ISEAS Occasional Paper No. 69

Malnutrition, Health Resources and Education in Peninsular Malaysia

Tan Loong-Hoe

MARUZEN ASIA

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by
Tan Loong-Hoe

Issued under the auspices of the Institute of Southeast Asian Studies

MARUZEN ASIA
1982

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ISBN 962-220-114-8
ISSN 0073-9731

Distributed by
MARUZEN ASIA PTE. LTD.
Block 7, Seventh Storey
Ayer Rajah Industrial Estate
Singapore 0513

Typeset by Maruzen Asia
Printed by Koon Wah Printing Pte. Ltd., Singapore

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PENINSULAR MALAYSIA

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Acknowledgements

My interest in the subject matter of this study arose from two quarters. First, to keep up a continuing discussion on the relevance of academic work to the larger Malaysian society with my Malaysian friends in the medical and public health fields, in particular — Phua Kai-Hong, Tan Heng-Soon, and Chan Chee-Khoon. Second, to remedy the ethnocentricism of my own Chinese upbringing and sociocultural milieu; and to understand the plight of my fellow Malaysians of another ethnic group. I am appreciative of the encouragement from my friends.

To Professor Marjorie Young (School of Public Health, Harvard University), who gave so generously of her time and valuable comments, I owe a debt of gratitude. I wish also to acknowledge the helpful assistance of Dr. Donald Snodgrass (Harvard Institute of International Development) and Dr. Judith Strauch (Department of Anthropology, Harvard University). Dr. Sharon Siddique, the Coordinator of the Publications Review Committee at ISEAS, deserves my praise for rendering valuable editorial improvements to the revised draft. The revision effort has also benefited in no small way from the comments and suggestions of anonymous reviewers to whom I am much obliged. I thank Professor Nevin Scrimshaw (Department of Nutrition and Food Science, Massachusetts Institute of Technology) for his encouraging response when I first broached the possibility of publication. I am grateful to Professor Donn Hart (Center for Southeast Asian Studies, Northern Illinois University) for his kind attention and serious interest in seeing my manuscript in print.

Various staff members at the Institute of Medical Research, Kuala Lumpur — the Librarian, Mrs. Ireland and her assistants, Dr. Y.H. Chong, Mr. Lim Ju Boo, Mr. Tee E. Siong, Puan Haliza bte Mohd. Riji, and Dr. Ajeet Kaur Gill — were kind in giving me time and useful research materials at short notice. Mrs. Pat Lim, the ISEAS Librarian, has also been extremely helpful in alerting me to some important recent material and taking an interest in my work.

Harvard-Yenching Institute and ISEAS made this study possible with their financial sponsorship. Lastly, I wish to convey a special appreciation to Professor Kernial Sandhu for his active interest and encouragement which moved me to a speedy and efficient completion of this study for publication.

Needless to say, I bear sole responsibility for what is written in this study.

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I. Introduction

I.1 MALNUTRITION; RELEVANCE AND IMPORTANCE OF NUTRITION EDUCATION

Malnutrition has been recognized by the present Malaysian Government as "an important health problem."[1] In the official documents such as the *Economic Report, 1975-76* of the Treasury, the Malaysian Government has shown increasing concern: "From a number of pilot studies, it was found that some malnutrition is prevalent among the lower-income groups."[2] The Institute of Medical Research in its report, *Research Projects For 1975-81,* also reflects this concern by giving "special attention" to topics such as Nutrition, Parasitism, Child Growth and Development and the related Sociocultural Aspects of Health.[3] Underlying the urgency "to reduce the pockets of malnutrition, especially in the rural areas", the *Third Malaysia Plan, 1976-80*[4] indicates that "by the end of 1975, there were (Applied Food and Nutrition Project or AFNP) projects in Trengganu, Kelantan, Pahang, Kedah, Perak and Selangor[5] covering a total population of 2.4 million." Between 1976 and 1980, the AFNP was expected to expand "to those areas with serious malnutrition problems as indicated by high mortality rates. . . ." Nutrition education is also regarded by the Government as an integral component in these efforts to deal with the "multiple and complex" causes of malnutrition in the country.[6] The relative significance of the malnutrition problem compared to that of the other countries in the Western Pacific Region is shown in Table 1.[7]

In Peninsular Malaysia, nutritional disorders[8] like Protein-Calorie Malnutrition (PCM), Anaemia (both child and mother), and Angular Stomatitis are evaluated as "moderate problems" while Xerophthalmia and Goitre are considered "mild problems". Indeed, these five disorders are the very nutritional diseases which "deserve the highest priority" according to a World Health Organization (WHO) report.[9] Bengoa[10] and Berg[11] also made a similar observation on the basis of much evidence: "There is little dispute that malnutrition is the biggest single contributor to child mortality in the developing countries" including Peninsular Malaysia. Similarly, a recent WHO study reiterated the global significance of the malnutrition problem: "Throughout the world, for lack of even the simplest measures of health care, vast numbers of people are dying of preventable and curable diseases, often associated with malnutrition, or survived with impaired bodies and intellects."[12]

TABLE 1. RANGE OF NUTRITIONAL PROBLEMS IN THE DEVELOPING COUNTRIES AND AREAS OF THE WESTERN PACIFIC REGION OF WHO

Country of area	PCM	Anaemia		Xeroph-thalmia	Beri-beri	Pellagra	Angular stoma-titis	Scurvy	Rickets	Goitre
		child	mother							
Asian areas										
Cambodia	+++	++	++	+	0	0	++	0	0	+
China	0?	?	+?	?	?	?	?	?	?	+?
Hong Kong	+	+	+	0	0	0	+	0	?	0
Laos[1]	++	++	++	+	0	0	++	0	0	++
Malaysia	++	++	++	+	0	0	++	0	0	+
Philippines	+++	++	++	++	+	0	+	0	0	++
Republic of Korea	++	+	+	0?	0	0	++	?	?	0
Republic of South Vietnam	+++	++	?	+	+	0	++	0	0	++
Singapore	+	+	+	0	0	0	+	0	0	0
South Pacific areas										
Cook Islands	+	+	?	0?	0	0	0	0	0	0
Fiji	++	++	++	+	0	0	+	0	0	+
French Polynesia	?	+	+	?	?	?	?	?	?	?
Gilbert & Ellice Islands[2]	++	++	++	+	0	0	++	0	0	0
New Caledonia	+	?	?	0	0	0	?	0	0	+
New Hebrides	+	?	?	0	0	0	?	0	0	0
Papua New Guinea	+++	++	++	+	0	0	+	+	0	++
Solomon Islands	+	+	+	0	0	0	+	0	0	0
Tonga	+	?	?	+	0	0	+	0	0	0
Trust Terr. Pacific Islands	+	+	++	0	0	0	+	0	0	0
Western Samoa	+	++	++	?	0	0	0	0	0	0

KEY: ? = unknown; 0 = not a problem; + = mild problem; ++ = moderate problem; +++ = major problem.

[1] Now the Lao People's Democratic Republic. [2] The Ellice Islands are now a separate territory known as Tuvalu.

SOURCE: *WHO Chronicle*, 30 : 64-69 (1976), p. 65.

Can all these tragic, possibly unnecessary, mortality and morbidity which are directly or indirectly attributed to malnutrition be contained and prevented from further exacerbation? If the answer inclines towards the affirmative, in what ways and to what extent can education be a supplementary preventive measure? Djukanovic and Mach provide a highly illuminating statement:

> High morbidity and high mortality, particularly among infants and children, are an index not only of a community's low health level but also of inadequate health education. *A great number of diseases could be prevented with little or no medical intervention if people were adequately informed about them and if they were encouraged to take the necessary precautions in time.* Prominent among these are childhood diseases, nutritional disease, during infancy, and diseases preventable by immunization. *Health education is particularly needed where the network of services is weak:* there, people must learn to protect themselves from diseases and to seek help if they need it (Emphasis added).[13]

In the rural regions of Peninsular Malaysia, especially in the more isolated, remote areas where a substantial proportion of the rural population is scattered, modern health care services are inaccessible or poor. Preventive health care with nutrition education as an integral part of the total health education efforts cannot be overemphasized as the immediately needed practical measure. The importance of nutrition education, as mentioned above, has been recognized by the Malaysian Government.

What, then, would be the appropriate nutrition education response specific to the malnutrition problem of the rural Malay communities in Peninsular Malaysia? To be operative, this nutrition education response must necessarily be deployed within the context of a comprehensive and effective rural health care system which is accessible to and acceptable by the client-population. What, then, constitutes such a rural health care system specific to Peninsular Malaysia?

These are the two central, intimately related questions that this paper endeavours *to resolve rather than solve.* Based on the interest of finding some solution to the malnutrition problem in the country from the educational perspective, emphasis on issues pertaining to the nutrition education programme planning at the community level will dominate. These educational issues, for example, planning and programming framework, appropriate content for the target population, etc., however, are largely derived from the consideration and formulation of the alternative health care system.

I.2 THE RURAL MALAYS AND THEIR IMPORTANCE IN THE MALAYSIAN NATION

In 1980, the estimated total population of Peninsular Malaysia is 11,849,000, which includes the four major groups or communities within this multiethnic society: Malays 53.9%; Chinese 35%; Indians 10.5%; and Others 0.6%.[14] Almost 80% of the total Malay population are found in the rural areas of Peninsular Malaysia. In the 1957 Census, the corresponding proportion was 88.8%.[15] Hence, over the last twenty-three years, the dominance of the Malay population in the rural areas continues with some perceptible rather than substantial changes in the distribution by strata.

Rural Malays, as a collectivity defined by their geographic distinction and sociological grouping,[16] are important within the context of the Malaysian nation in terms of both political and economic considerations.

Politically, by sheer numerical weight and the particular electoral weighting in favour of rural constituencies, the rural Malay population ostensibly has substantial political clout beyond their numerical significance.[17]

It is, therefore, not surprising that the Malaysian development policy in the last two decades has had a distinctively "rural bias,"[18] in marked contrast to the general "urban bias"[19] in the development policies of many developing countries. This rural-biased Malaysian development policy has essentially reflected the political clout of the rural Malay population. The outcome of this rural-biased development policy in raising the material standard of living for the rural Malays, however, is a different matter, facets of which will be discussed in later sections on the economic poverty of the rural Malays (II.2.A) and on the assessment of the Malaysian Government's provision of health services to the rural areas (III.3).

Economically, the rural Malays are mainly found within the peasant sector[20] of the Malaysian economy. The peasant sector or "the traditional rural sector,"[21] comprises the uneconomic smallholder rubber, single-cropped padi, traditional livestock and other agriculture, inshore fishing, and gathering of jungle produce. The smallholdings account for as much as 60% of the total agricultural land in Peninsular Malaysia. The other 40% of the land in the agricultural sector is made up of estates and government development schemes ("the modern rural sector"). In 1978, the traditional and modern parts of the rural sector — which approximately form the economic sector: Agriculture, Forestry and Fishing — contributed almost 30% of the Gross Domestic Product at factor cost.[22] For 1970, the corresponding proportion was 32%. Indeed, in at least the last eight years, the annual growth rate of this economic sector has been significantly low, compared to other sectors, for instance: manufacturing. As the traditional peasant economy has been relatively lacking in dynamism, its contribution to the total national output is relatively less significant, compared to the modern rural sector.

The economic significance of the rural Malays stems not from their lack of contribution to the wealth of the Malaysian nation but rather their chronic and intensifying plight — being left out in their share of the national economic pie produced by the rapid economic growth since 1957 when the country achieved political independence from British colonial administration. Given their dominant political role, the poor health and malnutrition of the rural Malay population is an important development factor which cannot be ignored.

I.3 SCOPE AND OVERVIEW OF THE STUDY

Schematically, the rest of the study will be arranged in the following sequence: Chapter II will provide a comprehensive assessment of the malnutrition situation, focusing on the rural Malay communities. It will also analyse the "complexity and multiplicity" of the etiology or causal factors producing the pattern of malnutrition discussed earlier. Chapter III will attempt to elucidate the traditional Malay medical health system; and, it will also examine the existing modern medical health care system. An alternative health care system which is more responsive — with respect to the criteria of access and acceptability — to the rural Malay population will be proposed. Within the framework of the proposed alternative system and its recommendations, Chapter IV will discuss the implications for nutrition education with reference to the planning and programming at the micro-community level. The objective here is not the formulation of a complete nutrition programme and a detailed design ready for implementation; but rather, to discuss, selectively, the important areas of preliminary concern in the planning and programming processes.

In conclusion, Chapter V will take up the question of how effective and to what extent nutrition education can contribute to overcoming the complex malnutrition problems amongst the rural Malay population. The intricacy of prescribing simple or sophisticated solutions to the "complex and multiple" malnutrition problems will be illuminated. The possibility and inherent limitations of any educational response (including the recommended nutrition programme) contributory to the eventual solution of the malnutrition problems will thereby be resolved rather than solved.

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