do you live in ?

Flat House

A room in a flat

35. Is your accommodation provided by your employer, or do you receive an accommodation allowance ?

35(a). If provided by employer, is your accommodation in a compound ?

Yes No

35(b). If in a compound, is it exclusively to accommodate

doctors ?

Yes No

36. If no, who else lives in the compound ?

37. If accommodation is provided by employer, was it:

Fully furnished
Partly furnished
Unfurnished

38. If fully or partly furnished, what is your opinion
about the furniture ?

39. How far is the accommodation from your place of work?

Near by
Quite near
Quite far
Very far

40. How do you get to work ?

On foot
By own car
By the workplace transport
By a lift from husband
Other - specify

SECTION THREE:

EMPLOYMENT

41. How did you secure your employment in Jeddah ?

With the help of friends
Through an advert in the papers
Offered the job
By applying to the Saudi Medical
Attache in Egypt
Through "internal contract"
Other - specify

42. Were you interviewed for the job ?

Yes No

43. If yes, by whom ?

44. Did you obtain a written contract for the job ?

Yes No

45. If yes, were all the contract conditions fulfilled ?

Yes No

46. Do you think that you have learnt or gained new
experience from your job in Saudi ?

Yes No

47. If yes, please specify

48. Do you feel that you have lost some of your skills or
experience by working in Saudi ?

Yes No

49. If yes, please specify

50. Do you perform the same duties in Saudi as in Egypt ?

51. Do you think that practicing medicine is easier in
Saudi or in Egypt ?

In Saudi In Egypt

52. If in Saudi/Egypt, why is that ?

53. In Egypt, did you work in:

The private sector The public sector
In both

54. Do you own a private surgery in Egypt ?

Yes No

55. If yes, what is its status now ?

56. In Egypt, how many hours did you work each day ?

57. In Jeddah, how many days do you work each week ?

58. What are your working hours arrangements ?

59. Do you work in shifts ?

Yes No

60. If yes, specify

61. Do you work extra hours ?

Yes No

62. If yes, specify

63. Do you feel that your salary is fair for the amount of
work you do ?

Yes No

64. If no, why ?

65. When did you start your work after arriving in Jeddah?

The same day	.....
The next day	.....
In the first week	.....
In the second week	.....
After a few months	.....
Other - specify	.....

66. Did you have to undertake any type of training before

starting your job in Saudi ?

Yes No

67. If yes, what kind of things did you learn ?

68 (a). Who explained these things to you ?

68 (b). How long did it take you to learn these things ?

69. What kind of difficulties did you face when you first started work in Saudi ?

70. What sort of difficulties do you have with patients ?

71. What sort of difficulties do you have with your colleagues?

72. Do you have any difficulties with the work place management ?

Yes No

73. If yes, specify

74. Are these difficulties, which you face in your job in Saudi, similar or different from those in Egypt ?

75. How long do you intend to work in Saudi ?

SECTION FOUR:

FRIENDSHIP AND SOCIAL NETWORK

75. How did you make friends when you first arrived in Jeddah ?

Through friends and relatives	.....
Mixing with other Egyptians in the work place	.....

Already knew them from Egypt	.....
Through neighbourhood	.....
Through husband	.....
Others	.....

76. Do most of your friends come from Egypt or from other countries ?

77. If from Egypt, are they doctors or from other professions ?

Doctors Other professions Both

78. Did you find it difficult to make friends in Jeddah ?

Yes No

79. Do you have any Saudi friends ?

Yes No

80. If no, why is that ?

81. If yes, how did you get to know them ?

82. Do you exchange home visits with your Saudi friends?

Yes No

83. If no, why ?

84. With whom do you spend most of your spare time ?

With family	.....
With Egyptian friends	.....
With relatives	.....
On my own	.....
Other - specify	.....

85. How do you spend your time during the week ?

86. How do you spend your time at the weekend ?

Visit friends and relatives	.....
Go shopping	.....
Go around the shopping centres	.....
Go to Al-Hemrra	.....
Visit the Holy mosque in Mekkah	.....
Other	.....

87. How did you use to spend your spare time in Egypt ?

88. Do you keep in touch with relatives in Egypt ?

Yes	No
-----	-------	----	-------

89. How do you communicate with them ?

Telephone	Letters	Other
-----------	-------	---------	-------	-------	-------

90. Do you keep in touch with friends in Egypt ?

Yes	No
-----	-------	----	-------

91. How do you communicate with them ?

Telephone	Letters	Other
-----------	-------	---------	-------	-------	-------

92. Do you follow closely news and events in Egypt ?

93. If yes, how ?

94. How often do you go to Egypt ?

Never	.....
Once a year	.....
Twice a year	.....

95. What do you miss most in your social life in Jeddah ?

SECTION FIVE:

GENERAL QUESTIONS

96. Given the choice would you like to settle in Saudi permanently ?

Yes No Don't know

97. When your job contract in Saudi expires, are you thinking of going back to:

Egypt
Another country
Don't know

98. If to Egypt, do you think that you will settle down there permanently, or travel abroad again for employment if the chance arises ?

Settle down permanently
Travel abroad for employment again
Travel abroad for employment again
if to Saudi
Don't know

99. When you go back home, would you return to your previous job ?

Yes No

100. If no, why is that ?

101. What kind of difficulties do you expect to face when you go back to Egypt permanently ?

None
Re-adjusting to life in Egypt
Coping with low standard of living
Gaining clients again
Don't know
Other

102. Where do you save your money ?

In Egyptian banks	.....
In Saudi banks	.....
In both	.....
Other	.....

103. How do you remit your money to Egypt ?

Through banks	.....
Take in person when going home for holiday	.....
Through friends and relatives	.....
Other	.....

104. Do you invest your money in Egypt at the moment?

Yes	No
-----	-------	----	-------

105. If yes, please specify

106. If no, how will you invest your money when you go back to Egypt permanently ?

107. Do you read the daily newspapers ?

Yes	No
-----	-------	----	-------

108. If yes, which newspaper do you usually read ?

Saudi papers	Egyptian papers	Both
--------------	-------	-----------------	-------	------	------

109. Do you have a car ?

Yes	No
-----	-------	----	-------

110. Have you been to Saudi cities other than Jeddah ?

Yes	No
-----	-------	----	-------

111. If yes, which ones have you visited and what was the purpose of the visit ?

112. Which of the following items do you have ?

Refrigerator . . . Washing machine . . . Cooker . . .
T.V.set . . . Video . . . Tape recorder . . . Other . . .

113. Which of those items do intend to take to Egypt when
you go back permanently ?

SECTION SEX:

THE FAMILY

114. Does your family live with you in Jeddah ?

Yes No

115. If no, why ?

116. If yes, did your family come with you when you first
arrived in Saudi ?

Yes No

117. If no, why is that and how long was it before your
family joined you in Saudi ?

118. Were there any difficulties in bringing your family
to Saudi ?

119. If yes, explain

SECTION SEVEN:

CHILDREN

120. Do you have any children ?

Yes No

121. If yes, how many/ how old are they ?

122. (if the respondent has children of school-age), do
they go to private or public schools ?

123. If they go to private schools, why is that ?

124. What sort of difficulties has/have your children
encountered at their schools ?

125. Do you think that your decision to move to Saudi has
affected your childrens' education ?

Yes No

126. If yes, explain

127. Do you think that your children will face some
difficulties when they go back to Egypt permanently ?

Yes No

128. If yes, explain

129. Do your children have any Saudi friends ?

Yes No

130. If no, why is that ?

131. If yes, do they exchange home visits with their Saudi
friends ?

Yes No

131. If no, why ?

132. Do you allow your children to go out of the house to

play with other children ?

Yes

No

133. If no, why ?

SECTION EIGHT:

DOCTOR'S SPOUSE

134. Does your wife/husband work in Jeddah ?

Yes

No

135. If yes, what does she/he do and how did she/he
secure employment in Jeddah ?

136. If no, did she/he use to work in Egypt ?

Yes

No

137. If yes, what was her/his job ?

138. (if spouse, or respondent is a women), does your
wife wear Hijab in Saudi ?

Yes

No

139. If yes, did she use to wear it in Egypt ?

Yes

No

SECTION NINE:

THE FAMILY FRIENDSHIP AND SOCIAL NETWORK

140. Does your family exchange visits with other Egyptian
families ?

Yes No

141. If yes, are these families ?

Colleagues' families	.....
Relatives	.....
Neighbours	.....
Other - specify	.....

142. Does your family know any Saudi families ?

Yes No

143. If no, why is that ?

144. If yes, how did they get to know them ?

145. How does your family spend their time when you are
at work ?

146. What sort of difficulties did your family encounter
when they first arrived in Jeddah ?

147. What does your family most miss in Jeddah ?

148. How many times each year does your family go back to
Egypt for a holiday ?

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