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THE TWIN PROBLEMS OF RURAL POVERTY AND ILLHEALTH

Poverty and illhealth go hand in hand wherever they exist in rural areas. The solution to illhealth in rural areas does not lie in the medicine chest of the doctor. The key to many such medical problems can be found in the rectification of the basic social or economic ills that afflict the community. How can the vicious cycle of Illhealth — Low Productivity — Poverty — Malnutrition — Illhealth be broken in the rural areas? The rural environment contains the greatest hazards to health. Would changing the environment help to lay the foundation for the takeoff into rural prosperity and good health? Would the people, who are traditionally bound to a rural way of life accept the sociocultural changes of a semiurban way of modern living? I shall try to deal with some of these problems.

Poverty is a problem not limited to the backward developing countries of the world. A highly industrialised country like the United States of America, which is the richest country in the world as 35,000,000 poor people out of a population of about 180,000,000. It is estimated that this 20% of the population who are poor enjoy only 5% of the National Income of the United States, while the affluent 80% enjoy 95% of the National Income. When the individual income falls below 10% of the per capita National Income of $M7,000 per annum, one is considered to be poor in the United States. A per capita income below $M80/- a month cannot buy you the necessities of life in the United States. It is interesting to note that in Malaya more than 60% of the population are subsisting on a per capita income of about $10/- a month or a family income of $30 - $40 a month.

Poverty in the United States is different from poverty in a developing country. When a country's production is far in excess of the needs of its people, measures directed at a more equal and more efficient distribution of wealth will wipe out poverty. In a developing country like Malaya where a large majority of the 7,000,000 people are peasants, who are eking out a subsistence on one to three acres of land, any move to divide the National Income, even equally amongst its people will find no solution to poverty nor will it generate prosperity. If the standard of living of the people is to be increased, the production of wealth in the form of goods and services should be increased many times.

The per capita National Income of Malaya is $900/- per annum and is the second highest in Asia. When compared with the per capita National Income of $M7,000 in a highly industrialised country like the U.S.A., or the per capita national income of $M4,000/- in Australia, it will be evident that Malaya cannot afford to immediately invest large amounts of money to fight poverty and illhealth. It is estimated that 60% of Malayans who live in rural areas enjoy only 10% - 15% of the Malaya's National Income of $6,000 million per annum. The seriousness of rural poverty will be appreciated if it is known that half the economically active persons in Malaya live in the rural areas. About 60% of our National Income is enjoyed by the urban Malayan Chinese population who are actively engaged in the commercial and industrial enterprises of the Nation, and who also pay most of the taxes. A large part of the balance of 30% probably goes as profits to the foreign commercial and industrial organisations which operate in Malaya; the balance is income accruing to Governmental organisations from property and entrepreneurship.

Poverty is not limited to the Malays, it also exists side by side amongst the Chinese and Indian peasants and rural workers in Malaya. The rural people are primarily occupied in small scale farming in uneconomical lots of land. The riverine and coastal people are employed in small scale fishing. The people in the interior get their income from hunting and collecting forest produce. People like the rural Malays lead a simple life. They

produce just sufficient for their needs. According to our economist Prof. Ungku Aziz some of these people live completely outside the money economy. A family income of $25 to $30 a month is average amongst the Malay peasants. This is less than $10 per capita in the family, and below 10% of the per capita National Income of $70/- per month. The Health and Nutrition of the family cannot be maintained on such a meagre precarious income. Poverty, Ignorance, Insufficient Land, and Illhealth are the causes of the family food being deficient in calories, vitamins, minerals, and the sorely needed proteins to nourish the children. Malnutrition is endemic in rural areas and it reduces the output of work.

The rural family who are malnourished because of poverty, soon become prey to the many diseases caused by an unfavourable environment. Malaria is the biggest scourge, and recurrent attacks of this fever soon make them unfit for hard work. Tuberculosis is a common problem. Ankylostomiasis and other worm infestation affect a vast majority of the rural people. Gastro-enteritis, dysentry and typhoid take a heavy toll of infant life. Cholera is beginning to rear its head in the rural areas in North Malaya. Filariasis and yaws are common in certain areas. Most of the people suffer from anæmia which saps their vigour. About 20,000 of the 30,000 deaths that occur annually in the rural areas are certified by the village policeman as due to fever or "Pyrexia of Unknown Origin." The exact cause of death of a large majority of the rural people is still a mystery to the Registrar General of Births and Deaths. The death rate in the rural area is more than 13.0 while the death rate for urban areas is about 8.0 or 9.0 Very few of these rural people seek admission to hospitals when they fall ill. However, they are now, not averse, to calling at the Government Rural Dispensary or at the Government Travelling Dispensary for outpatient treatment. About $\frac{1}{4}$ of the 4,000,000 rural people visit these travelling dispensaries. More than 60% of the people treated are Malays, and to most of them this is the only contact they have with a Modern Health Service. The treatment of sickness that is caused by the health hazards in the rural environment is not the answer to their suffering. These rural people need a healthy home environment in order to remain healthy.

It is obvious one cannot enjoy glowing health in an environment of mud, swamps, leeches, mosquitoes, flies, worms and germs, when even the water you drink and bathe in, smells and tastes of decay and dirt. To a doctor who works in this area there does not appear to be much of a dividing line between life, disease, and death.

Most of the wooden houses in which these people live may look shabby from the outside, but they do take pains to keep the inside clean. Since the water they use is already polluted, washing the house creates new dangers for the growing infant who is beginning his life within the protection of the house. Since the houses are uniformly spread in one or two acre lots over vast expanses of land there is no hope in the forseeable future to provide each house with filtered and treated running water.

Most of the houses have no latrines either within the house or outside it. The bush in the neighbour's land or in one's own land is the toilet for the older members of the family, and the land outside or under the house is used by the children. The pollution of the wells, ponds and rivers which are the only sources of the family water supply, is invariable under such circumstances. Gastro-enteritis, Dysentry, Worm infestation take their toll of infant life and infant health. The infant mortality in the rural areas is about 80 – 100 deaths per 1,000 live births, while the rate is half of this in the urban areas, where a more sanitary environment exists.

I may have painted a gloomy picture of the state of affairs in the rural areas. Those of us who live a lifetime in urban areas tend to overlook the want and misery that exists so close to us in the villages and kampongs. Our Government like all enlightened Governments is making a many pronged attack to eradicate rural illhealth and rural poverty. Land reforms to increase the size of the family holding to about 10 acres each are being introduced so that the family income will be raised from $30/- per month to $300/- per month. Agriculture, the mainstay of any rural economy, is being modernised. Labour saving

agricultural machines are being introduced into the farms. High yielding seed, and fertilisers are being distributed. Large schemes to improve the irrigation facilities are being undertaken. The diversification of crops and double cropping are some of the measures being introduced to increase the income of the farmer. Co-operative capital, and co-operative marketing facilities are being introduced to break the vicious holds of the money lender and middlemen.

General education and technical educational facilities are being provided in most rural areas to lay the foundations for creating the human resources required for rural progress. Roads, bridges and additional transport facilities are being extended into the rural areas at a rapid rate. This will facilitate the rapid exposure of the rural people to the modern urban ways of living, commerce and production.

The Health Services are being extended into the rural areas at a rapid rate. The midwife is the spearhead of the service. Every 2,000 people get a resident midwife and a midwives clinic costing $10,000/-. Every 10,000 people receive a Sub-health Centre, costing $100,000/- where there is a resident Nurse, two Assistant Nurses, Public Health Overseer and other staff. Five of such centres serving 50,000 people come under the control of a Resident Doctor, Resident Dental Surgeon and Resident Public Health Inspector. The whole Health Unit serving 50,000 rural people costs $1.6 million to build and large sums of money to maintain. The main function is to treat sickness amongst the rural people, make child bearing safe, provide child care, improve personal hygiene and personal care, and improve the sanitation in the environment.

Despite the concerted efforts of many Departments to provide the extension services to alter the environment and make it safe for the rural inhabitants, the planners appear to have overlooked the enormous cost in manpower, money and materials required to make safe more than 4,000 square miles of land occupied by the rural people. Most of us who are engaged in the construction of permanent anti-malarial works will appreciate the heavy expenditure required to make a few acres of land free from a single disease like malaria. The main problem to be faced when trying to improve rural sanitation is the fact that about 4,000,000 people are spread out in one, two, three or four acre lots, over 4,000 square miles of land in about 1,000,000 wooden houses of the primitive type. The vast majority of these houses have no purified water supply, no latrines, no drainage and no proper refuse disposal. What is the solution? How shall we provide a clean home and healthy environment to these 4,000,000 people so that illhealth can be eradicated?

No community can enjoy all the modern services of water, light, power, drainage, sanitation, shopping and other social services if they are spread out all over the country. The cost of taking such services to them is prohibitive. To enjoy the high standards of living of a modern civilisation it is necessary that we live in a close compact community. It is therefore necessary to introduce modern town planning in our villages and kampongs. In every village suitable high land which is dry and easily drained should be developed as a modern village centre for housing, in the same way that we developed Petaling Jaya as a modern suburb of the National Capital. Rural Re-housing and Rural Re-construction is the fundamental solution to Rural Illhealth.

The Government Commission which investigated the 1963 outbreak of cholera in South Malaya made many recommendations for the prevention of epidemics. One of these recommendations was for village development according to modern town planning. The Commission recommended:—

> "that the Government should introduce legislation to control the development of **villages,** towns and cities, in Malaysia according to modern town planning concepts, which should be binding at all levels of administration, and from which no deviation should be allowed if such action would lead to infringement of health rules, or cause a hazard to the Health of the community."

(Malaysia being a young country, early action along these lines will pay handsome dividends in health for the future, without causing much hard-

ship to the present generation. The haphazard development of Malacca without the aid of modern town planning should be a lesson for the rest of Malaysia, especially for local authorities).

The words used by the Commission are more or less the very same words used by the Malayan Medical Association when it made this recommendation to the Commission.

The Rural Re-housing which is necessary under this scheme to eradicate rural poverty and rural illhealth is far too vast to be shouldered by the rural people themselves. Government assistance is necessary for the planning and development of sites, for laying down all the common services, and for subsidising the purchase of houses. Government has not given much attention to rural re-housing. The United Nations Secretariat in its report on the World Housing Situation recommends that countries in Asia need to build annually no less than 10 houses per 1,000 of the population. On this estimate the 4,000,000 rural people in Malaya would require at least 40,000 houses every year. At $10,000 per prefabricated concrete low cost house, a sum of about 400 million dollars would be necessary. Can this money be found to provide for Rural Re-construction at an annual investment of about 7% of our National Income? When considering this we should remember that more than half the economically active people of Malaya live in rural areas, which contain about 60% of the population. Despite this only 10 – 15% of the National Income goes into their pockets.

If rural labour is used in the rural re-housing programme, and if most of the materials used are manufactured in the same region, and if skilled labour is trained in the rural areas, Government spending of the magnitude contemplated would boost the rural income and help to eradicate rural poverty. It is interesting to note that a measure contemplated to improve the environmental health should also help to alleviate poverty and thereby help to break the vicious cycle of ill-health — low productivity — poverty — malnutrition — illhealth. I commend this proposal for your contemplation. Should some of the present makeshift rural development plans, which may turn out to be ineffective and uneconomical in the long run, give way to a forward looking plan to modernise our kampongs and villages in gradual stages? Is this the key to eradicate poverty and illhealth and lay the foundations for Rural Progress? If town planning is to be introduced into the rural village have we in the past been siting millions of dollars worth of public and private buildings in the right area? Should we and the District Officers give this more thought in future? I leave these questions for your consideration.