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ATTITUDES ON HEALTH CARE OF VILLAGERS ATTENDING A RURAL CLINIC IN MALAYSIA

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INTRODUCTION

RURAL Malaysians use different health care resources to cure an ailment (Chen, forthcoming; Heggenhougen: forthcoming). The resources include traditional healers and cosmopolitan practitioners. It is questioned whether or not the practice of such medical pluralism calls for increased contact, if not collaboration, between practitioners of the different existing health care systems.

To get an idea of such pluralistic practices we interviewed one hundred persons attending a rural clinic in northwest peninsular Malaysia. The results of interviews with 100 people visiting a traditional, folk, healer has been recorded elsewhere (Heggenhougen; forthcoming B). The clinic is in a small town of about 3000 people. A hard surface road connects the town with a number of villages from which people come by bus, taxi, motorcycle or bicycle. Dirt paths connect nearer villages with the town. In addition to obtaining demographic data we asked the patients about the complaints for which they visit the clinic and about their views on the rural clinic in general. We were interested in their perceptions about etiology, whether or not other treatment methods had been attempted, and their reaction to, or use of, traditional healers or bomohs.

PROCEDURES

We interviewed persons waiting to be attended to at the clinic by asking demographic and open-ended questions during a two month period in 1978. We randomly interviewed recently arrived people so that they would not be delayed in being admitted to the clinic staff. Persons interviewed were assured confidentiality. They were told their participation would be voluntary and whether or not they agreed to be interviewed would not influence how they would be received or treated by the clinic staff. The interviews were conducted in Malay by two Malay men in their mid-twenties. Most of those interviewed were men. This no doubt makes for distortion as women might have refused to be interviewed by male interviewers (because of shyness or of being preoccupied with their children), but, unlike the situations reported for clinics elsewhere, the majority of persons attending this clinic (except for days set aside for maternal and child health) are men.

We felt some questions might be awkward for the respondents if asked of them directly, and thus in a number of instances we employed an indirect approach, assuming respondents would be more open when speaking about the attitudes and opinions of their neighbors (in general) whereas these might also reflect their own.

RESULTS AND DISCUSSION

The majority of patients came from the town where the clinic is located but a number came from as far away as ten miles. Of the 85 men and 15 women interviewed, ninety-three were Malays, three were Chinese, three were Indians and one "other." Twelve had no formal education, 25 had gone to school one to three years, 37 had gone four to six years, 7 had gone seven to nine years and nine had gone ten to twelve years. Among the respondents were seven students, 10 businessmen, four fishermen, five government clerks and four factory workers; the rest was either farmers, wives of farmers or people with odd jobs.

Eighty-two respondents were patients themselves. The other 18 were people (usually a

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parent) accompanying children who were the patients. Most complaints for which people had come to the clinic were minor (see Table I.).

Table I

Complaints as described by respondents

Complaints	Adult	Child
Fever	15	3
Cuts/sores/boils	13	4
Cough/sore throat	8	5
"Influenza" (cold)	8	—
"Twisted" bones	5	—
T.B.	5	—
Skin problems	5	1
Stomach ache	5	4
Toothache	4	—
General pain (and "nerves")	4	—
Asthma	4	—
Headache	3	—
Renal problems	2	—
Drug addiction	1	—
Mumps	—	1
Total	82	18

Sixty-six respondents said they had already tried another type of treatment for the ailment they presented at the clinic (see Table II). Seventy-seven percent of those with seven or more years of schooling had tried another health care resource before coming to the clinic with their present problem whereas only 64% of those with less, or no, schooling did so. However, more than twice as many of the least schooled (26%) had sought help from their neighbors than had the more schooled (10%). None of the more schooled denied that villagers sometimes went to both the clinic and the bomoh when sick, whereas 20% of the less schooled denied the dual use (possibly this reflects an attempt to seem "progressive" rather than the respondents' actual opinion).

Forty-one respondents had had their health problem three days or less and 68 had had it for less than a week. Twenty three had had the problem for at least a month; some indicated "several years." Contrary to other studies (Heggenhougen: forthcoming B), we found the length of illness could not be significantly correlated with whether or not another treatment method had been used before coming to the clinic.

Table II

Other health resources already used for current problem

Medicine from drug store[1]	23
Self treatment[2]	14
Chinese traditional medicine	10
Bomoh treatment	8
Help from neighbor or older person	2
Medicine from Malay medicine seller	1
Other	8

[1]The use of "medicine from drug stores" implies that people obtained the medicines specifically for their present problem.

[2]"Self-treatment" includes both the use of medicines obtained in provision shops or drug stores (often obtained at an earlier date for another but similar ailment) and a number of folk remedies still known to villagers (Heggenhougen: 1978A).

Fifty percent of our respondents felt some neighbors would not come to the clinic even if they were very sick because they were afraid of getting an injection. Others indicated that people would not come because they did not want to waste their time or because they had more important concerns than their health, an attitude which has been recorded in other societies (Messing, 1973).

When questioned how the people who do not come to the clinic cure their ailments, most respondents (41) indicated that the bomoh would be used; 34 said such people would first use medicines bought at the drug store. Twelve felt people would try home (folk) remedies; seven said that some people would go directly to a physician rather than to the clinic.

Only fifteen respondents said people will never go to both the clinic and the bomoh when sick. Twenty-seven said people will definitely avail themselves of both traditional and cosmopolitan health care resources, and 58 said people would do so sometimes. However, the overwhelming

majority (90%) indicated that this multiple resource use was only for certain, not for all, illnesses. Table III shows the complaints most frequently mentioned as those for which *both* the bomoh and the clinic would be used. The order of dual use for these problems was not indicated and is not easily established as there are other factors besides this type of complaint that influence resource use. It is generally agreed, however, that fractures are much more frequently presented to a bomoh than to cosmopolitan practitioners and certain other complaints are felt by many to be most appropriately dealt with by a bomoh (see Table III).

Table III

Complaints for which both bomohs and clinic are used by frequency of mention [some respondents mentioned more than one complaint]

Complain	Frequency of mention
Fracture	43
Fever	30
"Kayap" — abcess/sores	22
Measles	13
Cancer (?)	11
Snake bite	8
Skin problems	6
Stomach ache	5
Mental illness	2
Mumps	2
General body pain	2
Headache	2
"Sawan" — convulsions	1
Diabetes	1
Sore throat	1
Hypertension	1
Worms	1
Eye problems	1

When asked what action they would take if the clinic treatment did not seem to improve a patient's condition, 58 stated they would return to the clinic, 25 would go to the hospital, ten would to the bomoh, one would try home remedies and another Chinese traditional medicine. Of the more schooled, 65% would return to the clinic for a second treatment; 57% of the less schooled would do so. However, 26% of the less schooled would choose to go to the hospital as the second choice but only 19% of the more schooled would do so. Levels of schooling seems not to be a factor in choosing to go to a bomoh if the clinic treatment was found unsuccessful as this was the subsequent choice of 11% of the less schooled and 8% of the others.

When asked why or how they got the present ailment the following causes were given (see Table IV)-- as most of the complaints were minor, we felt it superfluous in this table to link causes with specific complaints. Table IV also records the respondents' perceptions (by frequency of mention) of why, in general, people become sick.

Table IV

Reasons given for having present problems and for becoming sick [in general] by frequency of response [some gave more than one reason]

	For present illness	In general
Improper food	9	33
Due to weather condition	33	2
Over-work	9	26
Ignores attention to own health	—	25
"Contagion"/germs	8	13
Accident	16	—
Don't know	12	—
Unhealthy environment ("swampy")	—	9
God's will	—	4
Poverty	—	4
No proper bath	—	3
"Fever" (?)	3	1
Natural cause of pregnancy	2	—
Hypertension	1	—
Worried by personal problem	1	—

Forty-three respondents felt that people could get sick by telling lies, by doing something bad to others, or by black magic. These respondents may be seen as having a more "traditional" etiologic perception than the 54 respondents who

felt that such activities could not cause illness. A much higher percentage (48%) of less schooled respondents thought people could get ill from telling lies, doing something bad to others, or from black magic than did the more schooled (31%). Both the "traditional" and non-traditional respondents reacted equally to questions about whether or not people make use of more than one health care resource for the same ailments. It is significant that only 43% of those believing in a more traditional etiology would return to the clinic for a second treatment if the first did not seem to work whereas 69% of the not so traditional respondent would return. As might be expected 19% of the first but only 4% of the second group, would next go to the bomoh. (For a further discussion of etiologic perceptions according to "predisposing conditions," "supernatural causes" and/or "physical causes" see Chen: 1970A and B).

Although 65 respondents felt that some people get sick more often than others (27 stated that all people become sick at the same rate) only one of those who thought the rate was unevenly distributed felt this was due to charms, the other reasons mentioned were that some people "don't take care of their health," some are often caught in "bad weather," some "eat improper food," some "overwork," some have "allergies," and other simply get sick more often because of "old age."

Ninety respondents felt there were certain types of illnesses which were best treated by the bomoh rather than by a clinic; only four felt this was not so (see Table V).

Sixty-one respondents knew of a neighbor who had gone to a bomoh; fifty-two felt the bomoh was able to help these neighbors and seven felt that he was not. Thirty-six respondents stated that they themselves had at one time or another gone to a bomoh but 64 claimed never to have seen a bomoh. Thirty-one stated they were helped by the bomoh and five that they were not helped. It is probable that the use of bomohs by the respondents was under-reported as they may have felt this method of treatment was not "modern" and might not be approved of by the interviewer (though the interviewers were trained to be neutral and to probe further when detecting responses which seemed to be for the purpose of pleasing the interviewer). In any case, most respondents were able to name a number of bomohs--a total of forty different bomohs were identified by the 100 respondents, twenty-eight of whom live in the immediate area and twelve live further away but were visited by the respondents or their neighbors.

Table V

Ailments felt to be best treated by a bomoh rather than by clinic, by frequency of mention [some mentioned more than one ailment]

Fracture	44	Fainting spells	3
"Kayap" (skin rashes)	36	"Karang" (V.D.)	2
Evil spirit	32	Convulsion	2
"Barah" -(cancer, tumor)	14	Diarrhoea	1
Measles	6	Exhaustion	1
"Resdong" (nose itch-ulcer)	4	Mumps	1
Snake bite	5	Poison	1
Stomach ache	5	"Semugut" (menstration problems	1
Fevers	4		

Whether or not a respondent knew of a neighbor who had gone to a bomoh, level of schooling was found not to be a factor, now was it a factor in distinguishing respondents who themselves had gone to a bomoh (since 34% of the more schooled and 35% of the less schooled indicated they had visited a bomoh). But it is significant that 74% believing in a more "traditional" etiology and only 49% of the not so traditional respondents said they knew a neighbor who had gone to a bomoh, and 45% of the traditional but only 27% of the not so traditional said they themselves had ever gone to a bomoh.

Fifty-four percent of the respondents knowing neighbours who had gone to a bomoh but only 28% of those without such neighbours thought the people who did not come to the clinic had their problems treated by a bomoh. Forty-seven percent of those claiming to have neighbours who had visited bomohs, but only 21% of those who did not think their neighbours visited bomohs said they had ever visited a bomoh. Of the respondents who had gone to a bomoh at one time or another 79% had first tried an

alternative method to cure the current problem before coming to the clinic whereas 60% of those claimed never to have gone to a bomoh had first tried another treatment method.

When asked what resource they would normally first use for most ailments, 67 respondents mentioned the clinic, and 15 the hospital, as their first choice. Eight stated they would first try medicine bought at the local store, seven would first go to a bomoh, two would try a traditional home remedy and one would first go to a private physician. This order changed when the respondents were asked to name the second resource choice, in case the first should not effect a cure, and it was found that 37 would then go to the hospital, 33 to the clinic, 15 to a bomoh, 12 to a private physician and three would "hope for Allah's blessings." Should this second choice of treatment also not produce a satisfactory result then 34 would go to the hospital as a third choice, 22 would "hope for Allah's blessings," 17 would go to a bomoh, nine would go to the clinic and one would go to a "specialist" (four did not answer). Level of schooling seem related to first choice of health care resource as indicated by Table VI.

Table VI

First health care resource choice by level of respondents' schooling

Type of health care resource	More schooled	Less schooled
Clinic	84%	61%
Hospital	8%	18%
Medicine from store	8%	7%
Bomoh	—	10%
Traditional home remedies	—	3%
Private Physician	—	1%

Twenty-one percent of respondents who themselves had never been to a bomoh would go to the hospital as a first means of treatment whereas only 6% of those having gone to a bomoh stated this as a first choice.

Of those who said the clinic was their first choice of treatment only 31% said that if the first treatment did not work they would return to the clinic, 36% would next try the hospital, 18% would go to a private clinic (physician), 12% would try a bomoh, and 3% would simply hope for Allah's blessing. Of those stating the first choice of treatment to be the hospital, 53% would return to the hospital if the first hospital treatment failed whereas 40% would next try a bomoh and 7% would hope for Allah's blessings. Of those who would use the bomoh as a first choice, 57% would next go to the clinic and 43% would go to the hospital if the bomoh treatment proved ineffective (however, the numbers are too small to be considered significant).

Though the numbers are small, it is still interesting that of the 15 respondents who would normally first use the hospital for an ailment, six (or 40%) would next go to a bomoh if the hospital treatment did not seem to work. One explanation for this might be that the hospital is seen as the highest order of cosmopolitan medicine and if this does not work, a different type of treatment (non-cosmopolitan) would then be appropriate. Often greater attention will be placed on the possibility of supernatural causation should cosmopolitan medicine be ineffective in treating the ailment.

On their preference of being treated by a physician or by a Hospital Assistant (H.A.), fifty-nine respondents stated they definitely felt that a physician could treat the ailment, for which the patient had come to the clinic, better than could the HA; another 33 felt this "might" be true. Only four did not feel a physician could treat the illness in question any better than could an HA (it should be remembered that most ailments were "minor"). Interestingly, a much higher percentage (68%) of the less schooled, than the more schooled (44%), definitely felt that a physician could treat the respondents' current problem better than an HA.

Sixty respondents stated that a physician is "better" in that he/she has more experience and knowledge. However, twenty-four felt that both HAs and physicians could treat the current ailment "more or less the same." Two stated that HAs could do it better (and another five made no comments). Forty-three respondents felt a physician could treat a "skin infection or minor cut" better than could an HA, 39 fel

that this might be the case and only eleven stated an HA could treat such cases as well as, if not better than, a physician. Thirty-five respondents commented additionally that both HAs and physicians could treat minor cases well.

When asked what might inhibit villagers from going to the clinic, 24 felt this might be due to the pressure of their work, 19 to the cost of travel, 17 to length of time, 12 to uncertainty about the effectiveness of clinic treatment, 11 to the lack of care for children while they were away and the rest gave a variety of other reasons. Forty-six respondents stated that what they liked most about the clinic was the "free treatment," 25 liked the "effective treatment best," eleven appreciated the proximity of the clinic to their home. When asked why some people would not go to the hospital, even though they were referred there by the clinic, 49 thought this was because "they are scared," 26 because of financial considerations, and ten because "they don't want to be admitted." Eighty-one respondents said they would go to the hospital immediately if referred by the clinic, 17 stated they would wait a few days, and two would not go at all.

The great majority (85%) felt that most people are "satisfied" (63) or "very satisfied" (21) with the attitude of the clinic staff and with the treatment and care received. Ten percent felt they were "not always satisfied" and only 5% stated they were "not satisfied."

A number of reasons why people might feel they are not treated properly were not receiving an injection (though others fear injections), not being listened to with a stethoscope, relapsing after discontinuing prescribed medications once some improvement has occured, and not achieving immediate recovery (cosmopolitan medicine is reputed to cause prompt and miraculous cures; if it does not, it is believed to have been improperly administered). Those who had at one time gone to a bomoh were more reserved in their statements of being satisfied with the clinic, in fact 20% of this group said they were "not always" satisfied whereas only 6% of those who do not go to bomohs felt they were "not always" satisfied with the clinic.

The villagers make frequent use of the clinic; 29 stated that this was their second visit in six months, 33 had been to the clinic from three to ten times, nine had visited the clinic more than ten times and only 29 stated that the current visit was the only one within the past six months. Most earlier visits had been for fever (19) or cough (18) but eleven other problems (mainly minor) were specifically indicated, such as cuts (6), stomach ache (6), asthma (5), chest pain (4), toothache, measles, worms, etc. Only one respondent indicated that he did not get better from an earlier clinic treatment; 85 said they did and 4 were not certain. The respondents with less schooling use the clinic more often than those with more schooling.

When asked how the villagers could have better health care services, 24 suggested additional midwife clinics should be built, 21 felt there should be a physician at the clinic, and 16 felt a mobile clinic was needed; others felt that health education campaigns should be held in the villages and seven felt that miniclinics should be set up on the village level.

Eighty-five respondents felt it would be a good idea if someone from their village were trained to work in the village as a part-time health worker (possibly in a miniclinic) and an additional five felt this "might be a good idea," but nine were opposed to this. Fifty-five respondents said such a village worker would be the first health resource they would consult with a health problem, 32 said they would first go to the clinic, and another 11 that use would depend on the illness. Thirty-six commented, additionally, that they would go to the village health worker first, not necessarily to be treated but to obtain advice as to what to do and where to go, and another 14 felt it would save money and time to go to such a village health worker. Years of schooling was not a factor in differentiating reaction to the training, or the use, of a village health worker.

The role of the bomohs should not be overemphasized as a result of this documentation nor do I wish to extol their healing capabilities. It is difficult to speak of the bomohs as a unified group; they are folk healers who despite similarities differ from one another, and have learned through individualiz-

ed training. It is somewhat futile, without adequate criteria, to compare their capabilities to those of cosmopolitan practitioners.

What we have learned, however, is that villagers know a great many such traditional folk healers and sometimes use their services for the same (or different problems) as those they present at the rural clinic. This is evident even in areas where there are few complaints about the clinic and where the clinic is within easy reach of most villagers (no villager lives more than three miles from a clinic).

An explanation of the villagers' persistence in using bomohs might be that bomohs deal with the supernatural etiologic aspects--the "why"--of an illness whereas cosmopolitan practitioners limit their concerns to the natural aspects--the "how." Villagers concern themselves with both the "how" and the "why;" etiological explanations are often stated in *both* natural and supernatural terms. Visiting a bomoh is also more convenient and comfortable, because the setting is familiar and he pays greater attention to the feeling of the patient (Taib Osman, 1976; Heggenhougen, 1979). Many have argued that the very process of healing is important to the outcome of certain treatments and that the system of meaning in which the process occurs affects healing itself (some even argue that creating symbols of healing constitutes healing). It may well be that the very character of bomoh treatment makes it effective and attractive to villagers (Kleinman, 1973; Moerman, 1979).

As was the case with the one hundred patients of a well-known bomoh interviewed in Kedah who would also use cosmopolitan health care resources (Heggenhougen, forthcoming B), our interviews with the respondents at the clinic confirmed that the various health care systems are not seen as antagonistic alternatives but that multiple use of health care resources is practiced without a sense of conflict (Chen, 1975B).

It is important for cosmopolitan health practitioners to acknowledge that widespread multiple health care resource use exists because not only can such practice be beneficial or harmless, but at times (if duplication of medication is involved) such practices are harmful indeed. It would therefore seem beneficial that practitioners not only should be aware of other resources used by their patients but that they might consider having some contact with these resources (Jelliffee & Jelliffee, 1977).

Concordant with current deliberations by the Ministry of Health to establish mini-clinics at the village level and to staff them with specially trained villagers to provide health care services and information on a part time basis, it can be seen that the villagers in this survey overwhelmingly would support such an idea and would avail themselves of such services. Other surveys, conducted elsewhere in the state of Kedah, also confirm these findings (Heggenhougen, 1978).

Whether or not the villagers to be trained for this role should include some of the bomohs is a matter for consideration but not something to be unilaterally supported here; as in certain circumstances, no doubt, this would be beneficial whereas in others it might not be so--it becomes a matter of individual case consideration. Training and incorporation of such healers, of course, has been instituted in other countries and was also practiced for a while in Malaysia, particularly for the Orang Asli Health Service (Bolton, 1968). Many of the traditional village midwives (bidan) have been trained by the Malaysian government and function in cooperation with the government midwives (Chen, 1975A). Some have argued that for people to fully use and reap the benefits of cosmopolitan medicine greater contact and cooperation should be established between the traditional and cosmopolitan systems (Aho & Minott, 1977; Mahler, 1977; W.H.O., 1975). But whether or not folk healers are to be included in a new team approach to rural health care, such a team must, in any case, be aware of their existence and of the villagers' reasons for their continued use.

It is of interest that the more educated villagers seemingly place greater value on the capabilities of the HAs, stating that HAs are able to treat minor ailments as well as physicians. The fact that most ailments presented at the clinic are minor does not necessarily negate the need for physicians in rural areas; there are problems only physicians can treat; but villagers must also be educated to realize that, for certain ailments, treatment by an HA is as good as by a physician. Otherwise, physicians will have to

spend much of their time treating cases that others with less training could treat equally well, thus consuming valuable health care resources by limiting the time physicians can spend on cases that require their highly developed skills and the time they need for teaching and for conferring with other members of the health team.

It is indeed encouraging that the president of the Malaysian Medical Association has emphasized the importance of primary health care and encouraged physicians "to make it their forte"; and that physicians are encouraged to practise in rural areas, and that rural postings are to be made more challenging and exciting (Kaur, 1979). However, public education is needed so that people seek treatment from health care personnel at the appropriate levels according to the seriousness of the ailment, rather than always look toward the physician no matter what the illness simply because the physician is at the clinic and is universally considered to be able to provide the best services no matter what the problem is.

SUMMARY

During interviews with 100 persons attending a rural clinic in northwest peninsular Malaysia, we found most people use the clinic for minor ailments and present their more serious health problems directly to a private physician, a hospital or a traditional healer (or a combination of these health care resources). Most of those attending the clinic had already tried one other form of treatment.

Certain ailments were said to be best presented to a traditional healer (bomoh). People with low or high levels of schooling will use multiple health care resources for the same ailment but those with less schooling rely more often on their neighbours in times of illness. The less educated tend to make greater use of the hospital and the bomoh as a first choice of health care resource.

Most respondents feel a physician can treat an ailment better than can a Hospital Assistant. Public education efforts are needed to inform villagers of the capabilities of the various cosmopolitan health care practitioners.

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