PROCEEDINGS OF THE NATIONAL CONFERENCE ON SOCIAL PROBLEMS HELD BY THE DEPARTMENT OF SOCIOLOGY & ANTHROPOLOGY IN COLLABORATION WITH THE INSTITUT SOSIAL MALAYSIA (ISM) AND PRISON DEPARTMENT, MALAYSIA

د. نور عزلان محمد نور
DR. NOOR 'AZLAN MOHD. NOOR
رئيس قسم علم الاجتماع والأنثروبولوجيا
Head, Department of Sociology & Anthropology
Kulliyyah of Islamic Revealed Knowledge & Human Sciences

ON

27-28 NOVEMBER 2004

Edited by
Department of Sociology and Anthropology

INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

Published by:
IIUM Press
International Islamic University Malaysia

First Edition, 2008

Perpustakaan Negara Malaysia Cataloguing-in-Publication Data

National Conference on Social Problems (2004)
Social problems in Malaysia: the proceedings of the conference on Social Problems held by the Department of Sociology & Anthropology in collaboration with the Social Institute of Prison Malaysia on 27th-28th November 2004/edited by Department of Sociology and Anthropology
ISBN 978-983-3855-25-4
1. Social problems--Malaysia--Congresses. 2. Unversiti Islam Antarabangsa Malaysia. Kuliah Ilmu Wahyu dan Kemanusiaan. Jabatan Sosiologi dan Antrapologi. I. Title.
303.690917671

ISBN: 978-983-3855-25-4

Printed by:

MULIA ERAT SDN BHD (594344-A)
No. 51, Jalan Metro Perdana Timur 10,
Kepong Entrepreneurs Park, Jalan Kepong, 52100 Kuala Lumpur
Tel no. 03-6257 8004 Fax no. 03-6258 7004 e-mail. mesb66@streamyx.com

TABLE OF CONTENTS

MIGRANT ADJUSTMENT IN FACING SOCIO-PSYCHOLOGICAL PROBLEMS IN THE URBAN ENVIRONMENT

Mohd. Aris Othman
Noor Azlan Mohd. Noor

The main purpose of this paper is to discuss migrant adjustments to city life in reducing the socio-psychological problems they face in towns. One such adjustment is to recreate as much as possible rural life in the urban environment. Thus, besides the formation of associations, there is also an effort to bring rural institutions to the urban areas. One such institution is the *bomoh.*[1]

The first part of the paper discusses the institution of *bomoh* which is increasingly popular among the urbanities. It is the contention of this paper that the institution of *bomoh* which is traditionally a rural institution is brought to the town to serve the needs of the urbanities. Based on the belief that certain diseases cannot be cured by modern doctors, migrants go to *bomoh* to seek treatment. Such diseases as *ketegor,*[2] *saka*[3] and *santau*[4] seem to be within the domain of the *bomoh.* The data in the paper will show that there is not only an increase in the number of such institution in town, but also in the diversity of areas of diseases and treatment covered by the *bomoh.*

The second part of the paper discusses another mechanism in reducing the shock of urban life. This is the role of voluntary association. There are many types of voluntary associations. However for the purpose of this paper only ethnic associations are discussed. The Baweanese *pondok* is one such association.

Part 1

This paper examines health issues with special reference to the knowledge and utilisation of medical systems among urban Malays[5] in Malaysia. There are three main objectives in this paper: first, to describe knowledge, attitudes and perceptions in relation to health and illness within the context of daily life; second, to identify the dominating factors that affect individuals' decisions to opt for one

or the other or both of the health services—village and hospital treatments—available to them in urban setting; and third, to describe and account for the utilisation pattern of health services of urban Malays.

One would assume that urban dwellers are often assumed to be more inclined to utilise the hospital health facilities, for the services rendered are within easy reach. The basis of this assumption is that accessibility is significant in relation to the utilisation pattern of health services among the population. We know that the urban population have easy access to the various hospital health services in the event of illness, compared to their fellow Malays in the rural areas.[6] Rural Malays on the other hand, are often assumed to be "traditional" and more isolated from modern health services than urban dwellers.[7] As a result, *ubat kampung*[8] is widely practised and utilised by the rural Malays.

A further point to bear in mind in relation to this study is that earlier accounts of Malays in relation to health and illness show that scholars, irrespective of whether they are western or local, have focussed on those living in rural areas.[9] The descriptive analysis sometimes seems to suggest that the only true Malays are rural Malays, thus ignoring those Malays who have migrated to and live in the urban areas.

A Brief Account on Theoretical Context of the Research

In this section, I intend to review first the establishment of modern medical services in Malaysia, and then some of the relevant theoretical literature from medical anthropology which has a bearing on the Malaysian situation and in particular on my own research. In Malaysia—then, Malaya—the infrastructure of modern medical care had been established during the British rule. 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. In the early days of British colonisation, the establishment of modern medical care was meant to treat European employees and their families, estate and mine workers. During British colonisation, between 1883 and 1910 in particular, many hospitals of varying sizes were built and established in the capital of each of the states in Malay Peninsula. In addition to the establishment of health services in the major towns, travelling dispensaries on buses and boats were provided for the remote areas of the states, for instance, Pahang and Kedah. Thus, attempts were made by the colonial health authorities to extend health services to the rural areas, and the establishment of the modern medical care in many ways improved the quality of life and health among the rural and urban population of the Malay Peninsula.[10]

During the 25 year period, i.e., from 1955[11] to 1980, a total of 69 main health centres, 258 health sub-centres, and 1413 midwife clinics were established in the rural areas of Peninsular Malaysia. By the year 1995, a total of 1991 rural clinics,[12] 592 health centres, 410 mobile units[13] were established and formed in the rural areas. In urban areas, 104 maternal and child health clinics, 64 polyclinics, and 115 hospitals were established and built for the urban population.[14]

In spite of the development and establishment of modern medicine, studies have shown that traditional medicine is still firmly rooted in Malaysia, particularly among the Malays. Colson in his study among Malay villagers in Jerantut District, Pahang, indicated that when an individual has a serious disorder, it is reasonable to assume that he might attempt to utilise every possible medication available to him. The study confirmed that the knowledge of what the sick individual believes to be the cause of his disorder allows a fairly accurate prediction of what resources or combination of resources he will employ. Disorders believed to be caused by natural agents, are treated at the clinic. Others, resulting from supernatural agents, the violation of *pantang*[15] or any ethical misconduct are treated either by the *bomoh* or self-treatment. Sometimes, an individual with a disorder caused by a spirit will go to the clinic for symptom relief but still trusts the native health practitioner to effect the actual cure.

A study on "The Utilization of Traditional Medicine-A Malaysian Example" concluded that many patients seek traditional treatments after other therapies have failed, to complement another form of treatment, or safeguard a cure already achieved. Some, however, consult traditional treatment before utilising other health resources. A further finding is that the longer the ailment persists, the higher the probability that people will attribute it to supernatural causes, and thus will make the *bomoh* the most appropriate healer to consult. In a traditional medical setting, the treatment provided by a traditional medical system may be particularly effective not only because of the efficacy of the medication used (as judged from a cosmopolitan scientific point of view) but because of the character of the treatment itself. The method of treatment may be particularly compatible with the patient's set of meaningful symbols and because of this its healing potential may be especially potent. Patients are at their ease and have no difficulty in expressing their health problems, and the *bomoh* is particularly adept at making people "feel better."[16] The *bomoh* tends to enquire in great detail into the patient's past and social background, requiring details of the patient's problems, life, family, and enemies.

In Malay society, Malays classify food, medicinal plants, illnesses and modern medicines according to a humoral scheme, i.e., hot-cold qualities.[17] This classification influences the individual's diagnosis of illness and the choice of diet and medical treatment. In relation to this, although Malays believe

that many Malay medicines can be classified as either "hot" or "cold," none is as "hot" as some of the medicines dispensed at the hospital. The idea that many hospital drugs are "hotter" than indigenous varieties leads Malays to believe that they are therefore quicker and more effective. Nonetheless, with some illnesses, the consequences of taking hospital drugs are believed to be much more serious. Measles, for instance, cannot be treated with hospital-based medicine as the heat of the drugs will cause the disease to turn inward on the patient and make him very ill. The Malays believe that the disease is much better treated by the *bomoh* with spells and "cold" remedies rather than relying on clinic or hospital physicians.[18] This Malay humoral classification system also significantly affects ideas and behaviour surrounding Malay women in reproduction. Studies have shown that Malay women who have accepted the precepts of hospital-based medicine, including wives of doctors and women who themselves possess advanced degrees in biological sciences, return, during the weeks that follow childbirth, to the humoural practices.[19] The reasons given for such behavioural practices, are mainly fear of haemorrhage, fever, damage to the womb, prolonged illness, rheumatism in later life, and generally a desire to guard their health.[20] This ethnographic evidence indirectly suggests the significant relationship between patients' belief and their compliance or otherwise with a physician's medical regimens.

Non-compliance with medical advice is considered a major problem in health care. Hunt *et al.*, employ a qualitative study of the illness experiences of 19 women in his attempt to understand non-compliance behaviour from the patient's perspective. Hunt argues that most of the existing literature considers patients' non-compliance attitudes from the doctor's point of view. The view assumes that only doctors have the authoritative knowledge to impose and provide valid explanations of illness and advise their patients of the most appropriate behaviour. Compliance, in this sense, is defined as the extent to which a person's behaviour[21] coincides with their medical advice. However, results show that even when patients have a good understanding of the medical information provided by the physicians, they do not necessarily comply with prescribed treatments. The study shows that people base their judgment about diagnosis and treatment on their own experience and interpretations of their bodily sensations. Whether or not a patient follows a physician's directions is not simply a matter of whether the patient can understand them, but also a question of how those directions fit in with the rest of their thinking and their lives. At this stage, Hunt argues, even though the patient's knowledge may be improved through the information given by physicians, improved knowledge is not necessarily correlated with increased compliance. In reality, patients regulate by modifying information given by the physician through their medical encounter and making appropriate adjustments in terms of daily lives. This self-regulation strategy is employed to control their symptoms. Patients who had modified their treatment practices expressed satisfaction with the diagnosis and treatment, for they felt they had gained knowledge of how to control their conditions. In other

words, treatment was not altogether abandoned, but only pursued when the symptoms were problematic. They reverted to their normal behaviour when they felt well.

Hunt's study shows that real patients are not passive recipients of recommendations. They are reflective actors who review information about health and illness and make decisions based on what makes sense given their experience of bodily changes, the framework of their prior knowledge, and their everyday life situation. They interpret and modify prescribed regimens that fit in with their life situation. Thus, the issue then is not so much on patient's non-compliance, but controlling symptoms with treatments that patients can live with,[22] or other words, self-regulation.[23] According to Conrad, self-regulation consists of reducing the dose, stopping for a time, or regularly skipping or taking extra doses of medication depending on various circumstances. The self-regulation approach allows patients to test the effect of the drug, to control their perceived level of dependence on it, to reduce the stigmatisation they experience and to accommodate the practical constraints on their use of the medication. This medication practice offers a patient-centered perspective on how people manage their medications, focusing on the meaning and use of medications. Thus, Conrad sees patients as active agents rather than passive recipients of doctors' orders. They interpret and modify the doctor's prescribed regimen and create a medication practice that may vary slightly or markedly from the prescribed practice. Consequently, what appears to be non-compliance from a medical perspective then, may actually be a form of asserting control over one's disorder.[24]

Another significant variable in studying utilisation of medical services which needs consideration is accessibility to the health services. Kloos provides an extensive facility-based study of health services utilisation in central, southern and western Ethiopia. The study reveals that the total cost of treatment comprises not only the direct treatment cost, but also the cost of transport, lodging and food away from home, and time lost from production and family support. These direct and indirect costs increase with distance travelled and duration of absence from production. The study has also shown that duration of illness is strongly associated with distance travelled. Patients with chronic health problems tend to employ different treatment strategies that usually begin with home remedies, and often end up with distant traditional healers or hospitals. Beside the treatment strategies employed by chronic ill-patients, another important finding observed in the study is non-use of medical care facilities. Kloos's observations of non-treated cases reveal that the highest proportions of ill persons are from the low socio-economic background irrespective of residence in urban or rural-based communities. These patterns reflect normative health behaviour in Ethiopia, which is characterised by (1) a wait-and-see attitude in the case of most mild and transitory illnesses, (2) the tendency of many people to delay the trip to modern health services until all other resources[25] have been explored and the disease is exacerbated or has reached a chronic stage. A similar case finding is

observed by Lieban in the Philippines in which the study reveals that many young children with respiratory illness are initially diagnosed from a traditional medical belief's point of view as *piang*.[26] Thus, many cases are treated by *manghihilo*.[27] This perception of the illness etiology not only affects the choice of treatment between traditional and modern, but may be hazardous for the patient's life.

In another study, Quah examines accessibility in terms of time and cost, geographical distribution of the services, educational barriers, and more importantly, perceived accessibility. Perceived accessibility refers to the individual's interpretation of his chances of obtaining a given health care service, i.e., the difficulty or ease with which he thinks he can enter the health care system. Cultural barriers are part of the perceived accessibility factor, for example, beliefs about the etiology of disease or illness, the stigmatisation caused by social labelling of diseases, such as for mental illness and leprosy. Other cultural factors include past experiences with health services personnel, and the person's own criteria of what is important in his selection of health services, for instance, time, cost, good manners of the practitioner or friendly atmosphere, effectiveness of treatment, and "sweet" medicines. In addition to perceived accessibility, the findings also show that educational barriers did have a role in the utilisation of health services. In other words, the information a person has about the health services available to him, and when he should seek health care is closely related to that person's formal educational level. Quah's observation suggests that, compared to less educated people, those with secondary school or higher education are: (a) more aware of the physician's role and their own rights as patients; (b) more likely to emphasise the importance of cleanliness and proper eating habits as factors defining a healthy person; (c) more likely to acknowledge the importance of regular exercise as a practice to stay healthy; (d) more prone to pay attention to health disorders that do not threaten the performance of daily work activities; and (e) more likely to go for regular medical check-ups.[28]

In the case of communication, there are two frequent complaints about communication with Western medical personnel. First, the unfriendliness of the personnel to those seeking services, and second, the difficulties in mutual understanding due to differences of language and culture.[29] However, Kurata's comparative study of patient satisfaction with health care services rendered at government-subsidised outpatient health care facilities in Kyoto, Japan and San Bernadino, U.S.A., suggests that the majority of patients from both sites were satisfied with all the medical care services received except two. Patients were satisfied with the courtesy and consideration shown by most of the health personnel, care received from nurses, and provider's technical skills and competence. The only two categories where dissatisfaction was frequently expressed were waiting time to see the provider at the clinic and the amount of time spent with the provider. In the case of waiting

time, patients spent many hours waiting before they could get into the exam room for consultation. Then, physicians spent limited hours or just a few minutes with patients during consultation prior to medical prescriptions. In this case, then, the findings indicate that the most important factor in satisfaction is related to the quality of communication between physician and patient, and the degree of trust and confidence that the patient has in the health care provider. This factor appears to be more significant than provider's level of training in biomedical procedures.[30]

Medical pluralism is another issue that needs to be looked into in analysing health systems. Frankenberg mentions the multiple pluralism concepts in which the issue discussed is not only the choice between allopathic and indigenous pathways to healing, but the fact that each of these pathways branch in their turn. He elucidates that those who opt for allopathy can choose between private doctors or clinics and government hospitals or clinics elsewhere. Similarly, indigenous healers can be of different types like snakebite specialists, midwives, sorcerers, exorcists, God-dancers, priests, and astrologers.[31]

Murray Last, on the other hand, elucidates how within a pluralist medical culture, there is (from the doctors' point of view) a hierarchy of medical systems, differing in their wealth and power and in the degree of their systematisation. In the case studied, traditional medicine is at the bottom of the hierarchy and is regarded as un-systematised. Although the latter is not recognised as a system, it can still be practised widely and be patronised by the public. One major reason for this, according to Murray Last, lies in part on the fact that patients, unlike doctors, recognise only a single, wide-ranging corpus of illnesses for which all the different healers among them could cure. Patients do not see the doctors' different systems as 'alternatives'; furthermore, some of the doctors do not act as part of a system. Instead, there is a whole medical culture within which the various systems or non-systems have affected each other over time. Along with this, the patient is also not interested in knowing why the cures work or the ideas behind them; nor are doctors necessarily interested in all the causes. On this account, Murray Last believes that to people in general and patients in particular, the notion of 'alternative systems' in actual fact is substantially irrelevant as far as pluralism in medical systems is concerned.

The several studies summarised above indicate a wide range of factors which in different parts of the world influence attitudes to health and illness and the choice of medical treatments. As we shall see below, many of the findings of these studies are confirmed by the Malaysian data. The value of a contemporary study of rural Malays does not, however, lie solely in confirming the conclusions of other researchers. Each different area studied has its own peculiarities, and these will change from one historical period to another. Thus our intention here is to describe the situation which obtains in

Malaysia today, to show the similarities and differences with situations in other parts of the world and to try to identify future trends and likely outcomes of present practice.

Utilisation Pattern of Health Services in *Kampung Ruban*

The section is concerned with the utilisation of health resources among the urban Malays of Kampung Ruban.[32] Table 1 is the summary of illness episodes and resources employed by urban Malays in Kampung Ruban.

Table 1
Illness Episodes and Types of Treatment Employed by Urban Malays in Kampung Ruban

Types of Treatment	Illness Episodes N	%
Government Health Services	6	9.7
Private Health Services	15	24.2
Malay Healers *(Bomoh)*	-	-
Self-Treatment	12	19.3
Multiple Combinations	22	35.5
No Treatment	7	11.3
Total	62	100

A total of 62 illness episodes were recorded during my fieldwork[33] period among the urban Malay informants in Kampung Ruban (see Table 1 above). These episodes were narrated by informants during the interview and related either to their personal experiences in the past or to current illness. Of these 62 illness episodes, 53.2% (33) were in the single-pattern of medication category, 35.5% (22) preferred multiple combinations of treatment, and 11.3% (7) sought no treatment at all for the illness suffered. Interestingly, none of those reported in Kampung Ruban sought a bomoh as the first option of medication during the onset of the illness event. In the single-pattern of medication category, 33.9% (21) of the 53.2% (33) employed ubat hospital or ubat klinik (hospital or clinic medicine) as the first option of medication during the onset of illness. In this particular instance, the health actions taken by the ill persons involved hospital health services either at the government health services (9.7%) or private hospitals and clinics (24.2%). Table 1 above shows that in the hospital medication category, a higher percentage of informants preferred private hospitals or clinics rather than government health services during the onset of illness.

Table 1 also shows that the remaining 19.3% (12) in the single-pattern of medication category preferred self-treatment as the first choice of treatment during the onset of illness. Table 2 looks more closely at instances of self-medication. There are two categories of self-treatment in regard to these illness episodes. The first is self-treatment with manufactured drugs sold either at the shops within the neighbourhood or pharmacists in the nearby town. These manufactured drugs include the western patent medicines, for example Panadol, Dusil, Cortal, Breacol, and etc. These are common medicines bought by informants for ailments such as headaches, stomach upset, abdominal colic, coughs, and diarrhoea. The following description was extracted from my interview notes with Murni, one of the informants;

> *Murni used to buy western patent types of medicine at the shops in the neighbourhood for her ailments such as headache and cough. She preferred either Panadol or Dusil for headaches, and Breacol for coughs. These medicines are available at the shops in the neighbourhood. She believed that those medicines provided quick relief, and were cheap and accessible. On many occasions, she would try these medicines first to see the results. If these medicines did improve her health status, she would not seek other forms of medication. Otherwise, she would seek medical advice from the private clinics that were close to her residential area. When she did this, she had to spend a bit more for the treatment.*

The second category of self-treatment refers to self-treatment with various types of village medicine. These medicines include locally-made medicines such as *minyak angin,* herbal concoctions and other household remedies prepared by patients to treat their illness. Some of these medicines are easily available in the market, and can be bought either at the shops in the neighbourhood or *kedai ubat Cina* known among informants as *sinseh* in the city centre. In relation to this category of self-treatment, Umar related to me the following:

> *Umar believed that tamarind essence was beneficial for treating sore throat symptoms of illness. The tamarind essence, according to him, was "cold" in properties and was able to treat other "hot" types of illness such as headache and fever particularly of demam hangat types of illness. For his sore throat, he prepared a glass of tamarind essence, and the essence had to be left in the open air for a night. Normally, he would leave it at the balcony of his house. The main intention was to allow the tamarind essence to collect the early morning dew because he believed this would alleviate the symptoms of the illness. According to Umar, he would continue treating his sore throat with the tamarind essence for at least three consecutive days to see the outcome. The treatment eventually improved his health.*

For Multiple Combinations of treatment, all 35.5% (22) preferred hospital medical resources as their first choice of treatment on the onset of illness. Of these, 35.5% (22); 25.6% (14) sought

hospital treatment at private hospitals or clinics, and only 12.9% (8) at government health services. Both private and government medical services are located within the city centre. However, perceptions and attitudes in relation to the treatment of the illness changed at the final stage of medication. Table 3 above shows that, in the final stage of medication, of 35.5% (22); only 3.2% (2) preferred hospital treatment for the illness, and the remaining 32.3% (20) preferred either other medical resources, namely, village medication working side-by-side with hospital treatment (22.6%) or those who had shifted entirely to village treatment to treat their symptoms of illness (9.7%). Table 3 above shows the sequence of treatment employed by informants for Multiple Combinations category.

Table 2
Illness Episodes, Etiology and Types of Self-Medication Employed by Urban Malays

Urban Malays	Illness Episodes	Illness Etiology	Types of Self-medication
01. Rahman	stomach upset	food	*minyak angin*
02. Umar	sore throat	weather	tamarind essence
03. Haji Samsuri	fever, headache	food, weather, age	medicine vendor
04. Ramlah	fever, headache	food, weather, age	medicine vendor
05. Jalal	diarrhoea	food	medicine vendor
06. Sofiah	fever, headache	weather	medicine vendor
07. Udin	*angin* pasang-pasang	wind	village treatment
08. Marzuki	knee-pain	old age	*minyak angin*
09. Murni	fever, headache	old age, weather	medicine vendor
10. Lela	headache	menstrual period	medicine vendor
11. Cik Seman	bodily pain symptoms	old age, work	minyak angin
12. Maimunah	headache	food	medicine vendor

Table 3
Sequence of Treatment Employed by Informants for Multiple Combinations Category

Informants	Illness Episodes	Health Services[i] (G/P)	Choice of Treatment[ii] 1st.	2nd.	3rd
Saud	hypertension	G	Mrx	Mrx+Trx	-
Lijah	womb cancer	G	Mrx	Trx	Mrx
Umar	hypertension	P	Mrx	Mrx	Mrx+Trx
Baharom	stroke	G	Mrx	Trx	Trx
Talib	knee-pain	P	Mrx	Mrx + Trx	-
Azmin	bodily pain	P	Mrx	Mrx + Trx	-
Rokiah	backache & waist-pain	P	Mrx	Mrx + Trx	-
Asiah	*kudis sawan* (impetigo)	P	Mrx	Mrx	Trx
Saari	kidney stone	P	Mrx	Trx	Mrx
Hassan	sorcery type of illness	P	Mrx	Trx	-
Salmiah	sorcery type of illness	P	Mrx	Trx	-
Sofiah	diabetes	G	Mrx	Mrx + Trx	-
Hasnan	asthma	P	Mrx	Mrx + Trx	-
Azian	hypertension	G	Mrx	Mrx + Trx	-
Affendi	flu & headache	P	Mrx	Mrx + Trx	-
Jamil	abdominal colic	P	Mrx	Mrx + Trx	-
Hisyam	stroke	G	Mrx	Trx	-
Jali	kidney stone	P	Mrx	Trx	-
Maimunah	hypertension	G	Mrx	Mrx + Trx	-
Nasir	hypertension + diabetes	P	Mrx	Mrx + Trx	-
Johan	knee-pain	P	Mrx	Mrx + Trx	-
Zaleha	hypertension	G	Mrx	Mrx + Trx	-

In the Multiple Combinations category, I have interviewed Jali aged 70 years old described his illness as noted in these fieldnotes:

> *He remembered suffering from kidney stones at the age of 64. During the event, he had difficulties in urinating, and at the same time suffered abdominal pain and waist-pain symptoms of the illness as the result. He went to Fatimah Hospital at Ipoh Garden, a private hospital, located four km away from home to seek medical advice and for further treatment. They took an X-ray, and advised Jali to go for medical surgery to remove the stones in the kidney as soon as possible. He did not have to wait a long time for surgery. The surgery was successful. After the surgery, Jali did not go for any follow-up treatment at the hospital for his illness. Instead, he bought and consumed* ***lobak putih***[36] *which he believed would relieve water retention in the kidney. He believed that this* ***petua*** *suggested by his colleagues in the village would improve his health particularly in preventing kidney stones in the future.*

A similar set of symptoms is described by Saari, one of the informants in the neighbourhood. Saari aged 56 years old, was a teacher in one of the Chinese primary schools, but is now a pensioner. His experience is as follows:

> *In August 1996, he complained of having* ***buang air tidak tos***[37] *and having to go to the toilet frequently. Occasionally, he had waist-pains. He went to seek medical advice at the State General Hospital in Ipoh, an urban centre located four km away from his house. However, the doctor in charge treated his case as a mild illness and did not provide him with a satisfactory medical prescription. He was given a kind of pain-killer for his illness which was able to relieve the pain for a short period of time. The medication prescribed did not improve his health.*
>
> *In the meantime, one of his colleagues at the Chinese primary school advised him to seek a* ***sinseh's*** *medical advice. He went to the* ***sinseh's*** *shop as recommended together with his colleague's written prescription in Chinese on a piece of paper to buy the medicines. He spent RM3.00 only for the medicines. He complied with the* ***sinseh's*** *medication for three consecutive days, and to his surprise, he discovered a powder-like substance discharged together with his urine. He believed that this powder-like substance in the urine could be related to stones in his kidney. Although the* ***sinseh's*** *medicine provided him with some relief for the illness, the medication ultimately failed to improve his health. Eventually, he decided to seek hospital medical advice to overcome the illness.*
>
> *On September 25, 1996 he went to the Ipoh Specialists Centre, a private hospital, for a further medical check-up of the illness. They took an X-ray and diagnosed that there were stones in the kidney. The doctor on duty then, advised him to undergo medical surgery to remove the stones and he spent RM3,538.00 for that purpose including the medicine prescribed after the surgery. After the surgery, the doctor in charge, wanted Saari to comply with the medication prescribed for him. He had to consume a kind of pill for a period of at least six months prior to his next visit for medical check-up. On April 24, 1997 he went for another medical check-up and X-ray at the Ipoh private hospital to see the*

result of the medication. He had to pay RM45.00 for that purpose. The doctors at the hospital confirmed that no more stones were present in his kidney.

The above two cases highlighted the different patterns of health and illness behaviour among the informants. Even though both informants, Jali and Saari suffered similar symptoms, the way in which they sought treatment was different. Jali went to seek medical treatment at a private hospital, but did not continue the medication after the surgery. Instead, he opted for *petua*, believing it would improve his health in the future. However, Saari acted differently. He went for the surgery at the hospital, but did not opt for village treatment or other available medical resources. Instead, he complied with the doctor's prescription.

The above accounts described several utilisation patterns of health resources among patients in the neighbourhood. We have seen that in some cases, they preferred the hospital medical system over other medical systems during the onset of the illness. In other cases, patients complied with the medication prescribed, while others did not. There were cases where patients employed both hospital and village treatments side-by-side in response to their symptoms. Thus, patients in the neighbourhood employ different strategies in seeking treatment for their illness. However, what makes them select a particular system of medication? In other, words what is the rationale underlying their decisions.

There are several issues and reasons employed by urban Malays in dealing with their health and illness episodes, and the way in which they seek for treatment especially during the onset of illness. The treatment employed can be one or a combination of some other treatments either to overcome or alleviate their illnesses. The decision in making the choice of treatment is influenced by many factors, namely:

(i) cost of treatment in terms of time and money
(ii) education. This includes for example one's educational background and the role of the urban health authorities in creating health awareness through various health campaigns, seminars and talks for the urban residents
(iii) the availability and easy access to hospital medical health services especially the private clinic or hospital
(iv) easy access to information for example through various reading materials, seminars and talks on the subject

These factors help us in many ways to understand the urban Malays' perceptions, beliefs, and attitudes towards their choice of medication, and also in answering why they opt for a particular treatment over the other.

Part II

The process of psycho-cultural adjustment varies from individual to individual. It is doubtful whether a ruralite will forsake his rural characteristics when he migrates to town. Similarly, in the process of psycho-cultural adjustment there is needed to not only maintain certain traditional institutions but also to strengthen them in the urban situation. Life in the rural areas characterized by the spirit of communication is being recreated in the urban centres by the formation of ethnic associations. These associations serve to meet religious, psychological, cultural and socio-economic needs of migrants to towns. Such associations could import new norms to members so that they can be better prepared to adapt themselves to the new environment.

Data in this paper were mainly collected from a research done in Kampung Baharu which is located within the Kuala Lumpur city boundary and neighbouring Kampung Datuk Keramat. The uniqueness about Kampung Baharu is that it still maintains the status of an "agricultural" Malay settlement instituted at the close of the 19th century.[38]

Kampung Baharu provides an example *par excellence* of an urban Malay village with a lot of characteristics analogous to a Malay village. Contrary to popular belief, Kampung Baharu is not a homogenous Malay community for besides Malays, Indonesians ethnic groups such as Javanese, Minang Kata, Bewanese, etc., have settled in the community at the dawn of the colonial era. Kampung Paya[39] in Kampung Baharu is an established Javanese neighbourhood, while the Minangkabau tend to be concentrated in and around commercial centres. The Malays tend to be concentrated in the northern half of the community.

According to the census of population 2000, the Malays dominate other ethnic groups in terms of members in Wilayah Persekutuan Kuala Lumpur. Of a total population of 1,305,792, Malays and other Bumiputera amount to 1,234,022 while Chninese 536,777, Indians 140,696, Others 17,570 and non-Malaysian citizens 71,770 (Refer to Table below for the details).

Table 4
Total Population by Ethnic Group, Mukim and State, Malaysia, 2000

State: WILAYAH PERSEKUTUAN KUALA LUMPUR

Administrative District/ Mukim	Total	Malaysian Citizens							Non-Malaysian citizens*
		Total	Bumiputera			Chinese	Indians	Others	
			Total	Malays	Other Bumiputera				
TOTAL	**1,305,792**	**1,234,022**	**539,039**	**527,821**	**11,218**	**536,777**	**140,696**	**17,510**	**71,770**
W/P K.LUMPUR	**1,305,792**	**1,234,022**	**539,039**	**527,821**	**11,218**	**536,777**	**140,696**	**17,510**	**71,770**
Ampang	35,554	33,032	19,009	18,634	375	8,038	5,392	593	2,522
Bdr. K.Lumpur	231,458	211,312	98,033	95,720	2,313	74,828	34,052	4,399	20,146
Batu	249,820	235,638	65,275	63,070	2,205	140,064	27,699	2,600	14,182
Cheras	11,842	11,499	4,415	4,365	50	5,944	995	145	343
Kuala Lumpur	281,236	263,929	119,633	117,318	2,315	112,077	28,160	4,059	17,307
Petaling	208,322	199,472	61,640	60,048	1,592	116,274	18,058	3,500	8,850
Setapak	259,089	251,105	145,489	143,330	2,159	77,845	25,621	2,150	7,984
Ulu Kelang	28,471	28,035	25,545	25,336	209	1,707	719	64	436

Two main assumptions have to be considered when discussing migrant adjustment to towns. Firstly, the migrants face the problem of psycho-cultural adjustment due among other things to the totally different environment they face in the urban situation. Implicit in this assumption is the idea that there is a kind of a dichotomy between a rural area and an urban centre which implies that the rural and urban centre areas are two different worlds separated from one another not only physically and economically but also psychologically and culturally.[40] Thus the new urban environment would give, at least initially, a psycho-cultural shock to the new migrant. Secondly, the assumption that there is actually no boundary that separates an urban from a rural area either physically or psycho-culturally and the two should not be looked upon as two separate worlds. Thus a rural illiterate who migrates to an urban centre need not face the problem of disorientation. The presence of families (neighbourhoods) in the urban centre may help the new migrant to settle down at least initially when he migrates to town. Kampung Baharu and Kampung Datuk Keramat cited earlier in the papers are examples of such a neighbourhood.

It has been stressed in the earlier part of this paper that problems related to psycho-cultural adjustment of migrants have prompted the formation of ethnic associations in towns. Such ethnic associations are formed to cater to the religious, social and psycho-cultural needs of the migrants. These associations have the main function of looking after the welfare of these members.

In the locality of Kampung Baharu, the Malays may be members of regional Malay association such as *persatuan anak johor*[41] or Persatuan anak Melaka.[42] Malays from other states may form their own associations too. Occasionally, we may read in the local paper that these associations appeal to their members to come for annual general meetings or annual dinners. Usually, prominent people are elected to be members of the working committee of such associations. To what extent these associations are important in helping their members adjusting themselves in the urban environment is difficult to ascertain. However, such associations have made it possible for Malays who come from one particular region to meet and renew old friendship.

Another form of voluntary association is the Bawean pondok which can also be regarded as an ethnic association since membership is mainly restricted to Baweanese who have migrated to Kuala Lumpur. The Pondok is a very well organized voluntary association which seeks to bring together Baweanese in a particular urban community. It is through the pondok that Baweanese especially the new migrants to the cities organize themselves. There are different groups of pondok and membership in these pendok depends upon the region one comes form. According to one Baweanese informant from Kampung Baharu, there are 138 pondoks in Singapore at one time (data not specified).[43] In and around Kuala Lumpur, there are pondoks in Kampung Pandan, Lumba Kudo, Segambut, Sengai Pencala and Kampung Datuk Keramat.[44]

The various pondoks and their associations will be invited for a gathering. According to unverified information given by Baweanese information in Kampung Baharu, a gathering of pondoks was organized in Selangor in 1956 and in Singapore in 1966 during which a series of games were played among competing pondoks.

The biggest pondok in Malaysia is located in Kampung Datuk Keramat. This is Pondok Pekalongan. Besides Pondok Pekalongan, there are two other pondoks in this neighbourhood. They are Pondok Gunung Malang and Pondok Beluar. In Kampung Datuk Keramat a Pondok is administered by a committee consisting of the President, Deputy President, Honorary Secretary, Assistant Honorary Secretary, Treasurer, and a number of committee members. In the case of pondok Pekalongan, there is also an information officer and other officials. These officials will hold office for one year. In the annual general meeting members will elect a new committee. The president also functions as the head of the pondok or Pak Lurah. Besides acting as an advisor, he also settles disputes between members of his pondok or between other pondoks. In short, he is responsible for the welfare and security of members of his pondok. Although, in theory, committee members of a pondok will hold office for one year, in practice a Pak Lurah will continue to hold office until he resigns.

Besides providing temporary accommodation for members and their families especially those who are sick, unemployed or who have no homes, a pondok also functions as an institution that helps to bring together not only Baweanes from Datuk Keramat and the surrounding areas but also Baweanese from other areas who come from the same region in Bawean. They cooperate in giving financial aid to build mosques, *suraus,* bridges, etc. The pondok can also help to trace friends or relatives of the new migrants.

Another important function of the pondok is giving financial aid to members and their families in case of death. Thus it functions as a death and burial society (*khairat keramat*). The amount of financial aid varies from pondok to pondok. In the case of pondok palalongan, the bereaved family is given $50. For pondok Gunung Malang, in case of death of a members' child below 21, the financial aid for funeral expenses amounts to $20. If the member or his wife dies, the bereaved family is given $120. In the case of pondok beluar, the maximum amount of $70 or given of a member or his wife dies. If a son under 18 or a daughter under 21 dies, the bereaved family is given $50. The minimum amount of $35 is given in the case of death of member's father, mother, or in-law who was staying with members before death.[45]

Besides Baweanese, the Javanese also have strong associations that seek to bring together Javanese who migrate to an urban area. It is stated in the earlier part of the paper that the Javanese have their own neighbourhood in the locality of Kampung Baharu. Javanese migration to Malaysia dated back as early as the Malacca period (1400-1511). It has been reported that Javanese labourers had been engaged in jobs that needed strength and skill such as the building of stockades.[46] Without going into details on the history of their migration from Indonesia, suffice to say for the purpose of this paper that today they form an important element in the Malaysian population. Like other ethnic groups, the Javanese have also migrated to urban and suburban centres to avail themselves of the economic opportunities made possible by industrialization and economic expansion.

Conclusion and Discussion

Regarding the institution of *bomoh* in the first part of the paper, the cases highlight some interesting points. On the choice of treatment, it is evident from the cases above that urban Malays prefer to seek hospital or clinic treatment first in comparison to other treatments in treating their illnesses. In addition from my observation, this study also shows us that urban Malays are beginning to use biomedical terms such as stress, concept of diet, physiology, hormones, germs-concept in relation to the etiology of illness, and the knowledge of the different types of food based on biomedical models such as *khasiat* and *tidak khasiat* or carbohydrate, calcium, protein, acidic and vitamins

in describing several of their illness episodes. There are several factors that can be associated with this phenomenon.

The first is education. There are two important aspects relating to this. The first is the informants' educational background. This factor is significant for it has a great effect on one's perception, attitude and belief in understanding the different patterns of health, illness and health-seeking behaviour, especially the choice of treatment. The second factor is urban residents being exposed to plenty of information. They are able to gain knowledge and information from many different sources such as reading materials which a easily available in the market, attending seminars and talks, health educational programmes either via radio, television, or those organised by the urban health authorities at many different places within the Ipoh town for the urban dwellers. For all these reasons, in terms of education, urban residents have better exposure and opportunities to improve their knowledge on matters relating to health and illness.

The second is the doctor-patient relationship. Here, frequent contacts with medical doctors during medical consultation also influenced urban Malays in choosing the treatment. During the medical consultation, the doctors on duty, in some cases, who were also their close friends, not only prescribed the medication, but did also provide them with biomedical information pertaining to the illnesses suffered. On this account, terms such as carbohydrates, balanced diet, fats, pharmacy, germs-concept, food poisoning, food nutrients, and allergic, to name a few, and how these affected one's health were commonly used. Based on this factor, the ability to employ those terms in discussing various issues concerning health and illness was not surprising for urban Malays.

Apart from the above factors, several *ceramah*[47] by *ustaz*[48] in Kampung Ruban's mosque also played an important role in shaping the informants' attitude towards the choice of treatment. Evidence shows that one of the reasons for several informants not seeking a *bomoh's* treatment first is due to the belief that some of the village treatments are against Islamic teachings. Some of them were committee members of the mosque in Kampung Ruban. They attended several *ceramah* held in the mosque which led them to believe certain issues were against Islamic teachings. They were told by the religious teachers or *imam*[49] in their *ceramah* for instance that seeking a *bomoh's* help with the assistance of any guardian spirits or other supernatural forces was against Islamic teachings. This included the use of non-Quranic verses for their *jampi serapah*, and a *berjamu*[50] ceremony. In the *berjamu* ceremony they had to prepare several items such as candles, saffron rice, eggs and coconut which to be presented before the spirits. These practices, according to *ustaz* and *imam*, were against Islamic teachings. On this belief, in many illness episodes such as diarrhoea, stress, headache, cuts, *pekang* and *sakit sendi-sendi tulang,* urban dwellers preferred to seek

private medical advice to alleviate their illnesses. So modern religious teaching is clearly influential in the urban context.

The other factor of equal importance is income. Income is considered an important factor in determining the patient's decision in seeking treatment. Prior to this decision what influence the urban Malays to opt for a particular treatment over the other is their perceptions between private and government hospitals or clinics. On the whole, urban residents perceive that there is a great difference between private and government hospitals or clinics. They perceive that private hospitals or clinics provide better medical facilities and care compared to the government hospitals or clinics. In addition they are also very much aware—based on the knowledge and information of the illness suffered—the significance of getting treatment without delay. They do not adopt a wait-and-see attitude. Several informants were willing to spend a large percentage of their incomes for private medical health services. After all many urban residents have means to do so.

Aside from income, the other factor which influences the usage of health services in the urban area is the actual location of the health services. In an urban centre like Ipoh, patients in Kampung Ruban have easy access to all medical facilities allocated to them. The facilities provided by either the government or private health services are located within four km of their residential areas and good public transport makes these facilities easily accessible. This makes them more inclined towards selecting private clinic or hospital medication in comparison to other treatments available in the urban areas. For the urban Malays of Kampung Ruban, the private clinic was located just within a walking distance. For all these reasons, they prefer to seek treatment at the private clinic first prior to other treatments like *ubat kedai*, village medical treatments such as herbal remedies, village ointment, and massage treatment. In some cases, patients of Kampung Ruban move from a private clinic to another private physician seeking either a second opinion or medicine to effect the cure. In other words, they keep searching until they find the right medicine as they often say, *ubat yang serasi*[51] in treating their illnesses. However, if the medication does not work, then the option is to seek village medical treatment. This does not often occur, however.

It is also evident from the above cases that the choice of practitioner and treatment frequently depends on the duration and the nature of the illness itself. Patients in the urban areas believe that the longer the illness persists, the higher the probability that they will move from one medical system to another searching for an appropriate treatment in response to the illness. This includes illnesses like hypertension, diabetes, asthma, stroke, and knee pain. In some cases, patients also believe that the longer the illness persists, the higher the probability their symptoms are attributable to supernatural cause.

Finally, another point which needs to be noted is that the informant's social interaction is not confined to members of the same neighbourhood and of the same ethnic groups but also with other urban residents from different ethnic groups like Chinese and Indians. What matters here is the way in which the knowledge and experience are transferred from one particular ethnic group to the other. The possibility of this is higher among the urban residents in comparison with those living in the rural areas. This helps us understand the exchange and the transformation of knowledge from other ethnic group into the Malay world-view about health and illness and vice versa. I am not denying such possibilities among rural residents, but the opportunity for such interaction is limited. In most cases, for rural residents, the social interactions are mostly within and confined within the same village and to the same ethnic group.

The second part of the paper, looked at from one point of view, the existence of ethnic association as discussed above it appears to us that there is ethnic separation in so far as these associations are concerned. This may be an anti thesis to the effort of the authority to bring about integration among the ethnic groups concerned. However, from another perspective, these associations serve to provide services to their members especially in solving problems relating to their welfare and thus provide a cushion in reducing the shock of urban life and the problems of anonymity in the urban situation.

There is some kind of an urge to join these ethnic associations among the ethnic groups concerned. More of the informants interviewed never became members of any such associations before they migrated to the city. One of the Baweanese informants even said that such ethnic associations never existed in their country of origin. It has been emphasized that these ethnic associations may help to reduce the problem of anonymity. The formation of ethnic associations and maintenance of traditional institution such as the institution of *Bomoh* help to recreate rural life in the case of ethnic association. The frequent meetings, both formal and informal also help members to solicit one another for psychological comfort.

Notes

[1] A traditional Malay healer.
[2] Fever due to spirits interference.
[3] *Guardian-spirit.*
[4] Poisoning.
[5] Malaysia in this particular study refers to those living in Peninsular Malaysia only.
[6] The urban bias approach in relation to the provision of hospital health facilities in both rural and urban areas respectively will not be discussed in this paper.
[7] H.K. Heggenhougen, "Bomohs, Doctors and Sinsehs-Medical Pluralism in Malaysia." *Social Science and Medicine* 14B: 235-244, 1980.
[8] Village medicine.
[9] C.Y. Chen, Paul. "Indigenous Concepts of Causation and Methods of Prevention of Childhood Diseases in a Rural Malay Community." *Journal of Tropical Pediatrics* 16:33-42, 1970, 1973, 1975, 1981; Abdul Halin Hamid "Culture and Health Innovation: A Study of Persistence in the Use of Bidan Kampung in Rural Malaysia." Ph.D dissertation. Cornell University, 1983; Colson, Anthony 1969. "The Prevention of Illness in a Malay Village: An Analysis of Concepts and Behavior." Ph.D dissertation. Stanford University; Manderson, Lenore 1981. "Traditional Food Beliefs and Critical Life Events in Peninsular Malaysia." *Social Science Information* 20(6): 947-975, and Provencher, Ronald 1986. "Orality as a Pattern of Symbolism in Malay Psychiatry." In Becker, A.L., and Yengoyan, Aram A. (eds.) *The Imagination of Reality—Essays in Southeast Asian Coherence Systems*, 43-53. New Jersey: Ablex Publishing Company.
[10] Abdul Majid Ismail "The History of Early Medical and Health Services in Malaysia." *Malaysia in History* 27(2):6-15, 1974; Leng, Chee Heng 1982. "Health Status and the Development of Health Services in a Colonial State: The Case of British Malaya." *International Journal of Health Services* 12(3): 397-417; Ooi, Giok Ling 1993. "Health Care Development and Ethnic Medicine in Malaysia." *Third World Planning Review* 15(3): 273-286 and Parmer, J. Norman 1989. "Health and Health Services in British Malaya in the 1920s." *Modern Asian Studies* 23(1):49-71.
[11] Just before Independence.
[12] Rural clinics in this particular example include *klinik desa* and midwife clinics.
[13] Dispensary services, village health teams, flying doctor services and mobile dental services.
[14] Government of Malaysia 1996. *Seventh Malaysia Plan 1996-2000*. Kuala Lumpur: Percetakan Nasional Malaysia Berhad.
[15] Prohibitions.
[16] H.K. Heggenhougen, *Op. Cit*, 1980a and1980b. "The Utilization of Traditional Medicine-A Malaysian Example." *Social Science and Medicine* 14B:39-44.
[17] Laderman, Carol. "Symbolic and Empirical Reality: A New Approach to the Analysis of Food Avoidances." *American Ethnologist* 8:468-493, 1981, 1984, 1987a, 1987b, 1991 and Manderson, Lenore, *Op. Cit.*, 1981 and1987a. "Health Services and the Legitimation of the Colonial State: British Malaya 1786-1941." *International Journal of Health Services* 17(1): 91-112.
[18] Ibid, pp. 477–480.
[19] Ibid, p. 179.
[20] Manderson, Lenore, *Op. Cit.*, p. 963
[21] In terms of taking medications, following diets, or executing lifestyle changes
[22] Hunt, Linda M., *et al.*, 1989a. "Compliance and the Patient's Perspective: Controlling Symptoms in Everyday Life." *Culture, Medicine, and Psychiatry* 13(3): 315-334.
[23] Conrad, Peter 1985. "The Meaning of Medications: Another Look at Compliance." *Social Science and Medicine* 20(1): 29-37.
[24] Ibid, pp. 31-37.

[25] Traditional and transitional.
[26] An injury to the skeleton or muscle system.
[27] A traditional masseur.
[28] R. Quah, Stell "Accessibility of Modern and Traditional Health Services in Singapore." *Social Science and Medicine* 11: 333-340, 1977.
[29] N. Lasker, Judith "Choosing among Therapies: Illness Behavior in the Ivory Coast." *Social Science and Medicine* 15A:157-168, 1981.
[30] H. Kurata, John, *et al.*, "A Comparative Study of Patient Satisfaction with Health Care in Japan and the United States." *Social Science and Medicine* 39(8): 1069-1076, 1994.
[31] Frankenberg, Ronald 1980. "Medical Anthropology and Development: A Theoretical Perspective." *Social Science and Medicine* 14B: 197-207.
[32] The research for urban Malays was undertaken in a Malay urban-village or neighbourhood known as Kampung Ruban (pseudonym), and is located within the Ipoh Municipal area. The neighbourhood is four kilometres away from Ipoh, an urban centre and also the capital state of Perak.
[33] My field research in Kampung Ruban began in October 1996, and lasted for a period of 7 months till April 1997. Twenty households were selected for this study, and became my source of reference when analysing the data gathered during my fieldwork.
[34] Health Services: G: Government Health Services or P: Private Health Services.
[35] Choice of Treatment: Mrx:Hospital or Clinic Treatment or TRx:Village Treatment.
[36] White radish.
[37] Difficulty in urinating.
[38] The term agricultural here may be deceiving. One who goes to Kg. Baharu will not see any paddyfields and other signs of Malay agriculture. On the contrary the area is full of Malay houses and shop houses. Old life-Malay wooden houses can still be found interspersed with modern brick house. Modern brick houses belong to the more affluent Malays in the community. The term 'agriculture' must have something to do with the efforts of the early administrators to develop the area for agricultural purposes.
[39] Swampy/village.
[40] R. Redfield, "The Folk Society." *The American Journal of Sociology* LII(4), 1947.
[41] Johor Malay Association.
[42] Malacca Malay association.
[43] Roff on the Organization and Purpose of Bawean pandok in Singapore, 1967:179-180.
[44] Abdullah Al-Hadi on the organization and function of Bawean Pondok in Kampung Datuk Keramat, 1979.
[45] Abdullah Al-Hadi 1979. "Pondok Sebagai Satu Pernyataan Identiti Etnik Orang-Orang Bawean: Satu Kajian Kes Di Kampung Datuk Keramat, Kuala Lumpur." B.A. thesis. University Kebangsaan Malaysia, Kuala Lumpur.
[46] Gullick, J.M. 1955. "Kuala Lumpur 1890-1895." *Journal of the Malayan Branch Royal Asiatic Society* 28(4).
[47] Religious talks.
[48] Religious teacher.
[49] Religious leader.
[50] A ceremony that required a patient to propitiate the spirits.
[51] Appropriate medicines.