Introduction

The development of a comprehensive medical and health services within what is now Peninsular Malaysia, and the subsequent decline in the incidence of certain debilitating diseases has been a relatively recent achievement. It was not until after British interference in the affairs of the Malay States in 1874 that the machinery of the various state governments was turned to the task of designing a medical and health delivery system based upon Western Medical practice. Before this time the government of the various states were not interested in the health situation of their respective people—rather they were more interested in consolidating their own positions and acquiring wealth through trade. However with British interference more attention was placed on the health situation of the people, special emphasis was placed on health matters that affected their imperialistic aims of deriving maximum economic gains from their interference. Thus before Independence only an initial effort was made towards improving the general standard of health in the country.

With the advent of Independence in 1957 this initial effort was further strengthened by making health a federal matter and by establishing the rural health service. The latter has been extremely important to the government's overall programme of development as it expanded the medical and health services from their previously urban base and has equitably redistributed them throughout the rural sector of the country. As nearly 70% of Malaysians live in rural areas, the rural health services have gone a long way towards meeting the government's health objective of improving the general standard of health in the country. Much remains to be done in the field of medical and health services to bring Malaysia to a state of optimum health, but a significant portion of the ground work for this task has already been laid. With this paper, I will discuss how this early foundation was laid.

Traditional Malay Medical Practice:

Prior to the white man's arrival in the early sixteenth century, the Malay Peninsula has, at different historical moments been thrust into the path of the world's major cultural streams. This exposure to such a broad and diverse cultural pool has had important implications for the development of traditional Malay medicine. At the outset, Malay medicine is essential-
ly based on folklore, beliefs and customs. Built upon this foundation and inexorably intermeshed with this core are a number of Hindu beliefs and Indian folk practices, some of which later gave way to Islamic beliefs and traditional Arabic treatments. The resulting synthesis, as described by Dr. J.W. Fields, is a "blend of ancient folklore, Hindu mythology, Muslim orthodoxy, and Arabic pharmaco-poeia." Because Malay medicine has well learned the lessons of the Arabic and Hindu healers, the Malay folk practitioner has had at his disposal a wide range of treatments, far surpassing in depth and breadth than that which is found in the majority of other folk cultures.

Health for the Malays has traditionally been an individual matter — a family matter — the sole arena of the village's traditional folk practitioner (the bomoh). Armed with his incantations, treatments prohibitions, herbs and knowledge of folklore, the bomoh is viewed as man's link with the mystical unknown, and as such, he exercises a very powerful influence in the life of the rural kampung, even today. Countless examples from every day life in modern Malaysia can be used to illustrate the sway of the bomoh in the rural areas. The rite of berpuar, for example, is one such illustration. Berpuar is one of the many regional rites practised by the rural people to ensure a successful padi harvest for the forthcoming year. "No berpuar, no padi," insist Minangkabau Malays, and "for ten days... they drove the evil spirits down the course of the Rembau River, sacrificing a pink buffalo at the ulu, where the river emerges from the forest and a black buffalo at the hilir or river mouth. This ritual is followed by a taboo period on the shedding of blood.

The implications of a still powerful folklore and traditional cures like using and reciting verses from the Holy Koran on the development and expansion of Western medical practice throughout the country are many and varied. More on this will be discussed later.

Initial Colonisation (1511-1880):

The impact of the West was first felt on the Malay Peninsula with the Portuguese settlement in 1511 of Malacca. The Dutch replaced the Portuguese in 1641, and a little more than one hundred and forty years later the British established trading posts on the island of Penang. By 1795 the British had displaced the Dutch in Malacca and with the taking of Singapore in 1819 from the Sultan of Johore, the British had successfully consolidated their position along the western coast of the peninsula. Western medical thought was imported from Europe into the trading areas by the trading companies during these early years, and small treatment centres were established by the companies in Malacca, Penang and Singapore to treat their European employees and their families. Perhaps local persons were occasionally treated at these infirmaries, but there was no significant effort on the companies to cater to the health needs of the local population. With the dissolution of the East India Company in 1868, control of and responsibility for the health care of European government workers and private
traders were transferred from the private sector to the British Colonial Office. In 1867 the civil administration of the three coastal cities — Malacca, Penang and Singapore — was strengthened by the formation of the Straits Settlements under direct authority of the Colonial Office. This act gave the governments in each of these three areas a stronger hand in providing for health protection although the primary recipients of that care remained Europeans.

Hospital Development (1874-1910):

In the late 19th century, Chinese miners and labourers were brought in by Malay rulers to work the rich tin mines. With them they brought traditional Chinese medicine. As the Chinese continued to settle on the peninsula, Chinese herbalists, with hundreds of remedies derived from plants and animal organs, began to slowly settle in the growing towns. By 1880 a small Chinese hospital of 28 beds was built in Kuala Lumpur by a wealthy Chinese mine owner, marking for the first time the establishment of a non-European treatment complex of any size and permanence.

The British interference in the affairs of the Malay States in 1874 marked the beginning of a new era in Western medicine for the Peninsula. A British Resident was appointed to each State, and except for matters of Malay custom and religion, the advice of the Resident was law. Health matters fell under the Resident’s jurisdiction, and under government impetus, the general hospitals were built. Between 1883 and 1910 hospitals of varying sizes were built in the capitals of each of the four States. The General Hospital at Kuala Lumpur, built in 1883, was the first of what now constitutes a network of general hospitals in each of the eleven States of Peninsula Malaysia.

Less under direct British rule but still under her protection were the five Unfederated Malay States of Perlis, Kedah, Kelantan, Trengganu and Johore. These States had greater autonomy in the management of their internal affairs. General hospitals were also established in the capitals of each of these States, although they tended to be smaller and built later than their counterparts in the Federated Malay States. The General Hospital in Kota Bharu, for example, was probably a nine bed affair built around 1907.

By the turn of the century a clear, though fragmented, pattern of British control began to emerge along the Malay Peninsula. This control, the result of the treaties establishing the four Federated Malay States, the five Unfederated Malay States, and the three Straits Settlements, put Britain in a strong position to begin the task of improving the health of the various peoples residing throughout the country. Rubber and tin provided hard cash support for the British sterling and one of the government’s early efforts in the field of health was aimed at safeguarding the health of those workers who toiled on tin mines and rubber estates. On rubber plantations, for example, it was compulsory to have a small estate hospital with four beds for every 100 workers.

Additionally, a network of hospitals began to spring up across...
the country. By 1908, a wide pattern of hospital service began to emerge. There were 52 hospitals in the Federated Malay States, and each State had a state surgeon and a number of district surgeons. (The term surgeon in those days was used to designate general duty medical officers and not qualified surgical specialists in the strict sense of the word.) The primary services at this time were basically curative, though, and hospital treatment was for the desperately sick. In the majority of cases these patients were brought to hospitals to die. Health work, however, had made a few inroads in the major urban areas. Kuala Lumpur, in fact, set up among the British government personnel a sanitary board concerned with cleaning the streets, maintenance of the public market and so on.

British Colonial Medical Service and Public Health (1910-1942):

In 1910 a health department with headquarters in Kuala Lumpur was set up. This brought the health services in the Federated Malay States under a central administration. Heretofore the health services in each State had been the responsibility of that State's British Resident who usually was not a medical man, and for whom health was a fairly low priority item. Centralised control meant that this endeavour to improve health was now the responsibility of professional men who were better qualified to develop and direct those services. It also meant direct access to funds of the central administration of the Federated Malay States. The original health department was staffed by colonial government medical officers qualified in public health, and its main functions were chiefly related to environmental sanitation in Kuala Lumpur and the surrounding areas. By 1920 the staff had expanded to 31 medical officers and 8 sanitary inspectors.

With the further development of the rubber industry in the early part of the 20th century, more and more rubber plantations were es-
established. By 1920 there were 1,200 such estates. About this time government stepped in to strengthen their influence on the operation of these plantations. The enactment of the Rum Labour Code was one result of this action. The Code was designed to protect the welfare of the various workers and had specific guidelines for medical and health measures which must be undertaken by the estate owner to safeguard the health of the estate's employees. Outside the main cities, it was now the rubber estates (rather than the rural areas), upon which public health efforts were concentrated. Swamp drainage and mosquito larvacidal work to control malaria on estate property was undertaken by health workers employed by the plantation as was smallpox vaccination and other immunization work.

In the decades between 1910 and 1930, Medical Officers of Health (MOH) were appointed in the capital cities of each of the Malay States. In some, their functions were confined to the interior of those cities, and in others they extended to enforcement of sanitary conditions at the rubber estates and tin mines. In a few cities, material and child health clinics were established and some examinations were done on school children. There activities composed the vast bulk of health activities in the country at that time.

Quite separate from public health work, the medical services as represented by district and general hospital, had also been expanding. Small district hospital were being constructed in the major urban centres, and general hospitals had been established in each State capital. Acting as satellites to these institutions were the small "town dispensaries" which were begun by the government in a few towns and were staffed mainly by hospital assistants. These were male dressers or medical auxiliaries who had learned basic medical skills by apprenticeship in the hospitals.

By 1937 there was approximately one doctor for every 10,000 people in the Federated Malay States and in the Straits Settlements. This is based upon a total population of these two areas of a little more than 3 million people and total number of doctors being 304. Of these 304 medical officers in the government service, 12 were surgeons or other medical specialists, 137 were European doctors and 155 local doctors. The ratio, though, is misleading because the vast majority of these doctors were concentrated in the urban areas while most people continued to live in the rural areas. Vast areas of the country were still ostensibly without access to Western medicine.

As was mentioned previously, the primary function of the various hospital was the treatment of the desperately sick, and this was carried out mostly by the general practitioner. The specialities especially surgery, had gained a foothold in the medical service but they remained in the background for some time. This was due to the fact that most patients seeking admission to the hospital were suffering from non-surgical diseases (e.g. malaria, beri-beri, dysentery, cholera, etc.) and there was a lack of qualified specialists and trained assistants in the government service. These limitations did not totally retard the practice of surgery in
Malaya however, and some major surgery was performed in the general hospitals of the Federated Malay States as early as the 1920s. By 1927 a splenectomy was performed in the Seremban General Hospital, and an electrical beli and silver probes were used in 1919 at General Hospital, Kuala Lumpur to locate bullets lodged in deep tissues following a gun battle between police and gangsters. The lack of antibiotics and effective anaesthetics impeded the growth of surgery until later periods, but by 1937 over 14,803 operations were recorded in the Federated Malay States while 3,987 such operations occurred in the Straits Settlements. In the latter instance 37 deaths were also recorded.

From the foregoing it can be seen that since the onset of medical services, health has been a two-sided affair comprised of the "public health side" and the "hospital side." This division still remains today, although both "sides" are now under one central administration and are a federal matter.

The period between the two world wars was one of consolidation. Fewer hospitals were being built and attention was turned to improving the services already existing. From 1930 to 1942 the colonial public health and medical services were faced by several setbacks, one of which was the worldwide economic depression which made its presence felt in Malaya from 1925-34. Beyond the boundaries of the estates and mines, the only services offered to the rural areas were a few travelling dispensaries emanating from the hospital, and even these were curtailed during the depression.

The Second World War and Post-War Period (1942-1952):

In December 1941 the Japanese invaded Malaya, landing in the north and pushing southward to capture Singapore in February 1942. With the invasion, most of the European personnel in Malaya and Singapore were either evacuated or interned by the Japanese. The hospitals, therefore, were left in the hands of the local doctors who managed them throughout the Occupation. As in other countries hard hit by war, health matters were ignored. Some hospitals were taken for use by the Japanese forces and others were looted for supplies. The infant mortality rate in Kuala Lumpur, for example, leaped from 97 per 1,000 live births in 1940 to 156 per 1,000 in 1943. Outbreaks of diseases such as malaria, beri-beri and cholera were left unchecked, and the general health of the people deteriorated significantly.

In August 1945 the Japanese surrendered and the country came under British military administration, followed closely by civilian rule. The three political groupings which existed before the war were merged in 1948 and the Federation of Malaya was born. This new government was faced with the breakdown and neglect of medical and public health services during the Occupation which had taken its toll both in human terms of facilities. To correct this situation was one of the government's first tasks. The initial step to restore services to the people was the division of the twelve States into smaller
administrative units called "administrative districts." The administrative district was responsible for health matters as well as land control, tax collection, and road maintenance and this system provided the skeleton for a more systematic and efficient government structure. Currently, in Malaysia there are seventy such administrative districts and they — either singly or in combinations of two or three — constitutes one health district, the framework around which all public health service (both urban and rural) is fashioned. Forty seven such districts are currently in existence.

Beyond restoring order to the country and reviving the various social services, the accomplishments of the government during the post-war period included a large expansion in the number of district hospitals. By 1956 fifty such hospital existed throughout the country supported by ten general hospitals but most were still located in urban areas. Based at the various district and general hospitals were a few travelling dispensaries which penetrated into a few of the rural areas nearest urban areas. These travelling dispensaries served as a complement to the static dispensaries which had existed prior to the war in the small towns.

Maternal and child health clinics were established in scores of cities and towns in the post-war period extending health care to the most vulnerable groups in the populations. In the State of Pahang, for example, eight such clinic had been established in the State capital (then Kuala Lipis) and seven district towns by 1956. These preventively oriented clinics came under the administration of the Health District MOH and they have often formed the nucleus of what later became the rural health centre.

Origin of the Rural Health Service Scheme (1953-1956):

The "Emergency", the description given to the confrontation between communist insurgents and government forces, had its onset around 1948. Since communist guerillas derived much of their sustenance from Chinese settlers who had been driven by the Japanese to the edge of the jungle to live, a major counter-insurgency programme consisted in the systematic resettlement of about a half million of these people in "New Villages." Some 500 new villages were built between 1950 and 1953. The attraction of the new villages was that it gave these settlers their first clear title to a piece of land and it provided basic social services within the village, i.e. schools, community hall and health facilities. In the field of health, the Emergency not only contributed to a belated recognition of rural needs, but it also highlighted the special medical and health problems in the hundreds of Malay kampungs in which no guerilla action took place. With all the attention given to the Chinese in new villages, it was argued in Parliament, what about the social needs of the greater number of rural Malays?

As a result of this inquiry into the social needs of the rural Malays, a series of national programmes were started to focus attention on the rural areas. These included the Rural and Industrial Development
Authority (RIDA - 1951), the Federal Land Development Authority (FLDA - 1956), and the Ministry for Rural Development (1959) which was later known as the Ministry of National and Rural Development and now functions as the Ministry of Rural Economic Development.

It was part of this swelling tide of concern for rural welfare that the Rural Health Service Scheme was born. The first seeds of the idea were planted with the design of a model "rural health centre" at Jitra, Kedah, in 1953. This centre was established in 1954 and was to provide a broad scope of preventive and curative service to the surrounding rural population. Additionally, a training programme for staff to be placed in future rural health centres was instituted at the Jitra centre.

The First Development Plan of the Federation was scheduled for 1954-1956 and it contained the prospectus of the Rural Health Service Scheme. Initially, it was contemplated that twenty-five rural health centres would be built, more or less on the Jitra model. Around each of these would eventually be built four "sub-district health centres" and around each of these would be five "midwife clinics cum quarters" — the whole constellation serving about 50,000 rural people. With the pressures of the Emergency, only eight district health centres were built in this period.

The Five-Year Plans (1956-1970):

Even before Independence (1957), planning on a national level had begun. The first Five-Year Plan was scheduled for the period 1956 — 1960. The construction of numerous component of the RHSS were part of the plan. A further boost was given to planning in the health sector by transfer of all those responsibilities for public health and hospitals from the States to the Federal Government in 1958. Henceforward, both financial support and general direction (both technical and administrative) came from a unified national "Medical Department" — which later became the Ministry of Health. This arrangement permitted greater coordination of planning for the Rural Health Service with the planning schedule of other ministries.

By the end of the first Five-Year Plan in 1960, construction in the Rural Health Service had been completed as follows:-

- District health centres — 8
- Health sub-centres — 8
- Midwife clinics cum quarters — 26

Staffing of these facilities, however, was far from adequate, since training programme take longer than building programmes.

It was in the Second Five-Year Plan, 1961-1965, that the concept of the RHSS became better crystallized, in relation to the overall process of "rural development planning." In this period, it became clarified that the "Medical and Health Officer" in charge of each "Main Health Centre" would be responsible to the MOH of the health district. The District MOH in turn is responsible to the Chief Medical and Health Officer of the State — an official appointed by the Health Ministry and responsible for
all medical and health activities in the state. The State Chief Medical and Health Officer would meet with the State Rural Development Committees, the Health District MOH with the District Rural Development Committees (or Committees in his territory), and the rural Medical and Health Officer with any "kampung" Development Committees that were formed. In this manner close coordination of the health services with other government services could be maintained.

By the end of the Second Five-Year Plan in 1965, further construction had achieved 39 main health centres, 12 health sub-centres and 643 midwife clinic cum quarters. This was obviously a period of rapid progress, even though staffing of the rural health units could not keep up with the pace of construction. The very completion of buildings, however, provided an inducement toward the recruitment and training of personnel. Perhaps the most serious deficiency was in the number of doctors as most the main health centres were without a medical and health officer, theoretically the team leader. This critical gap was not filled until a decision was made in 1965 to import doctors for these posts from overseas.

The third Five-Year Plan (1966-1970) became known as the "First Malaysia Plan" since Malaysia had taken shape in 1963. It did not contemplate construction of further main centres, but did aim at completion of 60 more health sub-centres and 450 more midwife clinics. The relatively slower pace of construction was due to channelization of funds toward urgently needed improvement of general and district hospitals, as well as to permit consolidation of staffing of the various components of existing rural health units. As of December 1967, some 17 additional sub-centres had been built, plus 60 midwife clinics, bringing the total network to:

- Main health centres — 39
- Health sub-centres — 139
- Midwife clinics cum — 703 quarters

Construction and staffing of the various components of the Rural Health Service has continued to date although the progress was slowed somewhat by a recession in the price of rubber in the 1960s, causing Malaysia's revenue to dip. As of the end of 1972 the number of centres completed were as follows:

- Main health centres — 51
- Health sub-centres — 200
- Midwife clinic cum — 1107 quarters

Acceptance of Government Health Services:

Acceptance of the government's full range of medical and health services by the public has been generally satisfactory, although there are a number of factors which tend to lower the effectiveness of these facilities and services. Unfortunately, space does not permit a thorough examination of all these factors. Suffice it to say that at the still relatively strong impact of traditional Malay medicine upon the rural population has retarded the full utilization of existing services. Too often in cases of
illness in the kampung, the bomoh is first summoned and it is only after he has exhausted his bag of treatments that the advice of government medical and health workers is sought. Oft-times the crucial period in the illness has past and the patient when finally seen by the doctor has gone beyond the point of no return.

It has been suggested, though, that the spread and final acceptance of Western medical practice by all segments of the public will be carried on the tide of medical successes. Dr. J.W. Fields points out that the effects of an injection of arsphenamine in yaws are beyond philosophical argument, and however strong the rural people's faith in the bomoh, they will walk many miles to get an injection with this drug. Beyond mere successes using the technology of modern medicine, proper attitude on the part of the public and on the part of the health staff will most likely be the key that promotes effective and efficient utilization of government health services to reach an optimum level of health. As it has been stressed in the Second Malaysia Plan and the Government's Gerakan Pembaharuan the right attitude, a willingness to change with the times is the essential ingredient for the public to ensure Malaysia's Development. On the other hand, all categories of medical and health staff must be constantly receptive to the needs and desires of their patients, and must exercise understanding in the course of their duties. Only in this way can the government's health objectives be obtained and a higher standard of living provided for the people of Malaysia.