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RESEARCH ARTICLE

THE IMPACT OF SOCIO-RELIGIOUS BELIEFS AND RURAL POVERTY ON HEALTH CARE BEHAVIOR: CASE STUDIES IN THE POOR HOUSING COMMUNITY IN KEDAH, MALAYSIA.

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Abstract

Numerous studies have found that health-seeking behavior depends on the individual's socio-cultural differences, demographic profiles, level of economic conditions, religiousness and religious affiliations, and the availability of health care providers. Existing literature indicates that health status and health behavior among poor and low-income groups was found to be very low and vulnerable under conditions. This study examines health status and health care seeking behaviors in households of a resettlement housing unit *Kampung* (village) *Sadek* founded by the Kedah Regional Development Authority (KEDA), in Kedah (North East state in Peninsular Malaysia), Malaysia. Total 21 households sampled were interviewed face to face using the random sampling procedure. The open-ended questionnaire was administered to cover the various issues, including the demographic and economic profile, health behavior and religiosity, to investigate the nature and extent of health care behavior by beneficiaries of resettlement in hospitals and alternative treatment (traditional and spiritual). The results showed that health resettlement recipients seeking behavior are shown to public hospitals / clinics and traditional healers. The results indicate that the respondents experienced the acute condition of poor health, suffered several types of diseases. Due to the numerous barriers to accessing modern health services, households were linked to traditional health providers (indigenous to nature consist primarily of two traditional providers such as bomoh and religious authority *Imam*). This article proposes few recommendations including hospitals/clinics should be incorporated near the resettlement area of housing because their majority of the means of transportation is on foot to visit public health service and KEDA authority must take an initiative, such as the mobile clinic services during the weekend so that in addition to poor people go the hospital / clinic rather the service comes to the poor.

Introduction:-

Kedah is less developed with poverty and low income state in the northern region of Penansular Malaysia (West Malaysia) (Hassan, 2004). The Kedah Development Authority (KEDA) was established in 1981 (Aslam and Hassan,

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2003) under the Ministry of Rural and Regional Development (MRRD) in Malaysia, a program of the Kedah Regional Development Authority (KEDA) Project in the State of Kedah, in Malaysia. The project was initiated to strengthen socio-economic and infrastructure development at the regional level. The program has been accelerated for social and economic development in the region and to improve the income and standard of living of the rural population of the state of Kedah. Its one of the projects is the resettlement of the hard core poor, providing housing facilities to improve the living conditions of the beneficiaries. These beneficiaries of the settlement community are the lack of public services. In fact, very limited research has been conducted on the health seeking behavior of households in KEDA housing resettlements. Therefore, this article tries to fill the gap to investigate this hard core poor people, including their living conditions and social life that related to health seeking behavior. The purpose of this study is to explore the impacts of socio-religious beliefs and rural poverty on health care seeking behavior of beneficiaries of the resettlement housing community, *Kampung Sadek* (a village name).

Previous Studies:-

In a recent study by Rashid et al. (2012) in the United Kingdom, the Muslim population in the United Kingdom pursuing consultation of the spiritual intelligence of traditional healers of faith for psychiatric, marital and related problems. Healers argued that the strength of both methods would be more effective than the use of one alone. Their study suggests that there is a need for close collaboration between healers of faith and mental health workers in order to achieve a culturally sensitive health system. Furnham and Wong (2007) studied the British and Chinese on the causes, manifestations of behavior and treatments of schizophrenia. It was found that the Chinese had more religious and superstitious beliefs towards the causality and treatment of schizophrenia and preferred the use of alternative medicine. Osman (1972) describes the importance of the institution of Bomoh (the traditional practitioner of Malaysian folk medicine) in Malay culture. The Malaysian village Bomoh is a pillar of local society. According to the author, bomoh is an indispensable figure in a Malay people: in fact, without a bomoh, the village community feels the incomplete. Similarly, in a recent study by Kadir and Bifulco (2010) found that most Malay Muslim women seeking help for the mental depression of local spiritual healers and traditional Bomoh (a traditional and spiritual healer) rather than services Of medical treatment. Their study was carried out among Malaysian Muslim women living in Johor Bharu (a southern part of Peninsular Malaysia). It was reported that participants believe that seeking healing is part of strengthens religious faith and beliefs. Another, the causes of denial of medical treatments are the cost and belief that a strong 'will' and 'spirituality' are the best medicine. For example, participants who are separated and divorced with low incomes have financial difficulties in accessing hospitals or clinics. Researchers reported that healers are taking less money, thus increasing the seeking for healers among Malaysian Muslim women. However, some of them seek the solution of both combinations of medical and spiritual treatments.

Religious affiliation and sociodemographic factors influence the choice of clinic assistance and traditional healers. Fosu (1989) found that increasing age, education, and living children increased clinic use compared to traditional healers. In addition, it was found that Christian religious practice increased the use of the clinic but decreased the use of the traditional physician. While the lack of family support has a greater impact on respondents they prefer traditional practitioners. Religiousness is an important factor in the association with health status and the use of health care. The question is how to measure religiosity? The measure of religiosity refers to the association of an individual with religious services. For example, Macintyre et al. (2002) stated that criteria for a good measure of religiosity, such as frequency and attendance at religious services; Funds donated to religious institutions; And / or participation in activities related to religion. There is strong evidence that religious attachment has a greater impact on income and health outcomes. An investigation was conducted in two states of Kelantan and Terengganu among farmers' households in Malaysia, Abdelhak et al. (2012) found that religious practice has an influence on monthly income. She found that farmers who attended the place of worship and recited the holy book have found the generation of better income than those who rarely or rarely practice religious commitments. Their results also show that farmers who are more religious feel less stressed, less depressed and less discouraged. And, depression and relief sentiment has discouraged radically reduced monthly income farmers.

Nguyen et al. (2012) studied health care expenditures for poor and non-poor people in Vietnam. It was found that all income levels respondents borrowed money for hospitalization treatments; however, the poor have used more loans for outpatient and high-cost treatments. The payment method was found out of pocket in both public and private facilities. His research has found that the communal culture of the rural population in Vietnam is that households at all levels of poverty relied on help for the treatment of family and friends. The opposite scenario found in another study by Ismail R (2001) in Kedah and Terengganu establishes among the women of Amanah Ikhtiar Malaysia (AIM) beneficiaries and non-beneficiaries. Ismail R. (2001) found that most women do not believe in traditional

treatment. However, it was found that types of medical treatment depend on differences in income between AIM beneficiaries and non-beneficiaries. For example, some women who have higher incomes in AIM beneficiaries seek medical treatment in the private or clinical hospital, while non-beneficiaries seek medical treatment from a public or clinical hospital.

Krishnaswamy et al. (2009) studied the use of health services of Malaysian citizens and found that there are significant relationships between demographic characteristics and the use of services where age (observed over 60 years) has been an important indicator that increased the rate of use of health services among respondents. Ethnic respondents found the lowest rate of use of health services compared to Malaysians and Indians. Hui and Jomo (2007) studied equity in health care in Malaysia and noted that distance, travel and waiting time are the main berries to use health services. The rates of utilization of health services decreased with the increase in transportation costs, because distance is directly related to transport costs.

A. Methods and Procedures:

B. Study Site, Data Collection Techniques and Case Studies:

The study site was chosen one of the programs based on the regional development project of KEDA, a poor settlement area, Unit 65 in Kampung Sadek (village), Kedah state in Peninsular Malaysia (western Malaysia). A total of 110 houses were assigned by the KEDA authority in the settlement village. The beneficiaries have been staying in this study area from 20 to 23 years. The authority has provided each beneficiary with a plot about 50 feet wide and 80 feet long including a built house. The beneficiaries of this project were mainly the homeless poor selected by the village chief of several Kampung. For example, the head of the village has the power to appoint and recommend three homeless families to the KEDA authority for the allocation a house plot.

Respondents in this study are beneficiaries of the resettlement unit of the KEDA 65 plot, Kampung Sadek (Sadek village) in Kedah state of Malaysia. They were selected using the convenience sampling method. Twenty-one (21) beneficiary households heads were identified in a total of 110 beneficiaries of housing plots. Respondents have interviewed for information on their socioeconomic, demographic, religious, poverty and health care behavior.

An open and semi-structured questionnaire was prepared in three sections to observe the insights of the social, economic, demographic, poverty, health and religion participation of the respondents. A total of 21 heads of household (person assigned to the KEDA house) were interviewed between 2015 and 2016. Each interview lasted approximately two hours and thirty minutes to three hours and ten minutes. Another, a focus group discussion was conducted to observe various aspects of this community, including: demographic profile, socioeconomic status, religiousness, poverty, current health status and health beliefs, use of health services by housing recipients. Each focus group discussion (FGD) consists of seven respondents. The principal investigator and co-investigators physically went to the study area to collect data through face-to-face interviews and group discussions. Participants were screened for eligibility only the household tops those who were the true beneficiaries of the allocated housing by KEDA authority. Focus group sessions were held within the KEDA settlement area over the weekend when the workload was more likely to be lightweight and the greater opportunity for convenience of participants. For that we had to seek help from the president of the local unit chairman of this study site. This is a qualitative research, using case study methods to better understand and explain the behavior of health care in relation to socio-religious and rural poverty. It is found that the beneficiaries of the majority were declared in the settlement quite time from 10 to 25 years. Of the 21 respondents, 11 beneficiaries have received the land plot with a built house allocated for them 25 years ago, followed by 4 respondents was 22 years, 3 of the respondents was 23 years, and the rest of them were 20, 17 and 10 years ago.

Figure 1:- Map of Kedah State (the present study sights is circled in the map), Malaysia

Result and Discussion:-

Socio-demographic profile:-

Table 1 shows the sociodemographic profile of the respondents. The monthly income of the respondents was between RM200 to RM1000. However, there were also non-income paricpants consisting of under RM200 per month of 19 percent households. These non-income group participants stated that they are taking help of their children and neighbors, providing them with some necessary basic living things such as food and clothing. Those who earned monthly between RM401 and RM600 are 24 percent. It follows 19 percent from RM601 to RM800, 14 percent from RM201 to RM400, 10 percent and 14 percent to be RM1000 and above. From our in-depth interview, we found that some household income is not set, especially those who are involved in the occupation of rubber tapping holding which is dependent on the season; If there is a dry season they get the highest RM1000 while the rainy season only RM400. Another, there is a household is the exception that is earning quite a good amount because he and his wife participate in a small company making homemade cookies with monthly income RM1800.

Only a few respondents were found unemployed (33 percent), while others engaged in various occupations such as rubber sergeant, construction worker, security guards and small business owner. For example, 12 respondents were working in a rubber garden as a rubber tapper and construction site as a daily job. From the in-depth interview with households from poor settlement areas it is found that because working in the rubber garden is a seasonal employment, therefore some respondents are working part-time both in rubber garden and construction. Only 1 respondent was found involved in a small company in making homemade cookies. However, in terms of employment and economic status, the women beneficiaries were economically vulnerable than the male beneficiaries.

Table 1:- *Socio-demographic profile:*

	Frequency	Percentage percent
Age		
40-45	0	0
46-50	5	24
51-55	6	29
56-60	7	33
60 and above	3	14
	21	100
Gender		
Male	9	43
Female	12	57

	21	100
Marital status		
Married	18	85
Divorce	2	10
Husband left her	1	5
	21	100
Educational background		
Primary level	10	48
Secondary	7	33
Never been to school	4	19
	21	100
Income (monthly)		
0-200	4	19
201-400	3	14
401-600	5	24
601-800	4	19
801-1000	2	10
1000 above	3	14
	21	100
House hold size		
1-2	3	14
3-4	8	38
5-6	5	24
7-8	3	14
9-10	1	5
None	1	5
	21	100
Occupation of family head		
Unemployed	7	33.33
Rubber Tapper labour	12	57.14
Small business/Petty traders	1	4.76
Security guard	1	4.76

Monthly household expenditure on food, utility bills, health services, and children's education were also observed. It was found that majority households spend RM400 ringgit per month on all services. However, some of those spent below RM200, those who are unemployed and the children support them providing money for food. On average, expenditures were made especially for food between RM201 and RM400. Majority of the participants experience in absolute poverty. A total 71 percent participants reported that utility bills cannot be made, for example, the water bill. In terms of their health care expense, it was found that 62 percent households spend less than RM50 per month for both traditional and modern healthcare treatment solutions. The remarkable results of this study are some of the participants are paying a monthly fee as instalments to the loan provider organizations. Of the 21 participants, it was found that five 24 percent participants have borrowed from microcredit NGOs or poor government loan funds. These monthly installments depend on the total loan amount.

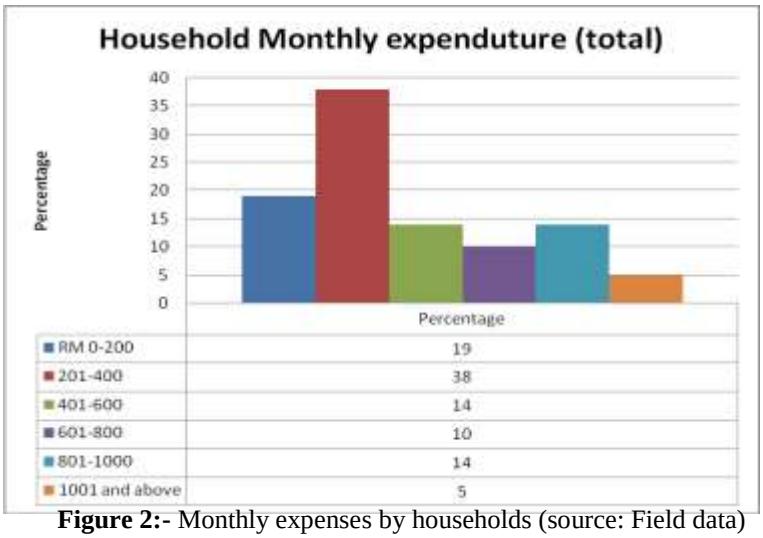

Figure 2:- Monthly expenses by households (source: Field data)

Table: 2:- Respondents monthly expenditure

Types of expenses	Frequency	Percentage percent	Types of expenses	Frequency	Percentage percent
Monthly expenditure (total)			Food expense		
RM0-200	4	19	0-200	8	38
RM201-400	8	38	201-400	6	29
RM401-600	3	14	401-600	7	33
RM601-800	2	10		21	100
RM801-1000	3	14			
RM1001 and above	1	5	Children education expense		
	21	100	None	9	43
Bills and utilities			RM0-100	6	28
RM0-50	15	71	RM101-200	5	24
RM 51-100	6	24	RM201-300	0	0
RM 101 an above	1	5	RM301-400	1	5
	21	100		21	100
Health care expense			Others expenses		
RM0	5	19	None	16	76
RM 0-50	13	61	RM0-100	2	9
RM 51-100	2	10	RM101-200	2	9
RM 101-150	1	5	RM201-300	1	5
RM151-200	1	5		21	100
	21	100			

Community life, living conditions and basic services:-

To understand the life in the settlement, the participants were asked the satisfactory question about housing conditions and other available services. It was found that the common and real structure of the houses provided by the KEDA authority does not seem satisfactory, according to the recipients. With a house to live includes kitchen and a toilet are the main structure of the house provided by authority. Most of the beneficiaries have been renovated the house and extended some additional rooms of the actual structure of the house (See figures 1 to 3). Figure 1 shows the real structure of housing allocated to the poor. Figures 2 and 3 have shown that the receptors have done some renovation with additional rooms. The results found that 75 percent of the houses were renovated and extended to a couple of rooms by the participants while 25 percent participants reported that they did not renovate the house because of their limitation of financial ability. The results indicate that these 25 percent of the participants

live in very poor housing conditions. It indicates that the original structure and the available housing were not enough for the beneficiaries. From 38 percent participants say that homes are not enough for them.

It was noted that the majority of participants owned transportation, such as 76 percent owned transport includes personal car, motorcycle and van, on the other hand, 24 percent of participants lack transportation. Those respondents indicated they owned transport, from the interview, it was found that majority respondents do not own or own transport, but their children do. For example, 19 percent own a car, 24 percent own a motorcycle, 33 percent owns both cars and motorcycles and 5 percent own car, motorcycle and van.

Figure 1:- The original house without renovation (Source: Field survey by researcher)

Figure 2:- Semi-renovated house (Source: Field survey by researcher)


Figure 3:- The house in the picture is fully renovated and extended from the original structure (Source: Field survey by researcher)

Socio-religious beliefs:-

The religious affiliation of this community found 100 percent of Muslims. They found engaged in various daily religious activities such as daily prayers, frequency of attendance at the mosque, reading of sacred books, and zakat issues. Of the 21 participants, 90 percent stated that they were religious persons, while others responded as such under certain conditions 5 percent and probably 5 percent. Table 3 indicates the level of religiosity of respondents in daily life activities. With regards to attending religious talks, 67 percent respondents replied that they attended religious talks organized by mosque, while 28 percent reported sometimes, 5 percent regularly. As reported by Mohd Kader Abd Razzak (see case study 4). Islam has five main pillars among them one is pray five times a day. It was reported by respondents that 81 percent always pray five times a day while 19 per cent reported that sometimes they pray. It was found that 86 per cent responded that they always pray on time while 14 per cent said they sometimes pray in time. They describe that even though they pray sometimes in a day but they perform fasting.

Their visit to the religious place for prayers found lacking attendants. We found that 19 per cent reported sometimes they visited, 14 per cent answered always goes, 14 per cent never and only Friday Jummah prayer 19 per cent. However, those who were not regular have said that they are too old and do not have the transport to go to the mosque. Many of them saying Musullah (small prayer hall) is near but the mosque is far from the KEDA settlement unit. But a majority of the respondents have attended events organized by local mosque such as Hajj course. In addition, 61 percent respondents mentioned that they have received counseling support from the masjid. Also, twice a week some of them learn how to read Qur'an. They have also get knowledge from the mosque *Imam* about prayer, *Ibadah*, marriage life and so on. Respondents socio-religious activities are shown in Table 3.

Table 3:- Respondents level of religiosity

	Frequency	Percentages percent
Do you regard yourself as a religious person?		
Yes	19	90percent
Most of the time		
Probably	1	5percent
Under certain condition	1	5percent
Never		
How many times have you attended religious sermons such as cerimah?		
Always	14	67percent
Regularly	1	5percent
Sometimes	6	28percent
Occasionally		
Never		

Do you pray five times a day?		
Always	17	81percent
Regularly		
Sometimes	4	19percent
Occasionally		
Never		
Do you go to mosque every day?		
Yes	4	19percent
No	9	43percent
Sometimes	4	19percent
Only Friday	4	19percent
Frequency of Mosque attendance?		
Once in a week	11	52percent
Never	1	5percent
One to three times per month	9	43percent
Do you pray in time?		
Always	18	86percent
Regularly		
Sometimes	3	14percent
Occasionally		
Never		
How often do you read the Qur'an?		
Always	7	33percent
Regularly	1	5percent
Sometimes	10	48percent
Occasionally		
Never	3	14percent
Do you pay alms Zakat or received Zakat?		
Pay Zakat	0	0
Never received Zakat	18	86percent
Fitra received	3	14percent

Health Behavior:-

This study was carried out in a poor settlement community that has certainly lower incomes and less interest in seeking help from modern medical services such as hospitals and clinics. Respondents have demonstrated their frequent visitation to traditional healer, in addition to other modern medical services of use by them. Our results indicate that most participants seek help from traditional healers, hospital and clinic, respectively. The results found that 67 percent of respondents reported seeking help from traditional healers, including bomoh (common in local culture, there are also bomoh ladies), Imam (provide oil message, do du'a from the Islamic scriptures (prayer and also provide a bottle of water), bio-belut putih, green leaves and other herbs Malay traditional medicine. However, 33 percent of the participants have shown interest in seeking help from medical facilities. In terms of medical service received by the respondents the result found that 33 percent of the participants visited public hospitals or clinics. Two medical services are available for this community these are the hospital packaging (a public hospital in Baling, Kedah) and Kupang clinic. The public health institution charges only RM1 (ringgit for Malay) with medicine, while the traditional healer also charges to a minimum. However, we found that the monthly expenditure on medical expenses from RM10 to RM100. Whenever they visit the health clinic or hospital costs around 30 ringgits include transportation costs. It was found that the total cost depends on the means of transport used by the respondents. They have mentioned that the main reason to visit the public hospital is the low cost. However, few respondents 14 percent have reported that they also use private clinics such as the clinic Roslan Kwala Pegan (a

private clinic near the attractions of the study) and Kupang Clinic. But, it was found that most of the respondents used traditional and spiritual local healers for their disease.

Respondents were asked about their health status given five excellent, very good, good, fair and poor conditions. It was found that 38 percent reported that their health status was poor, followed by 24 percent reported as good, 19 percent reported as fair, 14 percent were very good and 5 percent were excellent health condition. The beneficiaries of the settlement and their relatives experience various diseases such as asthma, high blood pressure, diabetics, bone and cold pain are common among participants. The participant's children suffered from chronic diseases such as thalassemia and asthma.

Barriers to accessing health care:-
Most participants reported that use of a public hospital (Baling hospital) is merely rare because of the distance from the KEDA settlement unit. Another, 90 percent responded that the main barrier is long queues in hospitals or clinics and waiting so long to see the doctor.

In general, long distance, length of waiting time and length of public bus service were found to be the main obstacle to the use of health care service. For example, participants reported that it takes two hours to reach the Baling hospital, while private car takes only 20 minutes. It is noted that the distance from the KEDA settlement housing area to the public hospital is about ten kilometers. Most respondents are not satisfied with the frequency of bus service. In addition, it was also found that some participants do not have transportation to the clinic or hospital; so they were seeking the help of neighbors in order to get health services. Some of them are visiting on motorbikes. According to our data, 62 percent of respondents reported having financial difficulties in seeking health services, 29 percent reported having financial and transportation problems, and 10 percent reported that there is no one there to accompany them to go to the clinic.

Case Studies:-
Case Study One:-
Cek Nolia Madaw is a 55-year-old female beneficiary of KEDA housing for the poor. She is living in the settlement housing project for more than 22 years. She is unemployed and has no source of income. Her husband left her seven years ago. Her daughter and two grandchildren living with her. She is taking care of her grandson and her granddaughter. Her daughter is taking care of her most basic thing. Also, sometimes she is selling mushroom to the villagers for her survival of daily living things. On the issue of health, Cek Nolia Madaw has visited both the medical service in public hospital and the traditional healer near the settlement zone. She is suffering from Ashma's disease and she needs to visit the hospital frequently. As he does not have transportation, he explained that she went to Baling public hospital by bus, she explained that it took about four hours to get to the hospital. Waiting for the bus in a long time is a major obstacle to visit the public hospital in the settlement housing area. The medical cost was not a problem, as only RM 1 ringgit fees required which also includes medical and other medication costs in public hospitals in Malaysia (for local). However, he also reported that he went to *Bomoh* (a traditional healer in Malaysia) to look for her health problems.

Case Study Two:-
Md. Razali Mohammad Noh is 56 years old (a beneficiary of poor housing plot under KEDA in Kampung Sadek, Unit 65, Kedah) a Malay Muslim man. Razali is working as a rubber tapper. Razali's monthly income is between RM400 to RM1000. Working in a rubber garden the salary could be flexible because it depends on rubber price and seasons. For example, rainy season is quite low-income RM400 while the dry season is RM1000. Additionally, his wife also earning total RM200 in a month working as a domestic worker. Razali's total family member is six. He renovated the house and expanded to with three additional rooms. His income and expenditures are almost equal. Razali took loan RM5000 from Amanah Ikhtiar Malaysia while he is paying an installment of every month RM60. Razali is a diabetic patient. Razali first choice to seek health solution is herbal and Malay traditional healers.

Case Study Three:-
Zulkifli Mat-Daud is 52 years old man of beneficiaries of KEDA scheme housing for poor at *Kampung Sadek*, Unit 65, house 27 (res.15). He attended up to elementary school. This housing plot is under his mother in law. He is working in one NGO with monthly RM1000. He has described himself as a religious person under certain conditions. According to him, "I perform fasting but praying sometimes. I have added that I can read the Quran, but

I only read it sometime, lazy to read regularly. "I do not seek help from the traditional healer. I have visited the hospital once in a month for high blood pressure.

Case Study Four:-
Mohd Kader Abd Razzak is 50 years old living at KEDA scheme unit 65 house 37. From 25 years, he is staying in this settlement plot. He is a construction worker with monthly income RM700. He seeks help from traditional Malay bone specialist which is based on herbal medicine. I have attended religious sermons or talk but if it is near his house. He said he never read the Qur'an because I do not know how to read the Qur'an.

Case Study Five:-
Mohd Esa Awang is living house 44 at Kampung Sadek unit 65 and 63 years old. His occupation is rubber tapper with RM450 monthly income. He has an income of RM 25 to 30 from making wood bird case per day. He said that "I do not read the Qur'an because I do not know how to read Qur'an. No person is here to teach me. He said sometime he prays five times a day.

Case Study Six:-
Azmi Bin Dola, aged 19 (answer 11), is a 59-year-old Malaysian man and one of the recipients of housing for the poor settlement unit 65, Kampung Sadek. He and his wife live in this settlement for about 25 years. They have no children. Azmi working in rubber garden and also construction work. His monthly income between RM800 and RM1000. Azmi reported that they visited both the health clinic and the traditional spiritual healer, especially Bomoh. His father is a bomoh. According to Azmi, the seeking help for health related problems visiting the public hospitals takes more hours, which need to wait a long time because of the long queue. Azmi also visited the private clinic Roslan Kwala Pegan (private jingle).

Case study Seven:-
Mohd Esa Awang is 63 years old, lives in 44, Kampung Sadek, KEDA unit 65 (responder 7). He is married and has six children. The actual house renovated with additional three rooms. His monthly income is RM450. He took the loan from TEKUN (Tabung Eknomi Kumpulan Usaha Niaga), a loan provider for the poor, an amount of RM3000. He went to see Bomoh for Broken Bone as he fell from the trees (only 15 kampung eggs). He also saw the hospital doctor for heart disease. According to him, "each time I visited the hospital I spent total RM30 ringgit while the government hospital only requires RM1 ringgit". In the last three months, he visited the hospital six times. Mohd Esa Awang explained that he went to see the doctor at 8 am but the doctor visited him at 2 pm. According to Mohd Esa Awang, the physician's behavior to patience was found negligent, arrogant, and poorly treated. The behavior of the doctor is not pleasant for patients. Another factor is that the hospital is far from the settlement unit. However, the clinic is nearby.

Conclusions:-

From the field observation, it was observed that the majority of beneficiaries are unhappy with ownership of the land or plot. First of all, they are unhappy because one of the agreements of this poor housing settlements is that the parents can give this to his daughter but not to his/her grandson. Another, respondents say that this housing scheme that is assigned to them is uncertain and not permanent. They argued that the authority of KEDA should give us land permanently. They are concern and even if they want to renovate the house for making better condition but fear that the authority of KEDA could take after he/she died. According to them, this is just to temporarily not stay as an owner. Also, they are not allowed to build boundaries. According to the participants, the KEDA committee looks after certain people that feel discriminated against.

This study aims to recommend some policy for the future involvement of the study unit to improve the life of the community as a whole. Therefore, the suggestions of this study are as follows: (a) Drainage system should improve in the housing area. Many participants suggest that for this society must have a proper drainage system. They have experience three times flood in every year. Due to poor drainage system water has stuck in the area so flooding happens; (b) cleanliness: the entire housing unit area needs to be clean to maintain a healthy environment; (c) financial support: participants expected some form of financial support to repair it; (d) Respondents said that spending so much time waiting for public transport leads to the lowest rate of utilization of medical services. Therefore, there should be shortening of the duration of the bus also the bus transports in this area should provide to take the children to school so they can reach the school and other facilities such as hospitals and clinics; (e) there

should be more health centers and doctors in this area and the authority should reduce the length of waiting time to visit a doctor/treatment.

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