KNOWLEDGE, ATTITUDE AND PRACTICES (KAP) OF MODERNISED INDIGENOUS PEOPLE TOWARDS MINOR ILLNESS IN BANTING, MALAYSIA.

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DECLARATION

(Thesis written in English)

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person.

I hereby declare that the work in this thesis is my own except for quotations and summaries which have been duly acknowledged.

The work was done under the guidance of supervisor (Miss Leong Siew Lian) at Cyberjaya College University of Medical Sciences, CUCMS.

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ABSTRACT

Minor illness although it may be seen as common, it has been a major challenge to the health of society especially amongst the indigenous population. Traditionally, like most indigenous communities, the Orang Asli perceived minor illness as harmless and it is always spiritual-related. Their willingness to accept the scientific information and modern medical management on minor illness has been doubtful though the government has provided convenient healthcare services, free education and mass media exposures. Thus, there is a need of updated data which can be done by a knowledge, attitude and practice (KAP) survey. This research study targets on three Orang Asli resettlements in Banting with a total sample size of 103 respondents, recruited using convenient sampling. Study finds that 43.7% of respondents scored good level of knowledge by questioning on the curability, risk of acquiring, causes, ways of transmission, various preventive measures and methods of treatment of minor illness. Study has found that 47.6% have positive attitude predisposition towards minor illness with 94.2% will go for modern treatment if it is free and harmless. They practise both traditional and conventional medicines equally with 96.1% of the respondents visited a hospital or clinic at least once due to a minor illness. 95.2% has ranked government hospital as their priority visit places if sick. Significant association ($p < 0.05$) are found among their levels of knowledge with gender, educational status and preventive measures practice. Generally, a majority of the indigenous people have a moderate KAP towards minor illness with significant number of respondents who tend to pay extra attention towards it. Further government efforts to promote awareness to the community are necessary to instil a better cognition on minor illness.

ABSTRAK

Penyakit ringan walaupun dilihat sebagai perkara yang biasa, ia boleh memberi cabaran yang besar kepada kesihatan masyarakat terutamanya dalam kalangan pendudukan peribumi. Secara tradisinya, seperti kebanyakan komuniti peribumi, Orang Asli menganggap penyakit ringan sebagai sesuatu yang tidak berbahaya malah sentiasa mengaitkannya dengan roh jahat. Kesanggupan mereka untuk menerima maklumat saintifik dan perubatan moden pada penyakit ringan sentiasa diragui walaupun kerajaan telah menyediakan perkhidmatan kesihatan yang mudah, pendidikan percuma dan pendedahan media massa. Oleh itu, kita memerlukan kajian yang berkaitan dengan pengetahuan, sikap dan amalan untuk mengumpul maklumat atau data yang terkemas kini. Kajian penyelidikan in mensasarkan tiga perkampungan Orang Asli yang baru di Banting dengan saiz sampel sebanyak 103 responden, telah dikumpulkan secara persampelan mudah. Kajian ini mendapati bahawa 43.7% responden mendapat skor tahap pengetahuan yang baik dengan mempersoalkan hal-hal megenai degan kesembuhan, risiko-risiko, sebab-sebab, langkah-langkah pencegahan dan kaedah-kaedah rawatan penyakit ringan. 47.6% daripada mereka mempunyai kecenderungan sikap yang positif terhadap penyakit ringan dengan 94.2% bersetuju akan menerima rawatan moden jika ia adalah percuma dan tidak membahayakan. Mereka mengamalkan perubatan tradisional dan konvensional secara seimbang dengan 96.1% daripada mereka pernah mengunjungi hospital atau klinik disebabkan oleh penyakit ringan sekurang-kurangnya sekali. 95.2% telah memilih hospital kerajaan sebagai tempat rawatan utama. Hubungan yang signifikan ($p < 0.05$) telah didapati antara tahap pengetahuan mereka dengan jantina, taraf pendidikan, sikap dan amalan pencegahan. Secara umumnya, majoriti Orang Asli dikatakan telah memperolehi KAP yang sederhana terhadap penyakit ringan dengan sebilangan besar responden bermula untuk memberikan perhatian terhadapnya. Pihak kerajaan perlu meningkatkan tahap kesedaran dalam kalangan masyarakat secara aktif.

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LIST OF ABRREVIATIONS

IWGIA	International Work Group for Indigenous Affairs
JAKOA	Jabatan Kemajuan Orang Asli
JKOAM	Jaringan Kampung Orang Asli Malaysia
KAP	Knowledge, Attitude and Practices
JHEOA	Jabatan Hal Ehwal Orang Asli
NHS	National Health Servive
STH	Soil-transmitted helminthic
TB	Tuberculosis
UNSDN	United Nations Social Development Network
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 INTRODUCTION TO RESEARCH TITLE

1.1.1 KNOWLEDGE, ATTITUDE AND PRACTICE REVIEW

A knowledge, attitude and practice (KAP) survey is a representative study of a specified population in order to assess the extent and collect information on range of one's understanding, positive, negative or neutral attitude and action or a behaviour with regard to a particular topic – in this case minor illness (WHO, 2008). KAP surveys have been widely used to gather information for planning public health programmes in countries over the Nation (Launiala, 2009).

As noticed, studies on minor illness in worldwide have always been on the diseases themselves – diagnosis, signs and symptoms, preventive measures and treatment. Hardly any study has been done on the knowledge, attitudes and practices aspects of the minor illness amongst Orang Asli. Henceforth, a KAP study would best complement this unexplored area of research. Indigenous people's knowledge, attitudes and practices regarding minor illness have a strong influence on their decision to seek treatment, health care, modern medicines, etc. The influences could be positive, negative or neutral and have an ultimate impact on the success of the health programs implemented in the community. Again there is increasing recognition within the international aid community that improving the health of indigenous people across the world depends upon adequate understanding of the socio-cultural and economic aspects of the context in which public health programmes are implemented (Launiala, 2009).

It is presumed there is an *a prior hypothesis* that the modernised Orang Asli settlement in Malaysia is a community of indigenous population in the state of transition from the traditional health paradigm to the modern one. There is always resistance to change in this process with regard to modern style of healthy living (Chee et al., 2010). The Malaysian government, through its Jabatan Orang Asli, has been the main assertive authority in this hurried communal modernisation and transformation process – the work is piece meal, paying minimal attention to the necessity of a gradual absorption by creating community-owned solutions. The Orang Asli's were "forced" out of their tribal homeland for economic and political reason and kept in non-sustainable settlements as if by decree (Bear, 2006). Medical practice is enforced for good in the community but the knowledge, attitude and practice suffer a cultural shock to meet this sudden change into contemporary civilized people.

According to United Nations Social Development Network (UNSDN), in one of its postings: Development and Indigenous Peoples: Creating Community-owned Solutions, Posted by UNSDN on August 14, 2013, it is said:

"Perhaps the most well-worn clichéin the field of development is the saying "Give a man a fish, and you feed him for a day; show him how to catch fish, and you feed him for a lifetime."

Experts come in and 'teach' the Orang Asli community how to find solutions to their minor illness problems, remove their taboos and change for their own good. This would be perfectly acceptable if these ideas were then appropriated absorbed by the community, adapted to their aims and aspirations, institutions and customs (taboos), to become community owned health solutions. However, these expert-led, top-down approaches normally from the governmental bodies often leave very little opportunity for Orang Asli communities to speak up and demonstrate that the best solutions often come from within the Orang Asli communities themselves.

From this standpoint, our research team will design a survey and program of implementation that takes into consideration to provide opportunities for this appropriation (absorption) by encouraging them to speak out aloud during the one-on-one, friendly and participative interviews over a period. It is hope that all the information, data gathered and the report from this KAP survey would become useful reference or support for medical, psychological and social workers who wish to help the indigenous population in future.

1.1.2 INDIGENOUS PEOPLE OF MALAYSIA REVIEW: CONCEPTS AND FACTS

There are an estimated 370 million indigenous people living in more than 70 countries worldwide (WHO, 2013). The indigenous people of Malaysia represent around 12% of the 28.6 million people in Malaysia (IWGIA, 2011). Orang Asli (aborigines) are the indigenous people of Peninsular Malaysia. There are three main groups of Orang Asli (Negrito, Senoi and Proto-Malay) with each group comprising 6 sub-groups with ethno-linguistic differences (JHEOA, 1997).

One of the most cited descriptions of the concept of the indigenous population was given by Martinez Cobo J. R., the Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities, in his famous Study on the Problem of Discrimination against Indigenous Populations (2004). "Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories." This historical continuity may consist of the continuation of culture such as religion, living under a tribal system, costumes and language whether used as the only language, as mother-tongue, as the habitual means of communication at home or in the family.

Although the indigenous population represents a rich diversity of cultures and traditions yet they continue to be among the world's poorest and commonly neglected community to receive the benefits of modern medications (WHO, 2013). The health status of indigenous peoples varies significantly from that of non-indigenous population groups in countries all over the world (WHO, 2007). Another excuse for poor indigenous people healthcare is that many of them live in hills or remote area and partially isolated from the town, the chance to get clinical health service is low (Baer, 2006).

However, after independence, Orang Asli in Malaysia are progressively moved into small quarters on bulldozed tracts with scant access to areas for foraging, fishing, or even gardening, but with more or less empty or conditional promises of modern infrastructure delivery. New-village medical clinics may indeed be built but too often no doctor or nurse is ever seen there at the pre-colonial state (Baer, 2006). Conditions are improving as whole as time goes by. They are becoming modernised indigenous people.

The specified population of this study is the modernised indigenous population (urban) which does not include those living in rural area. According to Moore's conceptualization 1963, this process of modernisation is a 'total' transformation of a traditional or pre-model society into the types of technology and associated social organisation provided with government support that is economically prosperous and relatively politically stable (Finkler, 1996). Modernisation also resulted in the introduction of western medicine that gradually replaces traditional medicine practices (Ong *et al.*, 2011). The modernised indigenous population selected in this study is the Temuan in the Banting Orang Asli settlement consists of Orang Asli who have been exposed and influenced by the modern living and culture, and have partially adopted in degree or even fully practice this modern culture.

1.1.3 MINOR ILLNESS REVIEW: THE FACTS, CONCEPTS AND PRACTICES ON ILLNESS AND DISEASE

A clear distinction between the phrases “illnesses” and “diseases” is that: patients suffer “illnesses”; doctors diagnose and treat “diseases”. In the physiology point of view “illnesses are experiences of discontinuities in states of being and perceived role performances; diseases, in the scientific paradigm of modern medicine, are abnormalities in the function and/or structure of body organs and systems” (Eisenberg, 1977).

Yet illnesses remain a chronic problem amongst these indigenous people. Of course everyone in the world is at risk of acquiring minor illness regardless of age, gender, religion and social economic status. So does the indigenous people. Traditionally, as social norm, when an Orang Asli suffered a minor illness evoked no general concern as they were considered to be harmless, since the victims could still function normally (Chee *et al.*, 2010).

Like most traditional communities, the Orang Asli have long perceived disease as being the result of a spirit attack, or of the patient’s soul being detached and lost somewhere in this world or in the supernatural world (Gianno, 1986). This is opposing with the biological concept of minor illness which it is a medical classification for a number of clinical problems and conditions whereby the illness is i) self-treated with herbs, with or without conventional medication, ii) uncomplicated iii) and does not prevent the patient from carrying out their normal functions for more than a short period of time. Hospitalisation is usually not required for such minor illness. The common examples of minor illnesses included fever, cough, cold, sore throat, headache, diarrhoea, parasitic worm infection, head lice infestation, and ear problem (Edwards *et al.*, 2002).

The Orang Asli also believes that such minor illness is better treated by incantations and ritual, than by modern medical practices. Treatment is usually given through healing ceremonies, coordinated by one or more shamans and invariably involving the whole community. Again, as opposed to the biological concept of disease, the Orang Asli concept of illness is culture-specific (Kleinman, 1973); healing is often a community effort (Chee *et al.*, 2010).

They always have doubts and resistances, and not too willing to accept the modern-medicine. Although the government have developed a significant amount of healthcare services centres on their settlements. The Orang Asli health care services are recently made up of 125 treatment centres with designated locations where a mobile clinic visits periodically, 20 transit centres to allocate the patients and allows accompanying persons being housed while waiting to be transferred to a hospital for treatment and 10 health clinics (JHEOA, 2005). It was thought that the transit centre would encourage Orang Asli to seek treatment at the hospital, as it was believed that their primary fear was leaving their familiar forest surroundings and their families (Harrison, 2001).

1.2 LITERATURE REVIEW

A review of the literatures sourced from journals, electronic publication, public libraries, government departments such as JHEOA, social media and various international sources such as WHO, IWGIA and UNSDN were carried out in this research study. Below is a review of the literatures:

1.2.1 MINOR ILLNESS REVIEW: PARASITIC DISEASES

A study on a total of 1699 deaths in children under the age of five (aged 28 to 1824 days, excluded neonates) amongst the Malays, the non-citizens and other Malaysians (mainly Orang Asli, Bumiputera Sabah and Sarawak) in the year of 2006 was done by the Ministry of Health, Kuala Lumpur, Malaysia. It is reported that "certain infectious and parasitic diseases are among the second highest causes of deaths (18.8%)" (Wong *et al.*, 2008).

"Intestinal parasitic infections are distributed throughout the world, with high prevalence in poor and socio-economically deprived community especially among rural Orang Asli" (Norhayati *et al.*, 2003). A cross-sectional study of the prevalence and distribution of soil-transmitted-helminthic (STH) was conducted among 281 Orang Asli children (aborigines) aged between 2 and 15 years, from 8 Orang Asli villages in Selangor illustrated that "the overall prevalence of *A. lumbricoides, T. trichiura* and hookworm were 61.9%, 98.2% and 37.0%, respectively" (Al-Mekhlafi *et al.*, 2006).

Although the study showed high incident of indigenous people getting parasitic infection regardless of whether they are living in rural or urbanized areas, but according to one KAP which was carried out among 215 households from 13 villages in Lipis district, Pahang, Malaysia revealed that a high overall of "61.4% of the participants had prior knowledge about intestinal parasites but with a lack of knowledge on the transmission (28.8%), signs and symptoms (29.3%) as well as the prevention (16.3%)" (Nasr *et al.*, 2013). The conclusion drawn from this study indicated that indigenous population know about this disease but only surface knowledge.

1.2.2 MINOR ILLNESS REVIEW: DIARRHOEA

Again a similar study stated that "by taking Malay as the reference group, children in the Orang Asli ethnic group had 8.7 times higher risk of dying from diarrhoea" (Wong et al., 2008). It is well to emphasize here that most Orang Asli lack food security (Zalilah and Tham, 2002). With the majority of them living below the poverty line, their narrow margin of survival makes the Orang Asli's health situation precarious.

In, addition, there is one old KAP study on a typical minor illness (diarrhoeal disease) been conducted by a group of researchers on Australian Aboriginal Community in South Australia entitled "Diarrhoeal Disease: Knowledge, Attitudes and Practices in an Aboriginal Community". This study emphasized that diarrhoea without abdominal pain in aboriginal community is not considered serious enough to arouse medical treatment. In addition, low cognition regarding diarrhoea disease was found out with 51.7% did not know what is it about, 41.4% considered it to be an illness with abdominal pain and loose bowel actions and 6.9% said it was loose bowel actions alone. Therefore it is proposed that the community should be actively involved in designing, implementing and evaluating future interventions (Ratnaike *et al.*, 1988). Note that this study is in South Australia and not Malaysia. A KAP questionnaire is needed to confirm that whether the Orang Asli community in Malaysia perceived diarrhoea as a major problem.

1.2.3 PROBLEM STATEMENT

Notably, recent studies on indigenous population continue to focus on the occurrence of the minor illness itself and relate the causes without detailed investigation. Seldom KAP studies were conducted as a whole to include major minor illness that commonly attacked the community. Figuratively speaking, the symptoms caused by this minor illness, mostly parasitic and diarrhoea ranged from mild discomfort to death. If these diseases are not treated for a prolonged period of time, it may possibly spread to the whole village with disastrous impact.

Judging from the impact of modernisation due to their exposure to various media masses, western medicine, social and environmental factors we may now suppose that they reasonably possess an acceptable knowledge and understanding of minor illness. But how indigenous people react to such minor illness will depend on new research studies. It is a matter of time that modern knowledge, attitude and practice become nurtured into the indigenous population's second nature especially in the younger generation. When this transformation is complete perhaps their old taboos will be gone for good.

For decades the Malaysia government has been much concern about the well-being of the Orang Asli in the country. Yet in certain specification areas there are no studies which have been done on these indigenous people responses to KAP indicators. These responses are much needed for the government's strategic and policy making, and the implementation plans for betterment of the Orang Asli community. The need is there but the primary data are not available – a critical issue needs to be addressed here. So our KAP study is expected to provide a solution to this problem.

1.3 JUSTIFICATION

It is unfortunate that no major steps have been taken to promote awareness and precautionary attitude in the community with regards to minor illness despite the ostensible burden of disease (Chee *et al.*, 2010). This is probably due to a lack of baseline data on knowledge, attitudes and practices (KAP) of the population regarding minor illness of the indigenous population on modernised settlement in Malaysia. Insufficient research has been done locally on this topic so far.

Therefore, there is a need for more information and updated data regarding this KAP data baseline. This KAP study outcome can justify further planning in health intervention and education program implementation in the country to enhance prevention and instil better knowledge on minor illness. Specifically, the study will definitely be useful as it gives an insight about the KAP of the Banting's indigenous population towards minor illness.

1.4 OBJECTIVES

1.4.1 GENERAL OBJECTIVE

The general objective of this study is to evaluate the overall levels of knowledge, attitude and practice (KAP) of modernised indigenous population in Banting, Selangor towards minor illness.

1.5.2 SPECIFIC OBJECTIVE

The specific objectives in this study are:

a. To assess the level of knowledge of modernised indigenous people towards minor illness
b. To assess the attitude of modernised indigenous people towards minor illness
c. To assess the practices of modernised indigenous people towards minor illness
d. To determine the associations between the levels of knowledge and practice of modernised indigenous people with various variables

CHAPTER II

METHODOLOGY

2.1 STUDY DESIGN

A descriptive cross-sectional study was used in this research study. A descriptive study is one in which information is collected without manipulating the environment. Cross-sectional study was chosen because the data can be gathered from indigenous population in Banting just once over a period of a few days.

2.2 DATA COLLECTION TOOL

The data collection tool employed was a reliable KAP questionnaire set validated by means of a pilot study conducted a Bukit Tadom. The first draft of questionnaire was prepared before the end of April 2013. Pilot study was conducted at Kampung Bukit Tadom, Banting, Malaysia on the date of 15th May, 2013 prior to the real researches days. The purpose of this pilot study done is to test the soundness of our questionnaires and the methodology. 10 respondents were chosen for this purpose. Second amendment had been made on the questionnaire afterward corrections to the understandable levels by the respondents.

The questionnaire was finalized and presented as simple as possible and in bi-lingual for ease of understanding (Appendix C and D). It comprises of four sections including three main components that sought the level of knowledge, attitude and practices of indigenous population from Banting towards minor illness. In addition, this questionnaire was designed with the adoption of three different scales from the article by Ahmed AM (2010) to assess the following KAP components.

Section A refers to the respondent's socio-demographic details. The examined demographics in this study included gender, age, ethnicity, religion, employment status, education levels and even types of minor illness encountered in lifetime and ways of transportation to the nearest health care service centre.

Section B assesses the extent of understanding towards minor illness in terms of disease acquiring, causes, transmissions, preventions and seriousness (Launiala, 2009). Closed-ended questions was utilised in this section. Each respondent was required to answer every option by "Yes", "No" or "Do not know". Marks were calculated based on the cumulative point's collection from provided 6 main questions which carry of a total of 24 marks (Ahmed *et al.*, 2010).

Section C assesses the general feelings and beliefs towards minor illness, which are either positive, neutral or negative (Launiala, 2009). A 3-point Likert scale was adopted for this section. The respondents were required to answer the provided 7 statements by "Agreeing", "Neutral" or "Disagreeing". Every positive answer was allocated with 3 marks, 2 marks for neutral and 1 marks for negative responses (Ahmed *et. al.*, 2010).

Lastly Section D assesses the use of different treatment and prevention options taken towards minor illness (Launiala, 2009). Rank-order scale was applied to this section. The respondents were required to rank multiple options provided as first (1^{st}), second (2^{nd}) or third (3^{rd}) according to their preferences (Ahmed *et al.*, 2010).

2.3 SAMPLING METHOD

The sampling method employed in this research is convenient sampling. This method was used based on the principle of "take them where you find them". Whenever a household was entered to conduct a friendly face-to-face interview, any of the family members (number may up to 20 respondents per each household) who meet the inclusive criteria of study were considered to be one of the members of participant. This principle was also applied for those participants that approach us or the interviewers personally.

2.4 RESEARCH SITE

This study was conducted on a targeted sample size of 103 modernised indigenous adults out of 140 adults (based on information provided by JAKOA) from a total of three Orang Asli's villages in Banting, Malaysia, namely, (i) Kampung Bukit Tadom, (ii) Kampung Paya Rumput and (iii) Kampung Mutus Tua. All the three villages are located within 1 kilometre away from each. Those villages were new resettlement area for the Orang Asli community from the sub-group of Proto-Malay, Temuan in Selagor (JHEOA, 1997).

The actual research study was conducted with approval from Jabatan Kemajuan Orang Asli Malaysia (JAKOA) on two consecutive weekends, dated 8^{th} and 9^{th} of Jun 2013 and again on the 15^{th} and 16^{th} of Jun 2013.

2.5 SAMPLE SIZE

A total of 103 modernised indigenous people out of 140 adults from three Orang Asli's villages in Banting were interviewed house by house with their consent and also with the approval letter from JAKOA. The 'Tok Batin' (leader of the village) or representatives from the Temuan villages were informed about this study and requested to guide us on the survey site. Measures were taken to persuade participants into answering this questionnaire voluntarily. A token of appreciation was given to the participants.

The sample size was calculated using a determination formula as stated by Cochran (1977) and it was showed below:

Sample size Calculation

$$N = Z^2 \times \frac{P(1-P)}{\varepsilon^2}$$

$$= 1.96^2 \frac{0.5\ (1-0.5)}{0.05^2}$$

=384.16 sample size

Where,

N = required sample size

Z = reliability coefficient at 95% confidence interval (standard value of 1.96)

P = percentage picking a choice, expressed as decimal (0.5 used for sample size needed)

ε = margin of error at 5% (standard value of 0.05)

However, this initial calculated sample size was too large which could not fit into our population of study site (only 140 adults in the village), thus we recalculated it into finite population.

Correction to finite population

$$n = \frac{no}{1 + [(no - 1)/N]}$$

$$= \frac{384.16}{1 + [(384.16 - 1) / 140)]}$$

$$\approx 103 \text{ respondents } +/- 10\%$$

$$\approx 113 \text{ respondents}$$

Where,

n = required sample size (corrected for a smaller population)

no = required sample size (for large population)

N = population size

In order to cover up the possible risk of respondents drop off half way, loss of data or inadequate of data filled-in, a plus minus of 10% is necessary to be included to allow the ease of exemption of incomplete sets of questionnaire answered by the respondents. Despite excess number of questionnaire's collection, only a total of 103 sets of questionnaire was ultimately be accepted and counted.

2.6 ETHICAL CONSIDERATION

A consent and clearance from indigenous people in Bukit Tadom, Paya Rumput and Mutus Tua, Banting was obtained with the permission & approval from Jabatan Kemajuan Orang Asli Malaysia (JAKOA). Any advice and guidance from JAKOA was followed.

The research team had always respected the rights of the Orang Asli when conducting the survey, be socially responsible and behave ethically and professionally.

2.7 INCLUSIVE CRITERIA

The inclusive criteria for this study were:

- Adults 18 of age and above
- Indigenous people living in Kampung Bukit Tadom, Kampung Paya Rumput and Kampung Mutus Tua, Banting.

Orang Asli from other states but staying permanently in above listed villages were considered as members of participant. In attempt to make this study feasible, an interpreter or an assistant from the Orang Asli Department of Selangor (could be the head of villages) was required for purpose of successful communication and to minimized probability of misunderstanding due to differential in cultures. As indicated in one study, Temuan of Malaysia spoke languages belonging to the Malayo Polynesian stock. Although it is closely related to the Malay language spoken today in southern and western Malaysia, the probability of miscommunication may persist (Dunn, 1972).

2.8 EXCLUSIVE CRITERIA

The exclusive criteria for this study were:

- Not willing to be a candidate
- Unable to communicate in English/ Malay/ Chinese.

Respondents who do not meet with any of the above requirements were excluded at the outset of the study.

2.9 RESEARCH PROJECT FLOW

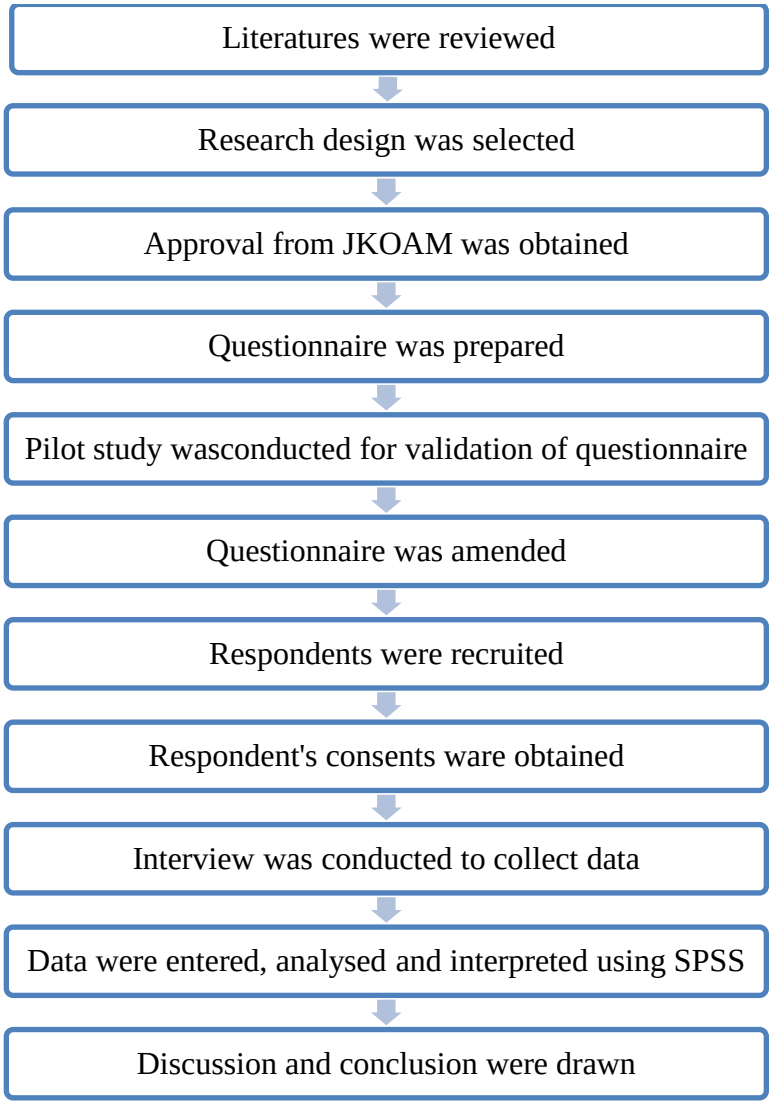


Figure 2.1 The flow of research project.

2.10 STATISTICAL ANALYSIS

All data collected were analysed using SPSS version 20.0 and a summary of the findings were drawn from analysing the data and information obtained. Continuous data was expressed as mean, median, mode, standard deviation, variance, using descriptive statistic, e.g. normal distribution. Categorical data was expressed as either percentage or frequency. Pearson-chi square or Fisher's exact test was utilised to draw association among categorical data.

CHAPTER III

RESULT

A total number of 104 sets of questionnaires have been adequately answered through face-to-face interview. One set of questionnaire is excluded due to incomplete data, failure of the respondent to adequately answer all the provided questions.

3.1 DEMOGRAPHICS AND BACKGROUND DATA OF RESPONDENTS

As shown in Table 3.1, female (67%, n=69) are more than male respondents (33%, n=34) in the three Orang Asli villages in Banting. Among them, 79.6% (n=82) are married, 14.6% (n=15) are single, remainder are either widow (n=5) or widower (n=1). All of the respondents being questioned are from the ethnic Temuan, subgroup of Proto-Malay (JHEOA, 1997). 99% of respondents are animistic while only 1 respondent is Christian. Based on the evaluation of occupational, most of the respondents are unemployed with majority are housewives (42.7%, n=44), follow by self-employed with the occupation of palm fruit collectors or peasants or truck drivers (37.9%, n=39), employed of either factory's workers or contractors (14.6%, n=15) and lastly minority are pensioners (4.9%, n=5). In general, their educational level is moderate with only 7 respondents never attended any formal schooling, mostly (47.6%, n=49) have attended primary school education, about half (43.7%, n=45) have managed to complete secondary school while 2 respondents went to higher education of either professional or post-graduate.

The most common transportation utilised by them to the adjacent healthcare service centre are motorcycle (67.0%, n=69) and followed by car (27.2%, n=28). Some of them (3.9%, n=4) choose to walk if no any transportation is available. Only 2 respondents cycle to the nearest clinic. None of them have chosen bus or boat. When asked upon their cost of transportation, only about one tenth of the respondents (12.6%, n=13) claimed their transportation cost of any kind to the nearest health care services is expensive.

Table 3.1 Distribution of respondents based on socio-demography.

Socio-Demography	N = 103 Respondents	
	Frequency	Percentage (%)
Gender		
Male	34	33.0
Female	69	67.0
Marital status		
Married	82	79.6
Single	15	14.6
Widow/Widower	6	5.8
Ethnic		
Temuan	103	100.0
Religion		
Animism	102	99.0
Christian	1	1.0
Occupation		
Self employed	39	37.9
Employed	15	14.6
Unemployed	44	42.7
Retired	5	4.9
Education		
None	7	6.8
Primary school	49	47.6
Secondary school	45	43.7
Tertiary institution	2	1.9
Mode of transportation to the nearest health care service centre		
Motorcycle	69	67.0
Car	28	27.2
Walking	4	3.9
Bicycle	2	1.9
Cost of transportation		
Expensive	13	12.6
Not expensive	90	87.4

According to Figure 3.1 the mean age and standard deviation (± SD) of respondents is 38.7 (± 14.5). The overall age of the respondents that participated in this research study ranged from the youngest adolescence of 18 years old to the geriatric age of 88 years old.

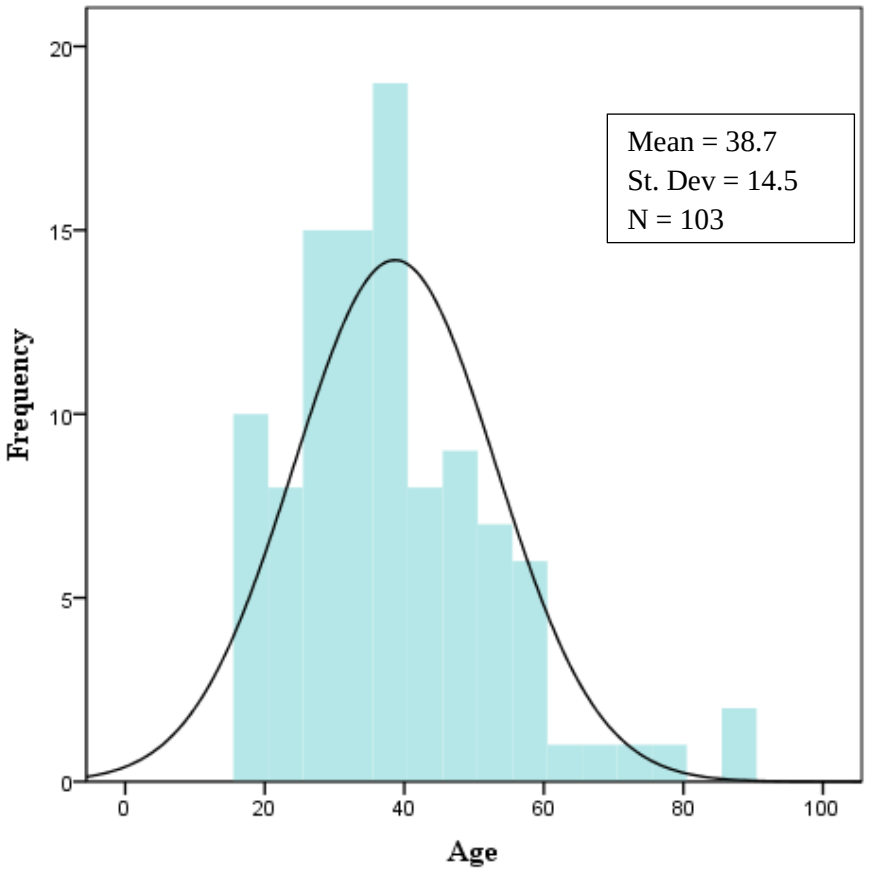


Figure 3.1 Distribution of respondents based on age.

The finding from Table 3.2 shows that cough (97.1%), fever (94.2%), cold (92.2%), headache (88.3%), sore throat (83.5%) and diarrhoea (67.0%) are the chief types of minor illness encountered amongst the indigenous people, whereas intestinal parasitic worm (43.7%) are less common, head lice (33.0%) and ear problem (16.5%) are the least common.

Table 3.2 Distribution of minor illness encountered by respondents in their lifetime.

Minor Illness Encountered	N = 101 respondents	
	Frequency	Percentage (%)
Fever	97	94.2
Cough	100	97.1
Cold	95	92.2
Sore throat	86	83.5
Headache	91	88.3
Diarrhoea	69	67.0
Head lice	34	33.0
Intestinal parasitic worm	45	43.7
Ear problem (Itchy/pain/purulent)	17	16.5

Note: [a] 2 respondents had never experience any of the above minor illness.

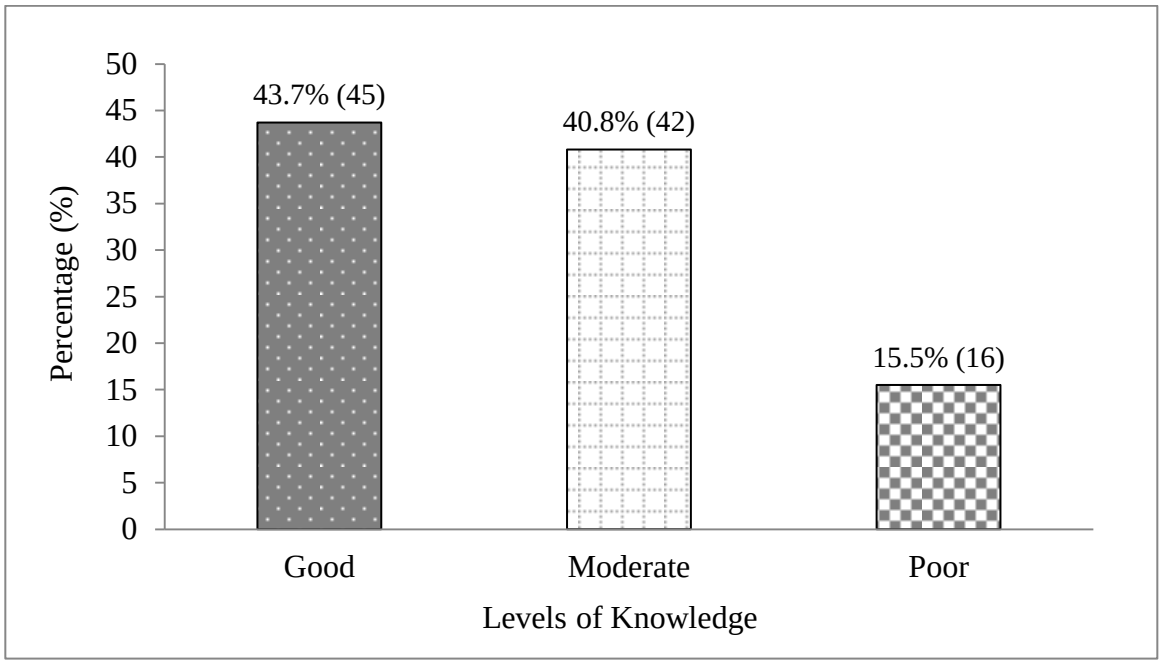
3.2 KNOWLEDGE ON MINOR ILLNESS

Overall Levels of Knowledge Towards Minor Illness

This knowledge study section comprises 6 main questions with its respective options. The overall levels of knowledge are categorized into three main groups based on the cumulative marks obtain from 6 main questions that carry a total of 24 marks. 1 mark is allocated for every right answer while no mark will be given to wrong and unknown answer.

The ranges of the levels of knowledge are distributed using percentages as indicators (0-49%=Poor, 50-74%=Moderate and 75-100%=Good). This analysis method is adopted from the article by Ahmed *et al.* (2010) and is applied to our study to become poor (0-11 marks), moderate (12-17 marks) and good (18-24 marks) levels of knowledge with its respective score.

With regard to the knowledge, most respondents have heard of minor illness. Some are not familiar with the phrase ‘penyakit ringan’ but they are clearer after being brief with given examples by the interviewer. Figure 3.2 reveals that very few number of respondents (15.5%, n=16) have no prior knowledge on minor illness. Generally, almost half of them (43.7%, n=45) displayed being aware of various types of minor illness based on their good score. Two fifth of the respondents (40.8%, n=42) have moderate score on it.



Note: [a] n = 103 respondents

Figure 3.2 Distribution of respondents with regard to the overall level of knowledge.

3.2.1 Curability of minor illness

Table 3.3 shows that almost all respondents (84.5%, n=87) have answered with confident that minor illness could be cured completely with the intake of medications, the remainder (6.8%, n=7) do not agree, while some (8.7%, n=9) have no idea about it.

3.2.2 Risk of acquiring minor illness

Study on the risk of acquiring (Table 3.3) has reveals that a high percentage of respondents (73.8%, n=76) knew that everyone is at risk of acquiring minor illness including themselves; some (16.5%, n=17) do not agree with the above statement. Only about one tenth of the respondents (9.7%, n=10) are uncertain of it.

Table 3.3 Distribution of respondents with regard to the curability and risk of acquiring of minor illness.

Statement	N = 103 respondents		
	Frequency (Percentage, %)		
	Yes	No	Do not know
A. Minor illness can be cured completely.	*87 (84.5%)	7 (6.8%)	9 (8.7%)
B. Everyone is at risk of acquiring minor illness including you.	*76 (73.8%)	17 (16.5%)	10 (9.7%)

Note: [a] All items marked with an asterisk * is allocated with 1 mark (indication of acceptable answer)

3.2.3 Causes of minor illness

Table 3.4 shows that when asked upon the causes of minor illness, lack of personal hygiene is the most answered option among the five choices which make up 85.4% of the respondents. Others are sedentary lifestyle (72.8%, n=75), poor diet (71.8%, n=74) followed by long-term exposure to agricultural chemicals (60.2%, n=62). Surprisingly, nearly half of the respondents (42.7%, n=62) have inappropriate perception that thought evil spirit as one of the cause of minor illness.

3.2.4 Prevention of minor illness

Table 3.4 has reveals that a majority of the respondents have knowledge of some preventive measures such as practice of good hygiene (91.3%, n=94), balanced diet (78.6%, n=81), exercise (76.7%, n=79) and taking herbs or traditional medicine (52.4%, n=54). However, nearly half of the respondents (48.5%, n=50) believe that good deed in life will be able to preclude them from getting minor illness.

3.2.5 Treatment of minor illness

Concerning the treatments of minor illness, it is found that almost all respondents (97.1%, n=100) have confidence and trust in conventional medications prescribed by clinic or hospital. Data shown only nearly half of the respondents (40.8%, n=42) are using herbs or traditional medications to treat minor illness. Predictably, 40 out of 103 respondents believe that “bomoh” is capable to heal minor illness.

Table 3.4 Distribution of respondents with regard to the causes, preventions and treatments of minor illness.

Statement	N = 103 respondents		
	Frequency (Percentage, %)		
	Yes	No	Do not know
C. Causes			
Lack of personal hygiene	*88 (85.4%)	8 (7.8%)	7 (6.8%)
Poor diet	*74 (71.8%)	15 (14.6%)	14 (13.6%)
Sedentary lifestyle	*75 (72.8%)	14 (13.6%)	14 (13.6%)
Long-term exposure to agricultural Chemicals	*62 (60.2%)	21 (20.4%)	20 (19.4%)
Evil spirit	44 (42.7%)	*40 (38.8%)	19 (18.4%)
D. Preventions			
Herbs or traditional medicines	*54 (52.4%)	11 (10.7%)	38 (36.9%)
Practice good hygiene	*94 (91.3%)	5 (4.9%)	4 (3.9%)
Balanced diet	*81 (78.6%)	14 (13.6%)	8 (7.8%)
Exercise	*79 (76.7%)	9 (8.7%)	15 (14.6%)
Good deed	50 (48.5%)	*35 (34.0%)	18 (17.5%)
E. Treatments			
Specific medication given by medical centre	*100 (97.1%)	3 (2.9%)	0 (0.0%)
Herbs or traditional medicine	*42 (40.8%)	17 (16.5%)	44 (42.7%)
Supernatural beliefs / Bomoh	40 (38.8%)	*45 (43.7%)	18 (17.5%)

Note: [a] All items marked with an asterisk * is allocated with 1 mark (indication of acceptable answer).

3.2.6 Transmission of minor illness

Table 3.5 shows that most of the respondents have answered correctly regarding cold (88.3%, n=91), cough (85.4%, n=88), head lice infestation (74.8%, n=77) and fever (73.8%, n=76) are transmissible among individuals through close contact. Data has recorded that 30 respondents believed headache is contagious; in fact, it is not. Concerning parasitic worm infection, only a quarter of them (25.2%, n=26) know it is spreadable to third party. More than half of the respondents (58.3%, n=60) know sore throat is transmissible if it is originated from infection by either virus or bacterial while 20.4% (n=21) respondents answered "no". Marks are allocated for both apposite answers (Edwards *et al.,* 2002). Regarding diarrhoea, a majority of respondents (43.7%, n= 45) have answered that it is transmissible among individuals while a quarter (33.0%, n=34) disagreed. In fact, both answers are acceptable in our study (Edwards *et al.,* 2002). Upon being interrogated on the causes of diarrhoea regardless which option they had chosen, their answer was solely accidental consumption of unhygienic food leading to food poisoning. The knowledge about transmission of ear problem shows only little information as 70.9% (n=73) of them uncertain on the answer. Among them, only 8.7% (n=9) answered "yes" while 20.4% (n=21) answered "no".

Table 3.5 Distribution of respondents with regard to the knowledge on transmissions of minor illness.

Statement	N = 103 respondents		
	Frequency (Percentage, %)		
	Yes	No	Do not know
F. Transmission			
Fever	*76 (73.8%)	12 (11.7%)	15 (14.6%)
Cough	*88 (85.4%)	7 (6.8%)	8 (7.8%)
Colds	*91 (88.3%)	4 (3.9%)	8 (7.8%)
Sore throat	*60 (58.3%)	*21 (20.4%)	22 (21.4%)
Headache	30 (29.1%)	*54 (52.4%)	19 (18.4%)
Diarrhoea	*45 (43.7%)	*34 (33.0%)	24 (23.3%)
Head lice	*77 (74.8%)	9 (8.7%)	17 (16.5%)
Intestinal parasitic worm	*26 (25.2%)	33 (32.0%)	44 (42.7%)
Ear problem (Itchy/pain/purulent)	*9 (8.7%)	*21 (20.4%)	73 (70.9%)

Note: [a] All items marked with an asterisk * is allocated with 1 mark (indication of acceptable answer).

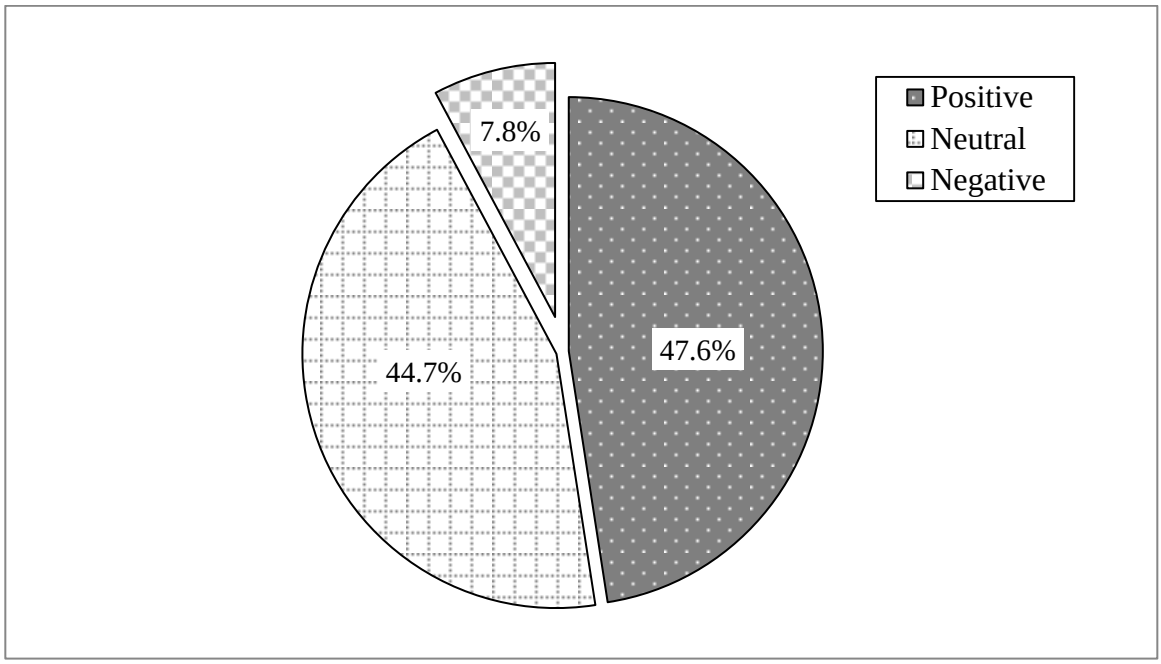
3.3 ATTITUDES ON MINOR ILLNESS

Overall Attitude Towards Minor Illness

This attitude study section comprises of 7 statements. The respondent is required to answer by agreeing, disagreeing or be neutral to each statement. Every positive answer is allocated with 3 marks, 2 marks for neutral and 1 marks for negative responses.

The attitudes section are distributed into 3 main groups based on the cumulative score by the respondents in which percentages is used as indicators (0-49%=Negative, 50-74%=Neutral and 75-100%=Positive). This analysis method is adopted from the article by Ahmed *et al.* (2010) and is applied to our study to become negative (7-<14 marks) neutral (14-<17.5 marks) and positive (>17.5-21 marks) attitudes towards minor illness with its respective score.

Figure 3.3 proposes in overall, a majority of the respondents (47.6%, n=49) are being analysed as possessing positive attitudes or perception toward minor illness while some (7.8%, n=8) are having negative attitudes. The remainder half are neutral (44.7%, n=46).

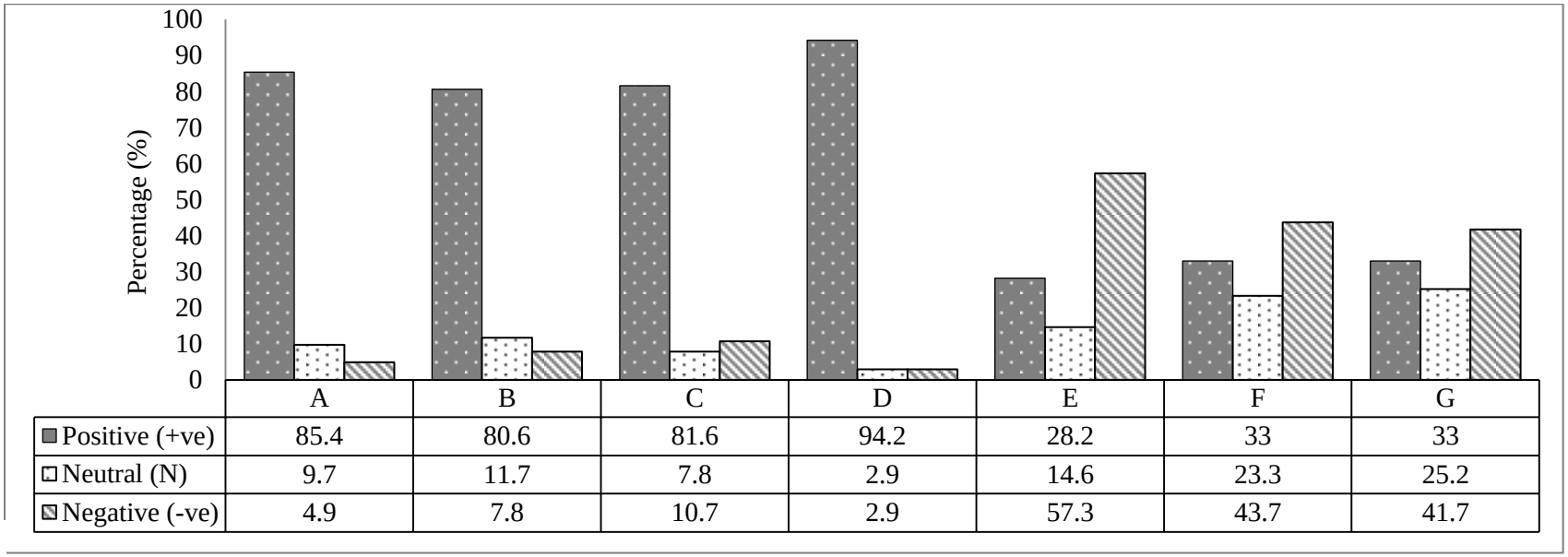


[a] n =103 respondents

Figure 3.3 Distribution of respondents in overall with regard to the positive, negative or neutral attitude toward minor illness.

3.3.1 Positive, neutral or neutral attitudes of respondents toward each attitude based statements

Figure 3.4 reveals that when asked upon if the government provides free consultation by western-trained-doctor, and proved no harm will they go for it? The answer is: 94.2% (n=97) of them agreed they will definitely go for it. Figure 3.4 also suggests that 85.4% of the respondents have agreed that the risk of acquiring minor illness could be reduced if preventive measure were taken. Noticeable, 57.3% (n=59) of the respondents thought that good deed able to reduce the risk of acquiring minor illness. Apart from this, it shows that 41.7% (n=43) of the respondents thought that minor illness can be cured more quickly if warded or being hospitalised. Amazingly, the sense of neglecting minor illness has greatly disappeared as majority of the respondents, 81.6% (n=84) are agreed with the statement that "minor illness can be a serious issue if left unattended." In addition, 80.6% (n=88) of the respondents have agreed that by giving extra attention, people with minor illness can be cured more quickly. Lastly, concerning the statement "minor illness cannot be cured completely because you are affected by it repeatedly", the data shows that 43.7% (n=45) of respondents are agreed with that.



	A	B	C	D	E	F	G
Positive (+ve)	85.4	80.6	81.6	94.2	28.2	33	33
Neutral (N)	9.7	11.7	7.8	2.9	14.6	23.3	25.2
Negative (-ve)	4.9	7.8	10.7	2.9	57.3	43.7	41.7

Note: [a] n = 103 respondents

[b] Every positive answer (Agreeing for A-D; Disagreeing for E-G) is allocated with 3 marks, 2 marks for neutral and 1 marks for negative responses (Disagreeing for A-D; Agreeing for E-G).

Question No. / Statement			
A	The risk of acquiring minor illness can be reduced if preventive measures were taken.	E	Good deed will reduce the risk of getting minor illness.
B	By giving extra attention, people with minor illness can be cured more quickly.	F	Minor illness cannot be cured completely because you have affected by it repeatedly.
C	Minor illness can be a serious event if left unattended.	G	People with minor illness can be cured more quickly if warded.
D	If consulting a doctor is free and cause no harm, you will go for it.		

Figure 3.4 Distribution of respondents with regard to the positive, negative or neutral attitude toward each attitude based questions.

3.4 PRACTICE OR BEHAVIOUR ON MINOR ILLNESS

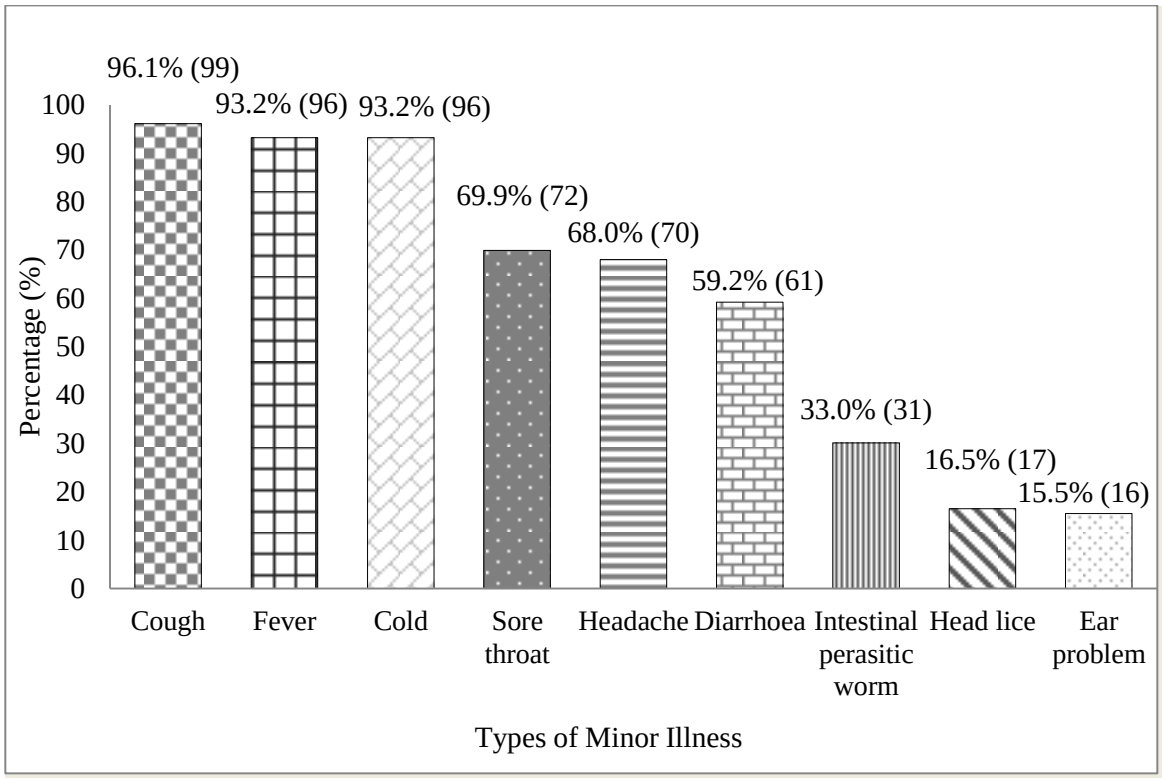
3.4.1 Hospital / clinic visit

Table 3.6 indicated that 96.1% of the respondents (majority) have been to a hospital or clinic at least once in their lifetime due to a minor illness while 2 out of 103 respondents had never.

Table 3.6 Distribution of respondents who has been visited a hospital or clinic in their lifetime due to various types of minor illness.

Statement	N = 103 respondents	
	Number (Percentage, %)	
	Yes	No
Have you ever gone to hospital/clinic due to a minor illness?	101 (98.1%)	2 (1.9%)

The statistics from Figure 3.5 shows that the chief complaints among them (the 99 respondents who have been to the hospital or clinic) were cough (96.1%, n=99), fever (93.2%, n=96), cold (93.2%, n=96), sore throat (69.9%, n=72), headache (68.0%, n=70) and diarrhoea (59.2%, n=61). Intestinal parasitic worm infection (33.0%, n=31) is less common to evoke their concern to pursue medical aid, while head lice infestation (16.5%, n=17) and ear problem (15.5%, n=16) are least common.

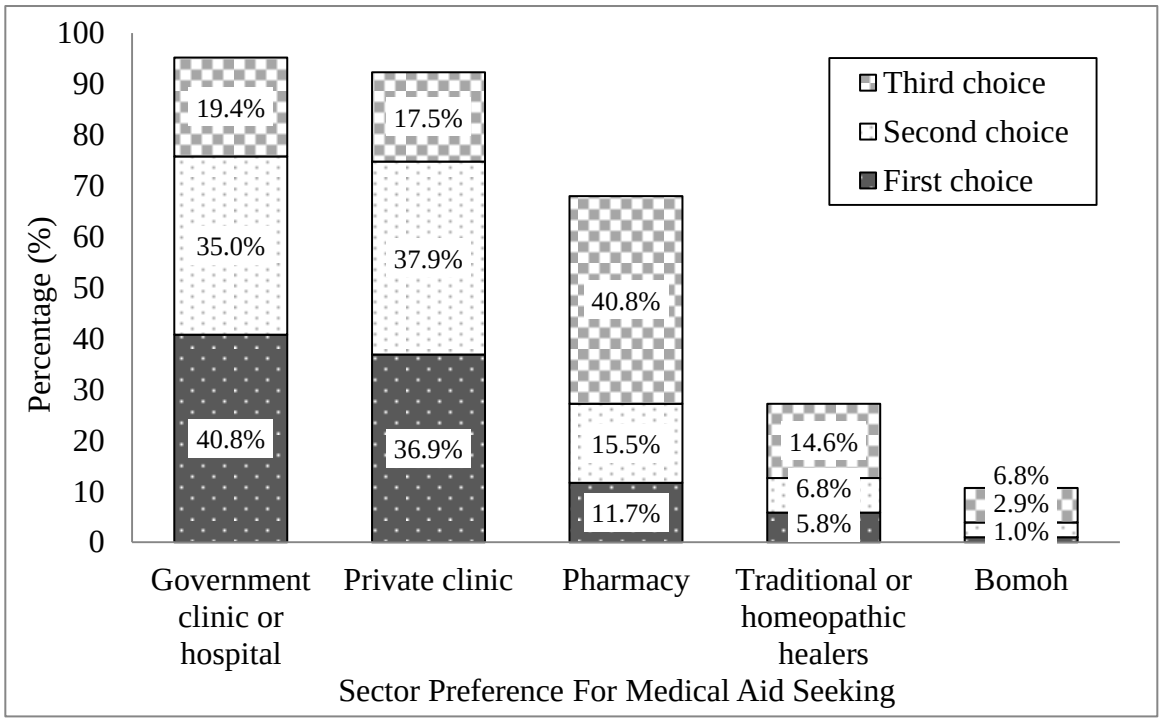


Note: [a] N = 101 respondents
[b] This question is proceeding only by those respondents that have been visited to a clinic or hospital in their lifetime due to any of the minor illness.

Figure 3.5 Distribution of respondents with regard to the past history of hospital or clinic visiting due to a minor illness.

3.4.2 Sector preference for medical aid seeking

Figure 3.6 reveals that a majority of the respondent has ranked government hospital (40.8%, n=42), private clinic (36.9%, n=38) and followed by pharmacy centre (11.7%, n=12) as their priority visit places. Only one lady ranked bomoh as her first for exorcism. There are 6 respondents that preferred traditional or homeopathic healings and ranked it as their priority place of visit. Again when asked to rank, 3 respondents have answered that they will first seek for Panadol® from the nearby convenient shop instead of any health care service centre if suffered from any of the minor illness. Surprisingly one respondent claimed that he will 'do nothing' when sick.

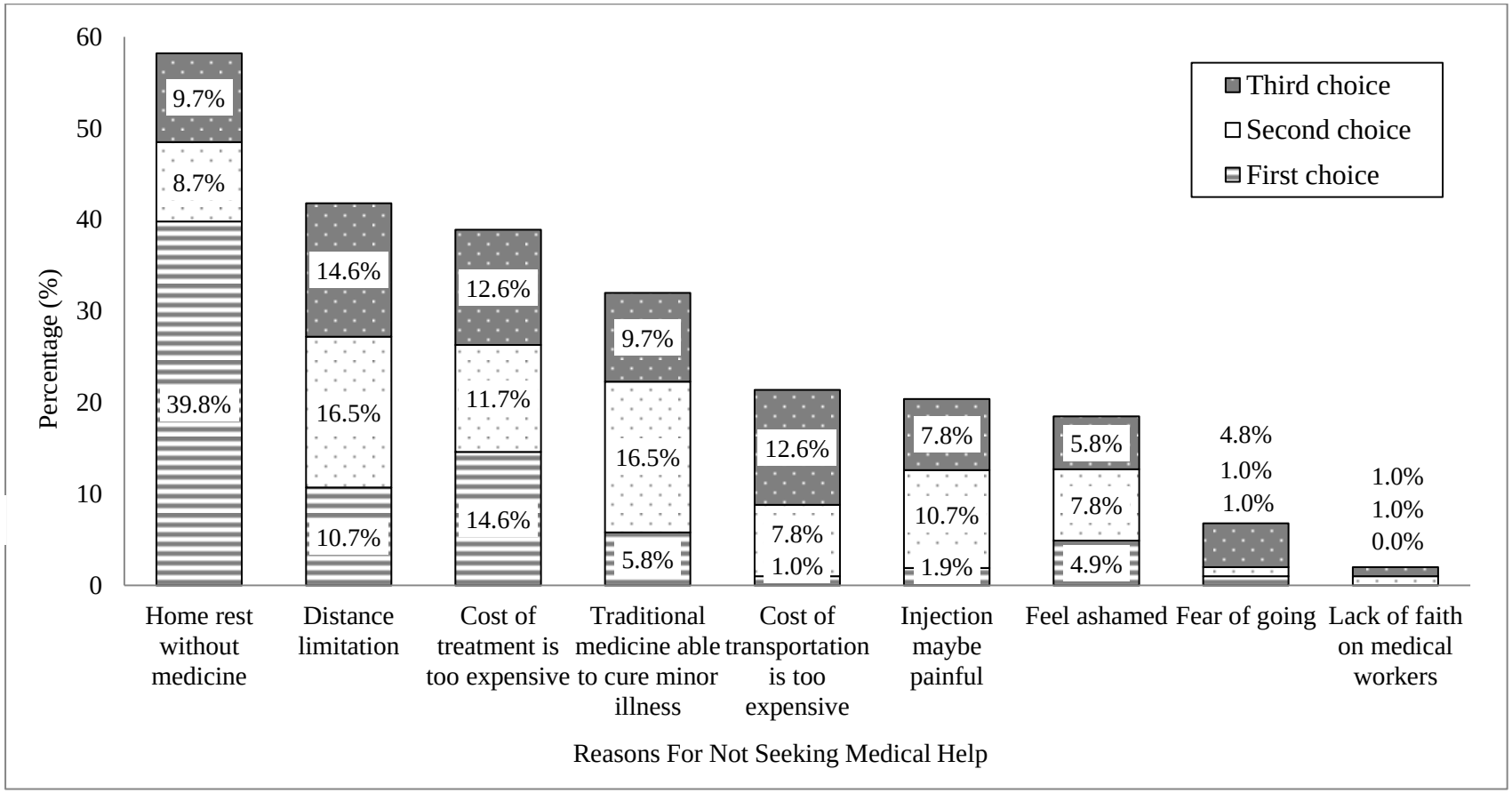


Note: [a] n = 102 respondents

Figure 3.6 Distribution of respondents with regard to the first, second and third ranking of places to visit when sick.

3.4.3 Reasons for not seeking medical help

Figure 3.7 reveals that ‘home rest without medication is able to cure minor illness’ is the most ranked excuse among all options that deter the respondents from approaching western-medical. To this, 39.8% (n=41) of them ranked this as their first reason, 8.7% (n=9) ranked as second while 9.7% (n=10) ranked as third. A total, regardless of their ranking preferences as first, second or third choice illustrates that, distance limitation (39.8%) is the second main reason, follow by unaffordable treatment cost (38.9%). Apart from the above 3 reasons, a noteworthy number (32.0%, in total) has mentioned that using herbs and traditional medicine is able to cure the disease. Some (21.4%, in total) claimed that the cost of transportation to reach nearby government hospital is high. Upon further questioning, one young lady emphasized the reasons that perplex her from pursuing medical aids is because she felt ashamed (first reason) and fear of going (second reason) due to the cold, sterile environment of the hospital setting. Regarding this ‘fear of going’ reason, there is additional respondent who has ranked the similar option as first. Subsequently, 5 respondents ranked ‘feel ashamed’ as their first reason that always perplex them from entering the physical examination room. Only 2 respondents out of 103 have declared that they are absence of faith on the medical workers. Remarkably, 21 respondents refused to answer this question. With this, 16 of them insisted that they will definitely consult a western-trained-medical doctor if they are sick. Reason implausible to change their action. While the remaining 5 claimed that they have no time for a doctor visit, since minor illness is harmless to them.



Note: [a] n = 82 respondents
[b] 21 respondents refused to answer this question.

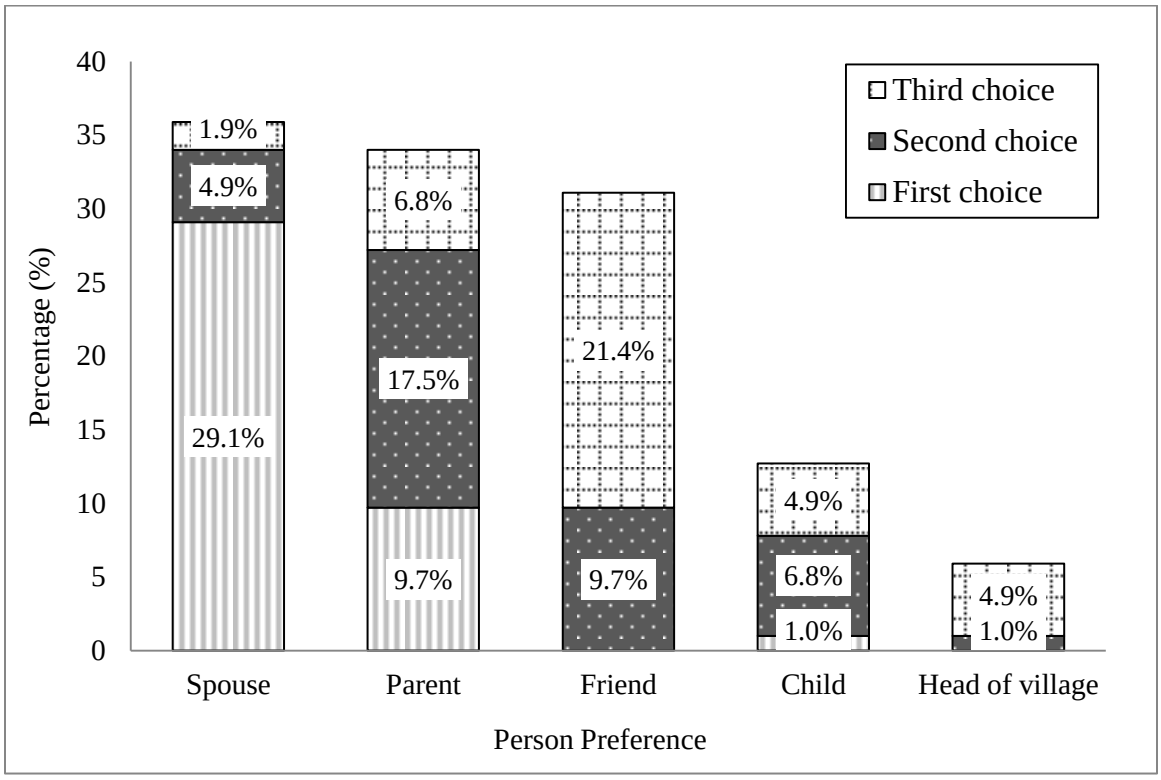
Figure 3.7 Distribution of respondents with regard to the first, second and third ranking of reasons for not seeking medical help.

3.4.4 Ranking of person preference on advice seeking before a medical doctor is approached

Table 3.7 reveals that of all the 103 indigenous people interviewed, only 41 have agreed that they will seek advice from surrounding people concerning minor illness. Over half of them (60.2%, majority) would not ask or tell anyone regarding their sickness because as clarified by them 'not to make others worry.' A majority of them (Figure 3.8) will first approach their spouse (n=30) for advice, followed by parents (n=10) and lastly child (n=1). None of the respondents have mentioned that close friend or head of village as their priority person to seek advice. If did so, they will commonly rank both in the third (3^{rd}) place which make up 21.4% and 4.9% respectively.

Table 3.7 Distribution of respondents with regard to the help seeking behaviour.

Statement	N = 103 respondents	
	Frequency (Percentage, %)	
	Yes	No
D. Have you ever seek advice from anyone due to a minor illness before approaching healthcare services?	41 (39.8%)	62 (60.2%)

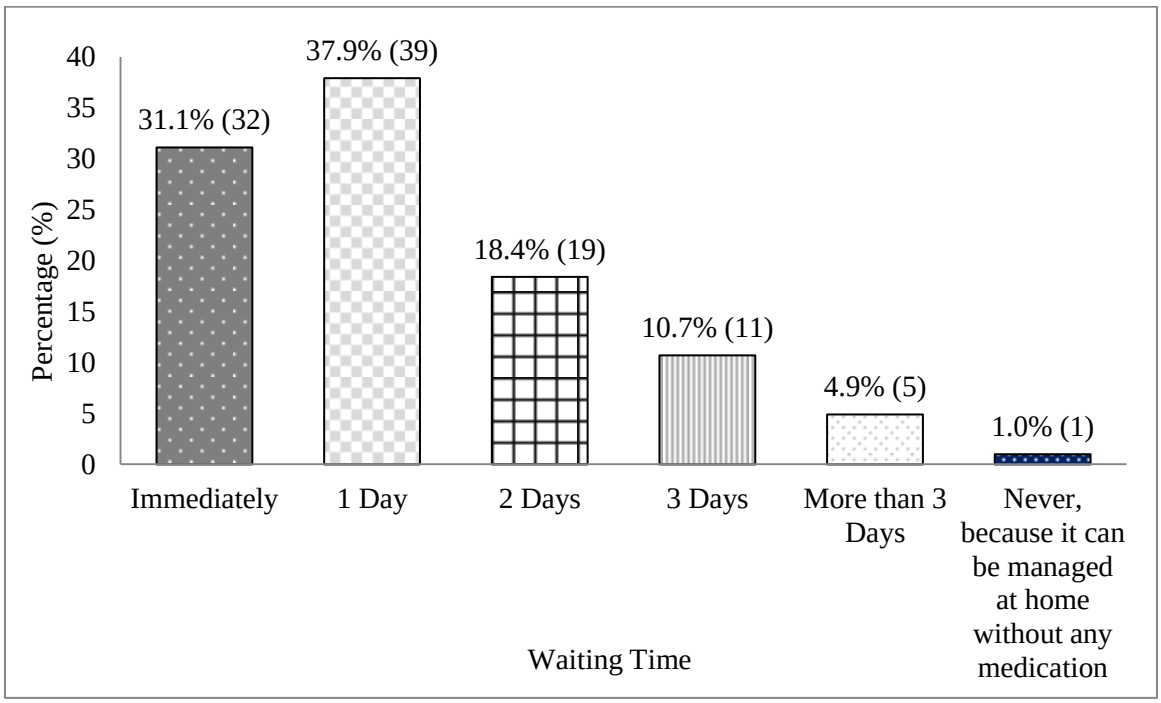


Note: [a] N = 41 respondents
[b] 62 respondents are excluded to answer this question.
This question is proceeding only by those respondents with advice seeking behaviour.

Figure 3.8 Distributions of respondents with regard to the first, second and third ranking of person preference for advice seeking.

3.4.5 Waiting time before approaching medical facility

According to the Figure 3.9, most of the respondents have normally waited 1 day (37.9%, n=39) before seeking for medical help. 31.1% (n=32) of them will seek medical help immediately if they are sick. Average waiting time answered by them are 2 days (18.4%, n=19), 3 days (10.7%, n=11) follow by more than 3 days (4.9%, n=5). One respondent had never seek for medical help because he assumed minor illness can be managed at home without any medication.

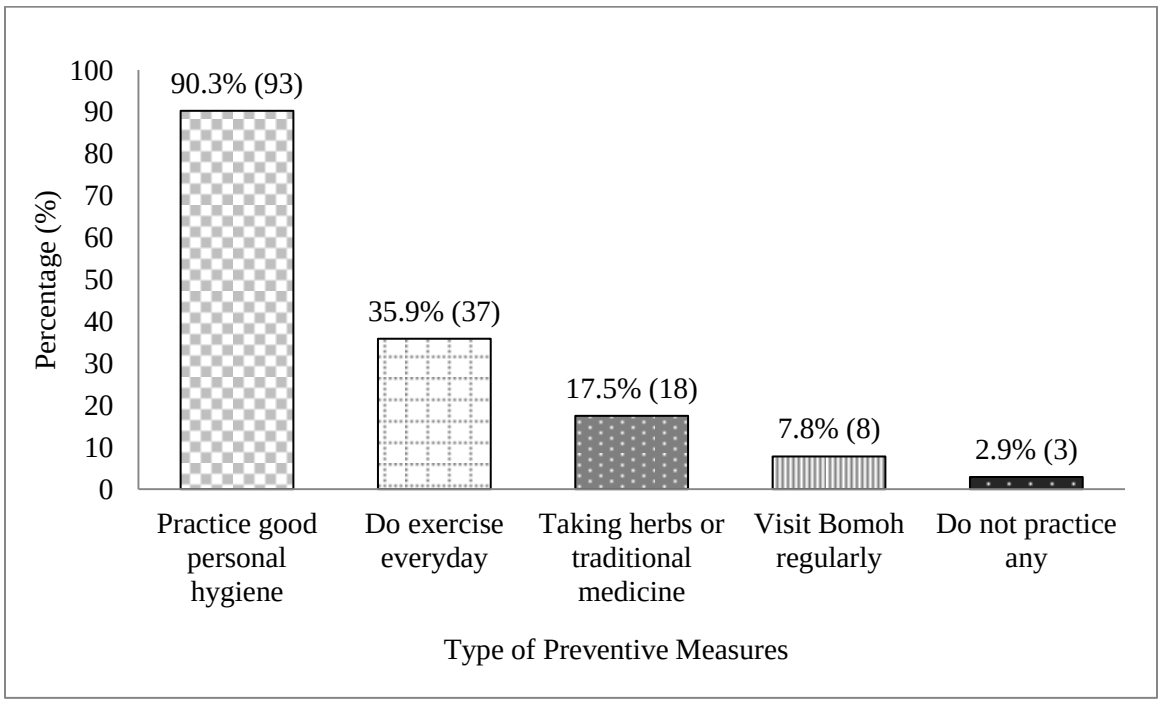


Note: [a] n = 103 respondents
[b] Each respondent is allowed to tick more than one options provided in this question.

Figure 3.9 Distribution of respondents with regard to the waiting time before seeking medical help.

3.4.6 Current preventive measures

Figure 3.10 reveals that 90.3% (n=93) are currently practicing good personal hygiene, followed by performing exercise everyday (35.9%, n=37) and lastly taking herbs or traditional medicine (17.5%, n=18) to avoid them from getting minor illness. It is not surprising that 8 respondents are currently practicing bomoh visit regularly. While 2.9% (n=3) respondents mentioned that they are practicing none of the above preventive measures.

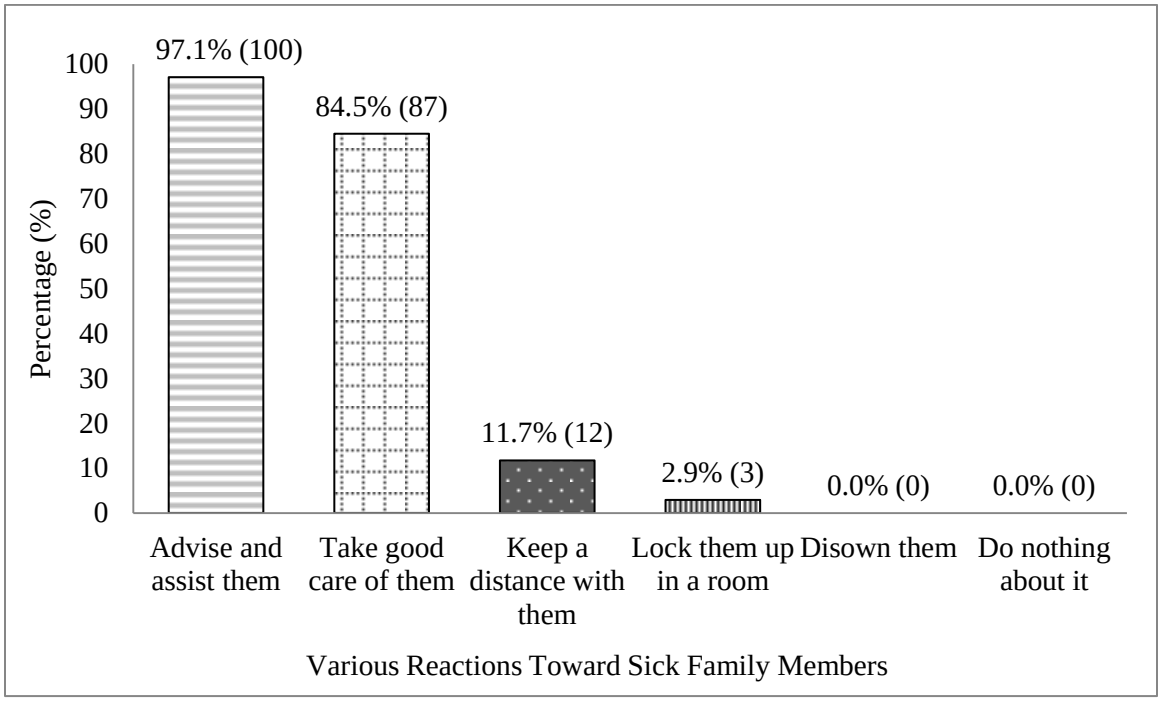


Note: [a] n = 103 respondents
[b] Each respondent is allowed to tick more than one options provided in this question.

Figure 3.10 Distribution of respondents with regard to their various current preventive measures on minor illness.

3.4.7 Reactions toward family members who are sick

Figure 3.11 shows a high percentages of indigenous people responded that they will advise and assist their family member to seek medical help (97.1%, n=100) and take good care of them at home (84.5%, n=87) if their family members are sick. Around one tenth of them (11.7%, n=12) answered that they will keep a distance while some (2.9%, n=3) even said they will lock up their family member in a room to avoid the transmission of disease. Notably, none of the respondents have mentioned they will disown their family members.



Note: [a] n = 103 respondents
[b] Each respondent is allowed to tick more than one options provided in this question.

Figure 3.11 Distribution of respondents with regard to their various reactions toward family members who is sick.

3.5 VARIABLES THAT ASSOCIATE THE LEVELS OF KNOWLEDGE AND PRACTICE TOWARDS MINOR ILLNESS

Table 3.8 illustrated that female respondents (92.8%, n=64) acquired mainly good levels of knowledge on minor illness. In contrast, there is a sizable number of male respondents (34.2%, n=11) being analysed as possessing insufficient knowledge in this aspect. Therefore, our study is capable of rejecting the null hypothesis as proven by the p value of 0.002 which lower than the determinant value of 0.05 using Fisher's exact test. Meanwhile, the study revealed that there is a significant association among gender and the levels of knowledge of modernised indigenous people in Banting on minor illness.

Our study also proven that a majority of the respondents with formal education (87.5%, n=84) acquisition of ideal score on this knowledge section regarding minor illness. However, 4 out of 7 limited illiterate personnel that did not went through primary, secondary or tertiary education fall on poor level of knowledge. A significant association among educational status and their levels of knowledge is drawn through this Fisher's Exact Test. Our study is capable of rejecting the null hypothesis as the p value is 0.011 which is lower than the determinant 0.05 value.

Conversely, it suggested that most of the respondents with a legitimate career fall on the good levels of knowledge (85.7%, n=46) and it is more or less equally to the unemployed including the retired personnel (87.3%, n=41). Noticeably, poor levels of knowledge are equally distributed among both employed (n=8) and unemployed (n=8) respondents. The finding shows there is no clear association between the levels of knowledge of modernised indigenous people in Bating on minor illness and their employment status determined through Fisher's Exact Test. This is proven by the failure to reject the null hypothesis with the p value of 0.115 which is greater than 0.05.

Last but not least, no significant association is drawn within the marital status of indigenous people in Banting and their score on the levels of knowledge through Fisher's Exact Test. This is evident from p value of 0.582 which is greater than 0.05 which indicates failure to reject the null hypothesis. Our study has pointed out that a majority of the respondents regardless of their marital status of being single (85.7%) or married (84.1%) acquired the similarly good levels of knowledge in this aspect.

Table 3.8 Distribution of respondents between the levels of knowledge on minor illness with various socio-demographic background data.

Levels of Knowledge / Variables	Score < 50% Poor (0-11 marks)	Score > 50% Good (12-24 marks)	X^2/dx	p value
	Frequency (%)			
Gender				
Male	11 (32.4)	23 (67.6)	1	*0.002
Female	5 (7.2)	64 (92.8)		
Marital Status				
Single	3 (14.3)	18 (85.7)	1	0.582
Married	13 (15.9)	69 (84.1)		
Employment Status				
Self / Employed	8 (14.8)	46 (85.2)	1	0.115
Unemployed / Retired	8 (16.3)	41 (83.7)		
Educational Status				
Formal educated	12 (12.5)	84 (87.5)	1	*0.011
Non-formal educated	4 (57.1)	3 (42.9)		

Note: *Significant association ($p < 0.05$)

Our study also agrees that a majority of respondents (87.0%) who currently practices various preventive measures has shown acquisition of good score on the knowledge section regarding minor illness. The preventive measures mentioned here included taking herbs or traditional medicines, performing daily exercises, maintaining well personal hygiene and visiting bomoh regularly. In contrast, 3 respondents who claimed they had never practice any of the preventive measures in their lifetime falls within poor levels of knowledge. This is again proven by the Fisher's exact test with p value of 0.003 which is lower than the determinant value of 0.05. Our study is capable of rejecting the null hypothesis, thus we concluded that the levels of knowledge of indigenous people in Banting is associated with their preventive measures taking behaviour.

Table 3.9 Distribution of respondents between the levels of knowledge of on minor illness with preventive measure seeking behaviour.

Preventive Measures / Variables	Practicing	Not Practicing	X^2/dx	p value
	Frequency (%)			
Overall knowledge on minor illness				
Poor (score < 50%)	13 (81.2)	3 (18.8)	1	*0.003
Good (score > 50%)	87 (100.0)	0 (0.0)		

Note: *Significant association ($p < 0.05$)

CHAPTER IV

DISCUSSION

4.1 DEMOGRAPHIC AND BACKGROUND DATA OF RESPONDENTS

As shown in the record, there are more female (67.0%) than male (33.0%) respondents in all the three Orang Asli villages in Banting. Regarding the missing number, a few housewives have explained that theirs husbands were not around due to workmanship engagement on the two consecutive weekends when the survey was being conducted. The age of the respondents ranged from 18 to 88 years old with a mean of 38.7 years old. This is in agreement with one KAP study on STH among Orang Asli showed significantly higher intentions of practicing appropriate preventive measures on individuals with mean age > 32 to avoid illness strike (Nasr *et al.*, 2013). Based on occupational evaluation, most of the 42.7% respondents are unemployed followed by 37.9% are self-employed, 14.6% are employed and lastly 4.9% are pensioners. Economically the ancient Temuan (about 35 years ago) was a hunting-gathering-fishing tribe with some subsistence agriculture of the slash and burn, and dibble stick variety. In many areas they were capable of surviving off of the products of the jungle; they were also gathering jungle products to sell to the non-aborigines (Bear *et al*., 1976). Notably in our current study the youth often hire themselves out as labourers to non-aborigines in their locality for several months at a time as a peasant, truck driver and palm fruit collector.

The entire respondents being questioned are from the ethnic Temuan, subgroup of Proto-Malay, as according to Department of Orang Asli Affairs (JHEOA, 1997), which are mostly concentrated in this area of high grounds or hills. Temuan villages are mostly to be found in the state of Negeri Sembilan and Selangor. These two states are among the fastest developing states in Malaysia. Thus the Temuan in these two states face challenges in adapting to development that brings about changes in habitats and natural sources (Ong *et al*., 2012). The study reveals that 99% of the respondents are animistic while only 1 respondent is Christian. Likewise, a similar study conducted in 1972 among Orang Asli indicated Temuan of Malaya were animists and spoken languages belonging to the Malayo Polynesian stock and closely related to the Malay language spoken today in southern and western Malaya (Dunn, 1972). The Temuan language may be regarded as a dialect of Malay. Temuan vocabulary data show somewhat higher congruence with Malay, at least in the district of Ulu Selangor (Bear *et al*., 1976). Hitherto, there are no major changes in the evolution of their beliefs and language.

Their status of education is generally moderate with 7 respondents never attended any formal schooling. However, mostly (47.6%, n=49) have attended primary school education, about half (43.7%, n=45) have managed to complete secondary school while only a few 2 respondents went to post-graduate. This is generally due to poverty, unfavourable social and natural environment and lack of opportunity and support by the urban sectors. However, the financial burden to higher education has been lessen by the government who provides them with free education from primary to secondary school levels, and allowance of RM2 per day per person for all the secondary school students. Such a strategy towards excellence in education has been successfully designed and implemented to help ease the burden of Orang Asli parents to finance the schooling and education of their children (JAKOA, 2012). A similar strategy by the Housing Aids Programme Project (PBR), 2009 has also been designed and implemented for subsidised housing. The outcome of this financial strategy would gradually witness an increase in the quantity of Orang Asli going for higher education (JAKOA, 2009).

The most common transportation utilised by them to the adjacent healthcare service centre are motorcycle (67.0%, n=69) and followed by car (27.2%, n=28). Some of them (3.9%, n=4) choose to walk if no any transportation is accessible. Only 2 respondents will cycle to the nearest clinic upon enquired. According to our findings, the opportunity of access to the health care services centre is generally well. This is due to the government's priority infrastructure effort and restructuring of the health service centre to facilitate ease of access within walking distance in the rural area (Safurah, 2007). When asked upon their cost of transportation, only about one tenth of the respondents (12.6%, n=13) claimed their transportation cost of any kind to the nearest health care services is expensive. Still the cost of transportation is not regarded as an obstacle for them to seek western medical help. In addition, government are also providing mobile clinic with doctors and nurses visits to the inferior area periodically (JHEOA, 2005).

According to our findings, cough (97.1%), fever (94.2%), cold (92.2%), headache (88.3%), sore throat (83.5%) and diarrhoea (67.0%) are the chief types of minor illness encountered amongst the indigenous people. While, intestinal parasitic worm (43.7%) head lice (33.0%) and ear problem (26.2%) are less common. When questioned upon intestinal parasitic worm infection, a majority of the respondents appeared curious and loss-of-words about its signs and symptoms and what they have witnessed before. They are doubtful about their own current health condition whether they had been infected or not. Similar finding was found from recent study in Lipis district, Pahang which reveals inadequate knowledge on STH infections among Orang Asli in rural Malaysia (Nasr *et al.*, 2013). There are several possible explanations why this population is still plagued with minor illness despite an improvement in their overall living standard. One of them is mild malnutrition. A majority still rely on locally produced food sources which are low in nutrients due to environmental conditions and the intake of seafood is also low (al-Mekhlafi *et al.*, 2005).

4.2 KNOWLEDGE ON MINOR ILLNESS

This study points out that only a small number of respondents (15.5%, n=16) has poor prior knowledge about minor illness with the net score of less than 11 marks out of 24 marks cumulatively collected from 6 respective questions. Generally, almost half of the respondents (43.7%, n=45) are aware of various minor illness based on their good score (18 to 24 marks) on this aspect. Two fifth of the respondents (40.8%, n=42) acquired moderate score (12 to 17 marks). The phrase "modernised indigenous people" indicates that most of the Orang Asli living in Banting have already been exposed and conditioned by the culture and practice of their new settlements for some time. The new settlement is a strategic plan of the government to relocate, improve, settle and control the scattered indigenous people who were previously living in the forest (JHEOA, 2009). Their knowledge now is assumed to be influenced by dissemination of various mass media to them in the new settlements and together with their personal experiences on various types of minor illness, the quality and level of knowledge has thus improved considerably. It is seen during our house-to-house interview, that most of the houses are installed with television and Astro devices. The Astro device here refers to the brand name of the Malaysian direct broadcast satellite (DBS) Pay TV service in which it transmits digital satellite television and radio to households in Malaysia. Moreover, these three Orang Asli villages are equipped with network (cell phone) coverage and they are able to communicate with the outsiders. In addition, their housing areas are built within walking distance to a nearby highly educated and technologically advanced Malays kampung. Their improvement on the levels of knowledge towards minor illness could thus be interrelated. Based on a study conducted among Temuan villagers in Kampung Tering, Kuala Pilah, Negeri Sembilan illustrated that Temuan villager's houses are built using planks and beams, with certain portion being built in the traditional native style using materials obtained from the surrounding forests. Several degree of adoption from Malay's cultures made these villages look more like a Malay village than a native one. (Ong *et al.*, 2012). Similarities of architecture have been found in our research area. This evident has

explained their situation of being well aware of several types of minor illness and the dramatic connection between Orang Asli and the Malays in Banting.

The study on knowledge about the curability shows that almost all the respondents (84.5%, n=87) know minor illness could be cured completely by using solely conventional medication of "taking of pills." Only 7 respondents have negative point of view. On further questioning, one of them explained that her grandchild had passed away due to high fever lasting for almost one week even though he had been taking pills. She felt rather miserable having to go through this trauma for 10 years. The thought of admitting her grandchild to the hospital was not considered by her at that time. Likewise, our current study reveals that 11 of respondents disagree with the statement of minor illness can be a serious event if left unattended. The remainder 9 respondents are uncertain about it and said they are being bewildered with minor illness because the illness comes and heal itself without any medication at some instances.

Study on the risk of acquiring minor illness reveals a high percentage of respondents (73.8%, n=76) discern that everyone is at risk of acquiring minor illness including themselves; some (16.5%, n=17) does not agree with the statement above. Remarkably, one of the respondents has not encountered with any of the listed minor illness except headache. Hence, he believes that not everyone will strike with minor illness – high occurrence risk amongst evil or sinned people. Similarly the present finding reveals that nearly half of the respondents (42.7%, n=44) have answered evil spirit as a one of the cause of minor illness. "Like most traditional communities, the Orang Asli have long perceive disease as being the result of a spirit attack, or of the patient's soul being detached and lost somewhere in this world or in the supernatural world" (Chee *et.al.*, 2007). This theory is again oppossed with the biological concept of disease and illness. As being told, evil spirit would primarily entanglement with those in attempts to harm or against people, especially personnel that are always being masterminded by their evil thoughts. When inquired further about causes, lack of personal hygiene is the most

answered option among the five choices which make up 85.4% of the respondents. Others are sedentary lifestyle (72.8%, n=75), poor diet (71.8%, n=74) and lastly long-term exposure to agricultural chemicals (60.2%, n=62). About the negative effects of agricultural chemicals on their health, one fifth of the respondents disagree and one fifth has no knowledge about this. Thereupon, our finding illustrated that in overall a majority of them are being analysed as possessing certain degree of self-awareness so they can realise the importance of taking care of one's health.

The survey on the Orang Asli's knowledge about minor illness prevention reveals that a majority of the respondents have knowledge of some preventive measures such as practice of good hygiene (91.3%, n=94), balanced diet (78.6%, n=81), exercise (76.7%, n=79) and taking herbs or traditional medicine (52.4%, n=54). However, nearly half of the respondents (48.54%, n=50) believe that good deed in life is able to avoid them from getting minor illness. This belief is somewhat becoming popular amongst modern religious healers and the New Ageists of our time. They have revitalized and re-examined this "belief" in the light of modern science. The healing of illness, in contrast, has to do with the complex social, psychological, and spiritual condition of the sick person and constitutes the proper domain of healing. A person with continuation doing of good deed to others perhaps may have some sort of spiritual deliverance that would propagate that person to better healing from illnesses. However the research is still in progress (Hanegraaff, 1996). Scientifically, good deed is still not acceptable as preventive measure for illnesses.

Regarding the treatment approaches of minor illness, it is found that almost all respondents (97.1%, n=100) have confidence and trust in conventional medications prescribed by clinic or hospital. Western-trained-doctors in clinics and hospitals were regarded as saviours. Observably, this can be perceived through theirs face expression during the face to face interview session and most of them answered with "of course" instead of "yes" when this option is being read out. Not surprisingly, 40 out of 103

respondents believe that “bomoh” is able to heal minor illness. It is anticipated to be one of the treatment methods under the category of non-conventional or traditional or complimentary treatment methods at the outset of the research study. Similar finding were reported in a study done in Kampong Pos Penderas, Pahang among the Jah Hut Orang Asli suggested that the indigenous people mostly associate ailments as caused by spirits and thus perform healing ceremonies to appease the spirits and bring about healing. Moreover, medicinal plants are often used by them for treating and healing of the sick (Ong *et. al*. 2012). Similarly in the present study revealed that 40.8% of them agreed that herbs and traditional medicines can cure minor illness.

In the study on knowledge about transmission, it is observed that a majority of respondents know cold (88.3%, n=91), cough (85.4%, n=88), and fever (73.8%, n=76) are highly contagious amongst individuals especially youth through intimate contact. Said by them, these three symptoms usually appeared simultaneously. These findings became reasonable if linked to the high incident of such minor illness amongst them. It is astoundingly that although only 34 respondents have encountered head lice infestation in their lifetime, finding reveals that 77 out of 103 know it is highly transmissible by sharing personal items or by direct contact with the body or clothing of an infested person. Upon in-depth inquiry, a misconception was discovered especially common amongst the indigenous mothers where they believe that their daughter’s head lice infestation came from the school and it will only spread amongst the girls, never the boys. This finding does not tally with a study of prevalence of scabies and head lice among children in welfare home in Pulau Pinang, Malaysia. It reported that head lice infestation happened not merely to girls but boys were at risk as well. By nature, head lice move towards shadow or dark coloured objects in their vicinity. Thus, long and thick hair provides favoured vicinity and promotes higher occurrence of head lice (Muhammad Zayyid *et al*., 2010). Study also reveals 30 respondents believed headache is contagious; in fact, it is not. Apropos to this, 54 out of 103 respondents have answered correctly. This finding is in agreement with a study conducted among 4,300 and 5,400 male and female non-aborigine adolescents in Maryland respectively reported that ‘the likelihood that an individual has

headaches will increases with the presence of a friend with headache' (Fletcher, 2009). Note, although those studies are done in differential nationality and country, similarity of misconception on its contagiousness could still happen.

Besides above mentioned types of minor illness, study proposes only a quarter of them (25.2%, n=26) know parasitic worm infection is spreadable to third party. Likewise a study conducted in Lipis district, Pahang which revealed the fact of inadequate knowledge on transmission of STH infections among Orang Asli in rural Malaysia who are still awaiting for government effort to instil better knowledge to the community by holding awareness campaigns (Nasr *et. al.*, 2013). The data records that 58.3% of them know sore throat is transmissible if it originates from infection by either virus or bacterial, said by them, sore throat usually occurs concurrently with fever. While 21.4% have no idea that sore throat which originated from irritation due to excessive cough, loud voice, etc. are not transmissible (Edwards *et al.*, 2002). Regarding diarrhoea, a majority of respondents (43.7%, n= 45) has answered that it is transmissible among individuals while a quarter (33.0%, n=34) denied. Upon being interrogated on the causes of diarrhoea regardless which option they had chosen, the first thought that appeared to their mind is unintentional consumption of contaminated food leading to food poisoning. Surprisingly, none of them have mentioned that diarrhoea can be originated from infection which is spreadable; contrariwise overdose with caffeinated drink or anxiety-induced diarrhoea is not spreadable. Both answers are acceptable in fact (Edwards *et al.*, 2002). Obviously their concept on transmission of diarrhoea is perhaps imprecise. The present study also shows among 103 respondents only 17 of them had experienced ear problem, either itchy, pain or purulent. Thence, the knowledge regarding its transmission showed only little information as 70.9% of them are vague with the precise answer. Among them, 8.7% (n=9) answered "yes" while 20.4% (n=21) answered "no". The fact is ear problem that originates from bacterial infection with purulent discharge as one of it sign and symptoms is transmissible among individuals through close contact. In contrast, allergy-induced itchiness or painful ear is not transmissible (Edwards *et al.*, 2002).

4.3 ATTITUDES ON MINOR ILLNESS

The overall result illustrates that a majority of the respondents (47.6%, n=49) are analysed as being possessing positive attitudes toward minor illness based on the high cumulative score in this section while minority (only 8 out of 103) have negative cognition towards it. The common negative perceptions among them discovered included 57.3% of the respondents thought that good deed will reduce the risk of acquiring minor illness. A logical consequence of this line of thought is that the Orang Asli would naturally believe that both their individual and their communal health are linked to environmental and social health. By doing good or giving care to society and the environment would significantly reduce the risk of their acquiring diseases, and if there is too much pollution, for example, or too much blood spilt, and taboos governing correct behaviour have not been followed, that is, oppose of good deed, then disease and even death will strike (Endicott, 1979; Howell, 1984). The Orang Asli is also very clear about the link between maintaining their environment and maintaining their health as well as sustenance (Chee *et al*., 2010).

Apart from this, the present study demonstrates that 41.7% (majority) of the respondents have interpreted minor illness could be cured promptly if warded or being hospitalised. This thought perhaps cast doubt and is inappropriate. Although one study realised that in reality the Orang Asli did not fully tolerate or accept long-term hospitalisation as a necessary means to regain health because such hospitalisation not only cut the patients off from their forest environment and their community but also deprived them of access to their traditional healers and treatments. Nevertheless, they are willing to give a try (Bolton, 1973). This situation is being rationalised by the successfulness of awareness being promoted to the indigenous people who have instilled uncountable knowledge on the importance of warding or hospitalisation during emergency. Not to mention, their financial burden on the cost of medication is being subsidised by the government when they approach western medical. However, as a

reminder, the term “minor illness” is a really a disease that is considered to be harmless and uncomplicated; does not prevent the victim from carrying out their normal function for more than a short period of time (Edwards *et al.*, 2002). Conversely, if the condition worsen which may include secondary infection hospitalisation may become essential. At this circumstance, it is no longer deemed to be a minor illness. Although hospitalisation is not indeed necessary, finding shows that a vast number of Orang Asli is tending to offer extra attention to such minor illness. Moreover, present study demonstrates a majority of the respondents (81.6%, n=84) have agreed with the statement that “minor illness can be a serious issue if left unattended.” The sense of neglecting minor illness has gradually disappeared.

Undoubtedly, study reveals that 80.6% of the respondents have agreed that by giving extra attention, people with minor illness can be cured more quickly. This finding is adversely with one study among Health Care of Orang Asli, stated that “traditionally in Orang Asli settings, when a person suffered an illness that was serious enough to warrant some action, it become a concern of the whole community.” Other ailments, such as cough and cold, evoked no general concern as they were considered to be harmless, since the victims could still function normally (Chee *et al.*, 2010). It is glad to witness such an evolution on their concept towards minor illness.

Regarding the statement “minor illness cannot be cured completely because you are affected by it repeatedly”, our data shows that 43.7% (majority) of respondents are agreed with it. On being questioned, one replied because she had recurrent attacks of cough and cold lasting for 5 to 8 days each recently. Thus she has the thought that those ‘invaders’ (scientifically refers to bacteria or virus) had never left her body regardless of any medicines taken. Her perception perhaps is right based on the shamanistic point of view but wrong from the scientific point of view. During the survey, it is observed that, many of the other respondents are confused by this question thus we use her perception as an example for clarification.

When asked upon if the government providing free consultation by western-trained-doctor, and proved no harm will they go for it? The answer is: 94.2% of them have agreed they will definitely go for it. Currently, there are designated locations (including Kampung Mutus Tua, Kampung Paya Rumput and Kampung Bukit Tadom) where a free mobile clinic visits periodically are available (JHEOA, 2005). This finding shows that the Orang Asli has slowly accepted western medication by changing from the thought of treating minor illness by incantations and ritual replaced by modern medical practices. Notably the programmes of organisations such as Canadian University Services Overseas (CUSO) and Cooperative for Assistance and Relief Everywhere (CARE) had resulted in significant improvements in Orang Asli health services, as well as an increasing readiness of the Orang Asli to accept modern medicine alongside traditional healing (Chee *et al.*, 2010).

Fortunately, our present study reveals that 85.4% of the respondents have agreed the risk of acquiring minor illness could be reduced if preventive measures were taken. Many of them even mentioned some appropriate preventive actions spontaneously such as hand-washing before eating and after defecation, cutting fingernails regularly and wearing shoes when walking outside the house. These appropriate preventive measures were all mentioned in a KAP study on STH among Orang Asli in Lipis district, Pahang. The findings demonstrated from ours and previous studies were tally. It is observed that the indigenous people are now closer to the era of knowing the importance and demand of self-sanitary and hygiene care by practicing it as a habit (Nasr A N *et. al.*, 2013).

4.4 PRACTICE OR BEHAVIOUR TOWARDS MINOR ILLNESS

The data records that 96.1% of the respondents (majority) have been to a hospital or clinic at least once in their lifetime due to a minor illness while 2 out of 103 respondents had never. Upon being questioned, one youth lady emphasized her reasons for not seeking western-medical aids is because she 'felt ashamed' (first reason) and 'fear of going' (second reason) due to the cold, sterile environment of the hospital setting and being phobia on the possibility of a painful procedure of medical therapy. Similar study had proven that their primary fear was leaving their familiar forest surroundings with their families and being forced to confront with the strange heath care services settling (Harrison, 2001). These psychologically barriers have always perplex them from entering the physical examination room. Moreover, a 30 years old man claimed that he had only suffered headache once amongst all types of minor illness listed to him. He mentioned that: 'home rest without medication is sufficient to antagonise diseases'. Study reveals that 39.8% of the respondent have similar context of concept as him. Apart from the above 3 reasons, study suggests that 14.6% has declared cost of treatment is 'too expensive' as their main excuses but this view point applied only to private clinic. Although the medical fee is high, the waiting time is always shorter. A single government hospital visit will at least consume them few hours. This determinant factor has challenged them to make decision among private and government sector for decades – this condition is again being justified by 5 respondents that emphasized 'lack of time' as their personal excuse. The following issues are geographical limitation, 10.7% of the respondents have ranked inconvenience due to distance as their first reason and the appeared of formidable rival, 5.8% of respondents are totally relied on traditional medicine to cure minor illness. Heller (1976) found that the greater the average travel, waiting and treatment time for an outpatient visit to a government facility in Peninsular Malaysia reduced demand for public health services. Unexpectedly, 16 of the respondents insisted that they will definitely persuade a western-trained-medical officer's advice whenever they were sick. They are devotees to medical doctors and will never seek any excuse to skip them. Only 2.9% do not fully believe in the medical workers meanwhile

97.1% are totally believe in them. The introduction of western medicine was the main thrust of the post-colonial health programme (Polunin, 1953) and it seems successful so far. For the minority portions, psychological barriers are unlikely to avoid them from seeking western medical helps. The underlying cause for this kind of result could be something else and it is likely due to financial constraints or poverty. A majority of them are still at poor margin (Chee *et al.,* 2010). This is again being authenticated by a definite benefit of using traditional instead of conventional medicine which has been mentioned by a significant number of people - that is, the sources of traditional medicines are mainly collected from wild or forest surrounding their housing area; there is no reason for them to spend unnecessary money. Study also recorded the enormous usefulness of herb-plants in making decoctions, infusions or poultices to be taken orally or applied topically (Ong *et al.*, 2012).

The statistics shows that the chief complaints among them (the 99 respondents who have been visited a hospital or clinic) were cough (95.1%, n=98), fever (92.2%, n=95), cold (92.2%, n=95), sore throat (69.9%, n=72), headache (68.0%, n=70) and diarrhoea (59.2%, n=61). In terms of treatment-seeking behaviour, almost all (99.1%) of the participants have mentioned that they will seek treatment from the adjacent clinic in case of diarrhoea and abdominal pain, while only one participant has mentioned that he will primarily approach a traditional healer (Nasr *et al.*, 2013). Present study records that only 31 out of 45 respondents have consulted doctor due to intestinal parasitic worm infection. Fascinatingly, among them, one respondent with his whole family members, even practice deworming agents intake periodically, as told by him, once in every 6 months. While head lice infestation is less common to evoke their concern to seek medical aid (only 17 have visited doctor). Some explained they prefer traditional techniques to remove nits and live head lice using comb with herbs. Regarding ear problem 16 out of 17 respondents had visited doctor to solve their problem. A study conducted among health status of Orang Asli community in Kampung Pos Piah revealed similar finding in which the prevalence of problem with ear discharge is significantly low with 2.9% as compared to other common illnesses (Norhayati *et al.*, 1998).

The present study indicates that 37.9% of the respondents (majority) have normally waited 1 day before approach medical facility. 3 respondents said they will predominantly consume a Panadol® tablet purchased from nearby grocery shop if feeling unpleasant and continues to observe their physical condition before paying a hospital or clinic visit. 31.1% of them will normally seek medical help immediately if they are ill. Average waiting times answered by them are 2 days (18.4%, n=19), 3 days (10.7%, n=11) followed by more than 3 days (4.9%, n=5). 1 respondent claimed that he will never pursue western-medicine aid because his concept is, minor illness can be managed at home without any medication.

Regarding the sectors preference, study reveals that a majority of the respondent has ranked government hospital (95.2%, in total), private clinic (92.3%, in total) and followed by pharmacy centre (68.0%, in total) as their priority visit places. Only one lady ranked bomoh as her first for exorcism and to build up protective shield on her own body. She normally will only seek treatment from government hospital (ranked as second) or clinic (ranked as third) on the second day if the illness worsen. Hence it can be seen that the Orang Asli are mentally prepared to accept modern medicine as they are ready to take advantages of the opportunities arising from it (Chee *et al.*, 2010).

The present study shows that 90.3% practiced good personal hygiene. To brief, few of the mothers point out that they will use solvent to wash their hands after touching infant's stool, before preparing foods or even after taking care of ill persons. These preventive measures are in accordance to one study of 24-hour-recall, KAP questionnaire on sanitary practice (Stanton *et al*., 1987). Regarding performing exercise daily, only slightly more than a third (37 respondents) is currently practicing it. Upon surveyed, most of them have no idea of what or how exactly exercise is, but few gentleman claimed that they were playing football weekly, while the ladies were doing housework daily. They assumed 'playing' and 'working' are the only exercises. Among them only 18% are currently taking herbs or traditional medicine. The shaman or healer is an important

anchor in the traditional Orang Asli health system. As Wolff (1965) noted, "the intimate ties created between patient and healer in a traditional framework reinforce a strong sense of socio-medical reciprocity that government officials or western-trained doctors are rarely able to replicate." It is not surprising therefore that the Orang Asli, the data revealed that 8 respondents are currently practicing it, have an intense desire for healing to be integrated within their local socio-cultural context. Traditional healers and their methods are thus unlikely to disappear easily from the Orang Asli culture (Chee *et al*., 2010). However this number of practicing has been reduced to a minimal level compare to the ancient times. This situation is being explained due to 'modernisation' which has threatened the usage of medicinal plants in many parts of the world. The usage of medicinal plants has been affected by modernisation as early as the first contact of native tribes with the westerners (Ong *et al*., 2011). Unexpectedly, 3 respondents answered that they are not practicing any of the preventive measures mentioned above.

Concerning the indigenous people's responses toward sick family members, study showed that a high percentage will advise and assist their family members to seek medical help (97.1%, n=100) and take care them at home (84.5%, n=87). One tenth of the respondents (11.7%, n=12) responded that they will keep a distance. A few (2.9%, n=3) even mentioned that they will lock them up in a room. Although their action perhaps is generally questionable and harsh, the reason given by them is to avoid the transmission of the disease – somewhat like 'quarantine' in medical science. Their harsh behaviour is probably due to the experience learnt from several tuberculosis (TB) attacks on the community where the symptoms are of similar nature. Somewhat their awareness was improved whenever they notice some similar symptoms. This finding is in agreement with one study regarding infectious disease, their awareness have been improved after several attacks by TB (Bedford, 2009).

4.5 VARIABLES THAT ASSOCIATE TO THE LEVELS OF KNOWLEDGE AND PRACTICE TOWARDS MINOR ILLNESS

Study demonstrates that there is no clear association ($p > 0.05$) between the levels of knowledge of respondents on minor illness and their employment status of whether being employed or unemployed. It is originally presumed that being an employee will has a greater chance of exposure to the outside world rather than being retained in the suburban areas like a housewife. Hence, there is a significant degree of influence and adoption to the epistemology of the outside world on minor illness. Similar study had also showed significantly better knowledge of working respondents towards the intestinal helminths, their signs and symptoms, ways of transmission and prevention than those unemployed (Al-Mekhlafi *et al.*, 2013). But the finding from our study did not seem to support our theory. The possible reasons are old culture and taboos die hard, change is difficult with old habits, it is not easy to change the inner essence of people and poor adaptability.

Similarly our study has proven no clear association ($p >0.05$) within their cognition about minor illness with and marital status. It is thought originally that married couples with a spouse working on a career will significantly give impact on each other's knowledge at any range. As discussed earlier, a majority of the respondents has ranked spouse as their prioritise personnel to approach for advice before they come out with the decision to pay a clinic or hospital visit. Again the finding from our study did not seem to support our concept. The singles who primarily seek advice from friends are certainly knowledgeable as well.

Conversely the study has reveals a definite association ($p < 0.05$) among the levels of knowledge of indigenous people in Banting towards minor illness with gender. As the time and fundamental evolution, personnel that stay at home most of their lifetime (e.g. housewives) are now having chance opportunity to expose themselves to common and

public acceptable knowledge through various media sources available to them at home. Such an indoor exposure to the outside world is analogous to a Chinese saying: 'Without going outdoors, a scholar knows the entire world's affairs'. Our finding is again in agreement with a study which concluded that "women's rates of utilisation of almost all health care services are higher than men's." They had more confidants and contacted more social agencies than the men, also suggesting that they found it easier to divulge personal information to others than the men (Corney, 1990).

Furthermore, significant association ($p < 0.05$) has been noticed among the levels of knowledge of indigenous people in Banting towards minor illness with their educational status. It is mentioned earlier, for decades the Malaysia government has been much concern about the well-being of the Orang Asli in the country by providing them with free education up to secondary school levels and financial funding (JAKOA, 2012). It is glad that the efforts by the government in promoting a positive healthy lifestyle living amongst Orang Asli in this region have been successful so far. The formal education provided by the government could contribute to the overall improvement of knowledge about minor illness of the Orang Asli.

As a matter of fact, knowledge itself is acquired through a learning process. However, the level of knowledge on minor illness is different and it increases with formal education, right behaviour or practice, positive attitudes or feelings and also the state of psychological and physical health of a person. Certain people although they are knowledgeable specifically on the preventive measures of common minor illness, but they do not seem to apply it to reality (al-Mekhlafi *et al.*, 2013). Fortunately our study shows a positive sign of indigenous people living in Banting are now paying extra attention and responsibility to one's health, with this, a significant association ($p < 0.05$) within their levels of knowledge on minor illness and their intention of practicing preventive measures.

4.6 STUDY IMPLICATION

A meaningful implication from this study of the indigenous people surmount intent of completing the questionnaire is that throughout the conversation their perception towards minor illness that lurks deep in their hearts for decades is now given the opportunity to release freely. Not surprisingly that such misconception that head lice infestation will only transmitted among school-aged girls but never transmitted to boys has come to our notice. More of the discoveries have been discussed earlier in Chapter 4.

All the data gathered and the report from this KAP survey would become a useful baseline database, reference or support for medical, psychological and social workers who wish to help the indigenous population in future. In addition information that obtained from this study can be used as reference (or as a pilot study) for more research to be conducted in future.

Through this research, a proper and a more customized intervention can be planned to target the indigenous population in other to improve their health status. Furthermore, this is also help to promote self-awareness among the indigenous people so they can realise the importance of taking care of one's health. This is also in line with the vision of Malaysia Ministry of Health to assist an individual in achieving and sustaining as well as maintaining a certain level of health status to further facilitate them in leading a productive lifestyle economically and socially. This study is a kick-start march of long running journey of medical and human rights victory for the indigenous of Malaysia.

4.7 STUDY LIMITATION

Several limitations have been noticed that can affect the data of this study especially during the house-to-house interviewing sessions. Lack of genuine communication from the indigenous people has been the main issue, as a majority of them shy away with suspicion from our interviewers. Some of them even lock up themselves in their brick cottages when the interviewers, whom they perceived to be outsiders approaching. They are unwilling to participate in this survey even though with an attractive token of appreciation offered to them by our team. Luckily, this did not reduce our intended sample size of at least 103 participants.

A limitation confronted is time constrain, as the research expiry date draws nearer. JAKOA limits us to only four days which is on the 2 respective weekends. Fortunately, we have gained full support from the 'Tok Batin' referring to the head of villages whom they are receptive, and hence make this research study successful, a total of 104 set questionnaires are adequately collected.

Another limitation is the unexpected disproportional balance between the male and the female counts in our sample with a majority female count that could lead to study bias. This imbalanced representative of the male could be due to insufficient time allowed by the head of the village or the male having to work elsewhere on the weekends as the number of the female and the male records has been proportional.

Also a majority of them seemed less sincere and tend to lie about their answers. This is a general psychological barrier limiting our accuracy in the research. In an attempt to reduce this tendency, an attractive colourful laminated questionnaire with a

more comprehensive sincere manner of explanation is to them so as to arouse their interest, remove their suspicion and instil openness.

Generally speaking, the result of our study does not suffice to represent the whole KAP situation of indigenous population towards minor illness of the whole country of Malaysia. This is due to the relatively small sample size of data collection (103 study size) and which has only emphasized on the following ethnic groups Temuan from Banting. It is just one amongst the six subgroup of Proto-Malay. As indicated there are another two main groups of Orang Asli Negrito and Senoi with each group comprises six sub-groups with ethno-linguistic differences (JHEOA, 1997).

CHAPTER V

CONCLUSION

5.1 CONCLUSION OF RESEARCH STUDY

In general, the overall results of our research study indicates that a majority of indigenous people staying in Orang Asli modernised settlement in Banting, Malaysia have a moderate KAP towards minor illness and they are ready to accept the modern medicine management.

The results of the present study points out that awareness about minor illness among all respondents is generally moderate with 43.7% of them scored good level of knowledge in this area. The measure is based on the following indicators - curability, risk of acquiring, causes, ways of transmission, various preventive measures and methods of treatment.

Despite of moderate knowledge, 47.6% of the participants are being analysed as possessing positive attitude or perception toward minor illness particularly on the seriousness of the illness, the methods of treatment, the preventive measures and their willingness in accepting health care services.

In addition, this study proposes that indigenous people practiced both traditional and conventional medicine more or less equally. The common practices of them to cope with minor illness includes solicit advice from spouse and provide one day waiting period to observe their own physical condition before paying visit to a government hospital. They are currently practicing good personal hygiene with a noteworthy number visiting bomoh regularly to avoid illness strike.

Lastly, a significant association ($p < 0.05$) are found among their levels of knowledge on minor illness with gender, educational status and their intention of practicing preventive measures.

It can be seen that vast number of respondents are paying extra attention on such minor illness. This also means that the efforts by the government in promoting a positive healthy lifestyle living amongst Orang Asli in this region have been successful so far. Therefore continuous exertion of concentration must be given to this population.

5.2 RECOMMENDATIONS OF FUTURE STUDY

Future research can be conducted in a more detailed manner towards each of the minor illness listed in our survey. Indicators used to assess their knowledge, attitude and practice may widen to include KAP survey the specifics - the disease curability, risk factors, signs and symptoms, causes of the disease, ways of transmission, various preventive measures, methods of treatment and the death rates specific or particularly to one type of minor illness of study. A non-KAP study can also be done for these same specific indicators as a complementary research study of the future. It can be suggested to conduct by using random sampling to avoid bias of selection of respondents.

Moreover, an individualised screening on participant towards various types of minor illness (eg. helminthic infection / head lice infestation) can be directly performed or on the spot using available test kits by future researcher to evaluate their prevalence instead of a survey type questionnaire to improve the accuracy of data.

It is the social responsibility for a community pharmacist to audit, suggest or perform a 24-hour-recall on KAP survey after awareness being held effort to establish significant degree of knowledge, attitude and practices among the indigenous community.

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APPENDIX A

CONSENT TO PARTICIPATE IN RESEARCH

KNOWLEDGE, ATTITUDE AND PRACTICE OF MODERNISED INDIGENOUS POPULATION TOWARDS MINOR ILLNESS IN KAMPUNG BUKIT TADOM, PAYA RUMPUT DAN MUTUS TUA, BANTING, MALAYSIA.

INFORMATION SHEET

This research study aims to identify the level of knowledge, attitude and practice (KAP) among indigenous population in Kampung Bukit Tadom, Paya Rumput dan Mutus Tua, Banting, Malaysia towards minor illness.

The accuracy of information and data are crucial to make the right decisions and beneficial to the society. Thus, we hereby request your full cooperation to provide us with accurate and honest answers. Question and answer session on the topic will take around 15-30 minutes.

We assure that all your answers will be treated with utmost confidentiality. The findings of this research will give us brief idea on the level of KAP of indigenous people in Malaysia towards minor illness.

We thank you for your participation.

CONSENT FORM

By signing this consent form,

1. I confirm that I have received, read and understood the consent form for this study. I have had sufficient time to review the information, consider my participation, ask questions, and consider these questions satisfactory.
2. I had been given assurance that all my answers will be treated with utmost confidentially.
3. I understand that I have the right to withdraw my consent at any time and discontinue my participation without any penalty.
4. I voluntarily agree to take part in this study.

Signature,

_____ Date:

( )

I/CNo.:

For any enquiry, please contact the following number:
Tan Yean Ling (016-7890237) *Student, Faculty of Pharmacy, CUCMS*
Leong Siew Lian (012-8817198) *Lecturer, Faculty of Pharmacy, CUCMS*

APPENDIX B

PERSETUJUAN UNTUK MENYERTAI KAJIAN

PENGETAHUAN, SIKAP DAN AMALAN (PSA) PENDUDUK PERIBUMI BANDAR DI KAMPUNG BUKIT TADOM, PAYA RUMPUT DAN MUTUS TUA, BANTING, MALAYSIA TERHADAP PENYAKIT RINGAN.

LEMBARAN MAKLUMAT

Kajian ini bertujuan untuk mengenal pasti tahap pengetahuan, sikap dan amalan (KAP) di kalangan penduduk peribumi di Kampung Bukit Tadom, Paya Rumput dan Mutus Tua, Banting, Malaysia terhadap penyakit ringan.

Ketepatan maklumat dan data adalah penting untuk membuat keputusan yang tepat dan memanfaatkan masyarakat. Oleh itu, kami meminta kerjasama penuh anda untuk memberi jawapan yang tepat dan jujur. Sesi soal jawab mengenai topik ini akan mengambil masa dalam lingkungan 15-30 minit.

Kami menjamin bahawa semua jawapan anda adalah sulit. Hasil kajian ini akan membantu kami memahami secara kasar tahap KAP penduduk peribumi di Malaysia terhadap penyakit ringan.

Terima kasih atas penyertaan anda.

BORANG KEBENARAN

Dengan menandatangani borang kebenaran ini,

1. Saya mengesahkan bahawa saya telah menerima, membaca dan memahami borang persetujuan untuk kajian ini. Saya telah diberi masa yang secukupnya untuk mengkaji maklumat, mempertimbangkan penyertaan saya, bertanya soalan, dan telah diberi jawapan yang memuaskan daripada penemuduga.
2. Saya telah diberikan jaminan bahawa semua pengakuan dan jawapan saya akan dirahsiakan.
3. Saya memahami bahawa saya mempunyai hak untuk menarik balik kebenaran saya pada bila-bila masa dan boleh menghentikan penyertaan saya tanpa sebarang penalti.
4. Saya bersetuju secara sukerela untuk mengambil bahagian dalam kajian ini.

Tandatangan,

_____ Tarikh:

( )

No. K/P:

Untuk sebarang pertanyaan, sila hubungi nombor berikut:

Tan Yean Ling (016-7890237) *Pelajar, Fakulti Famasi, CUCMS*

Leong Siew Lian (012-8817198) *Pensyarah, Fakulti Famasi, CUCMS*

APPENDIX C

Questionnaire

No.:

Research Title: Knowledge, Attitude and Practice of Remote Indigenous Population towards Minor Illness in Kampung Bukit Tadom, Paya Rumput and Mutus Tua, Banting, Malaysia .

Section A: General and Socio-Demographic Characteristics		
1. Age:	**2.** Gender: M / F	**3.** Marital status: Single / Married
4. Religion ☐ No religion ☐ Muslim ☐ Buddhist ☐ Christian ☐ Other (please specify): _____	**5.** Ethnic: ☐ Proto-Malay ☐ Negrito ☐ Senoi ☐ Temuan ☐ Temair	**6.** Occupation ☐ Self employed ☐ Employed ☐ Unemployed ☐ Retired
7. Mode of transportation to the nearest health care setting. ☐ Motorcycle ☐ Car ☐ Bicycle ☐ Bus ☐ Boat ☐ Walking ☐ Other (please specify): _____		**8.** Level of education ☐ No school ☐ Primary school ☐ Secondary school ☐ Higher education (Professional/Post-graduate) ☐ Other (please specify): _____
9. Is the cost of transportation expensive to you?		Yes / No

10.	Have you ever experienced the following:		
	Fever	Yes	No
	Cough	Yes	No
	Colds	Yes	No
	Sore throat	Yes	No
	Headache	Yes	No
	Diarrhoea	Yes	No
	Head lice	Yes	No
	Intestinal parasitic worm	Yes	No
	Ear problem	Yes	No

Section B: Knowledge of Modernised Indigenous Population towards Minor Illness				
No	**Questions**	**Yes**	**No**	**Do not know**
1	**Do you think minor illness can be cured?**	1	0	0
2	**Everyone is at risk of acquiring minor illness including you?**	1	0	0
3	**What is/are the cause(s) for minor illness?**			
	Lack of personal hygiene	1	0	0
	Poor diet	1	0	0
	Sedentary lifestyle	1	0	0
	Long-term exposure to agricultural chemicals	1	0	0
	Evil spirit	0	1	0
	Other (please specify): _____			
4	**How can a person prevent getting minor illness?**			
	Herbs or traditional medicine	1	0	0
	Practice good personal hygiene	1	0	0
	Balanced diet	1	0	0
	Exercise	1	0	0
	Good deed	0	1	1
5	**How can minor illness be treated?**			
	Specific medication given by medical centre	1	0	0
	Herbs or traditional medicine	1	0	0
	Supernatural beliefs / Bomoh	0	1	0
6	**Which of the following minor illness can be transmitted?**			
	Fever	1	0	0
	Cough	1	0	0
	Cold	1	0	0
	Sore throat	1	1	0
	Headache	0	1	0
	Diarrhoea	1	1	0
	Head lice	1	0	0
	Intestinal parasitic worm	1	0	0
	Ear problem (itchy / pain / purulent)	1	1	0
	Other (please specify): _____			

TOTAL SCORE : _____

Level of Knowledge:

☐ Range 1 : Good knowledge (18-24)

☐ Range 2 : Moderate knowledge (12-17)

☐ Range 3 : Poor knowledge (0-11)

Section C: Attitude of Modernised Indigenous Population towards Minor Illness				
No	**Questions**	**Agree**	**Neither**	**Disagree**
7	The risk of acquiring minor illness can be reduced if preventive measures were taken. Do you agree?	3	2	1
8	By giving extra attention, people with minor illness can be cured more quickly. Do you agree?	3	2	1
9	Minor illness can be a serious event if left unattended. Do you agree?	3	2	1
10	If consulting a doctor is free and cause no harm, you will go for it. Do you agree?	3	2	1
11	Do you agree that good deed will reduce the risk of getting minor illness?	1	2	3
12	Minor illness cannot be cured completely because you have affected by it repeatedly. Do you agree?	1	2	3
13	People with minor illness can be cured more quickly if warded. Do you agree?	1	2	3

Section D: Practice of Modernised Indigenous Population towards Minor Illness	
No.	**Questions**
14	**Have you ever gone to a clinic / hospital due to a minor illness?**
	☐ Yes (Please proceed to No. 15)
	☐ No (Please proceed to No. 16)
15	**What is/are the reason(s)?**
	☐ Fever
	☐ Cough
	☐ Cold
	☐ Sore throat
	☐ Headache
	☐ Diarrhoea
	☐ Head lice
	☐ Intestinal parasitic worm
	☐ Ear problem (itchy / pain / purulent)

16	**Which of the following places will you visit if you experience minor illness? (Please rank according to frequency. 1 for most frequently visited.)**	**Rank (1-3)**
	☐ Government clinic or hospital	
	☐ Private clinic	
	☐ Pharmacy	
	☐ Traditional or homeopathic healer	
	☐ Bomoh	
	o Do not seek for treatment	
	o Other (please specify): _____	
17	**If you would not go to the medical facility, what is/are the reason(s)? (Please rank accordingly – main 3 reasons are concerned. 1 for most concerned.)**	**Rank (1-3)**
	☐ Home rest can cure minor illness	
	☐ Traditional medicine can cure minor illness	
	☐ The cost of treatment is too expensive	
	☐ The cost of transportation is too expensive	
	☐ Inconvenient due to distance	
	☐ Injections may be painful	
	☐ I feel ashamed	
	☐ Do not believe the medical workers	
	o Other (please specify): _____	
18	**If you experience minor illness, who would you approach first to obtain advice? (Please rank according to frequency. 1 for most frequent.)**	**Rank (1-3)**
	☐ Spouse	
	☐ Parents	
	☐ Child/children	
	☐ Friends	
	☐ Head of village	
	o No one	
	o Other (please specify): _____	
19	**If you experience minor illness, how long will you wait before seeking medical help? (Please tick where appropriate.)**	
	☐ Immediately	
	☐ 1 day	
	☐ 2 days	
	☐ 3 days	
	☐ More than 3 days	
	o Never, because it can be managed at home without any medication	

20	**What is/are your current practice(s) to prevent minor illness? (Please tick where appropriate)**
	☐ I am taking herbs or traditional medicine.
	☐ I practice good personal hygiene all the time.
	☐ I do exercise every day.
	☐ I will visit Bomoh regularly.
	o I do not practice any preventive measure.
	o Other (please specify): _____
21	**How would you react towards your family members who acquire minor illness? (Please tick where appropriate)**
	☐ Advice and assist them to seek medical help
	☐ Take good care of them at home
	☐ Keep a distance with them
	☐ Lock them up in a room
	☐ Disown them
	o Do nothing about it
	o Other (please specify): _____

---------- END OF QUESTIONNAIRE. THANK YOU. ----------

APPENDIX D

Borang Soal Selidik

No.:

Tajuk Penyelidikan: Pengetahuan, Sikap dan Amalan (KAP) Penduduk Peribumi Bandar di Kampung Bukit Tadom, Paya Rumput dan Mutus Tua, Banting, Malaysia terhadap Penyakit Ringan.

<table>
<tr><th colspan="4">Bahagian A: Soalan Umum dan Latar Belakang</th></tr>
<tr><td colspan="2">1. Umur:</td><td colspan="2">2. Jantina: L / P</td><td>3. Status perkahwinan: Bujang / Berkahwin</td></tr>
<tr><td colspan="2">4. Agama
☐ Tidak beragama
☐ Islam
☐ Buddha
☐ Kristian</td><td colspan="2">5. Etnik
☐ Proto-Malay
☐ Negrito
☐ Senoi
☐ Temuan
☐ Temair</td><td>6. Pekerjaan:
☐ Bekerja sendiri
☐ Makan gaji
☐ Tidak bekerja
☐ Pesara</td></tr>
<tr><td colspan="3">7. Pengangkutan ke pusat kesihatan terdekat:
☐ Motosikal ☐ Sampan
☐ Kereta ☐ Berjalan kaki
☐ Basikal ☐ Lain-lain (sila nyatakan):
☐ Bas _____</td><td colspan="2">8. Tahap pendidikan:
☐ Tidak bersekolah
☐ Sekolah rendah
☐ Sekolah menengah
☐ Pengajian tinggi (Kolej / Universiti)
☐ Lain-lain (sila nyatakan):
_____</td></tr>
<tr><td colspan="3">9. Adakah anda rasa kos pengangkutan tersebut adalah mahal?</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td>10.</td><td colspan="4">Adakah anda pernah mengalami penyakit ringan yang berikut?</td></tr>
<tr><td></td><td colspan="2">Demam</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Batuk</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Selsema</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Sakit tekak</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Sakit kepala</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Cirit-birit</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Kutu kepala</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Cacing usus</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
<tr><td></td><td colspan="2">Masalah telinga (gatal / sakit / bernanah)</td><td>☐ Ya</td><td>☐ Tidak</td></tr>
</table>

Bahagian B: Pengetahuan Penduduk Peribumi Bandar Terhadap Penyakit Ringan				
No.	**Soalan**	**Ya**	**Tidak**	**Tidak Pasti**
1	**Bolehkah penyakit ringan disembuhkan sepenuhnya?**	1	0	0
2	**Sesiapa sahaja boleh menghidapi penyakit ringan termasuk anda?**	1	0	0
3	**Apakah faktor-faktor yang boleh menyebabkan penyakit ringan?**			
	Kekurangan kebersihan diri	1	0	0
	Pemakanan yang tidak seimbang	1	0	0
	Tidak bersenam	1	0	0
	Pendedahan kepada bahan kimia pertanian secara berpanjangan	1	0	0
	Perbuatan kuasa jahat	0	1	0
	Lain-lain (sila nyatakan): _____			
4	**Bagaimanakah seseorang boleh mengelakkan diri daripada penyakit ringan?**			
	Ramuan herba / ubat tradisional	1	0	0
	Menjaga kebersihan diri	1	0	0
	Pemakanan yang seimbang	1	0	0
	Bersenam	1	0	0
	Berjasa baik	0	1	0
	Lain-lain (sila nyatakan): _____			
5	**Bagaimanakah penyakit ringan boleh dirawati?**			
	Mengambil ubat daripada doktor / farmasi	1	0	0
	Mengambil ramuan herba / ubat tradisional	1	0	0
	Meminta pertolongan Bomoh / kuasa ghaib	0	1	0
	Lain-lain (sila nyatakan): _____			
6	**Antara penyakit ringan yang berikut, yang manakah boleh dijangkiti daripada sesiapa yang menghidapinya?**			
	Demam	1	0	0
	Batuk	1	0	0
	Selsema	1	0	0
	Sakit tekak	1	1	0
	Sakit kepala	0	1	0
	Cirit-birit	1	1	0
	Kutu kepala	1	0	0
	Cacing usus	1	0	0
	Masalah telinga (gatal / sakit / bernanah)	1	1	0
	Lain-lain (sila nyatakan): _____			

	JUMLAH MARKAH : _____
Tahap Pengetahuan: ☐ Tahap 1 : Tahap pengetahuan tinggi (18-24) ☐ Tahap 2 : Tahap pengetahuan sederhana (12-17) ☐ Tahap 3 : Tahap pengetahuan rendah (0-11)	

Bahagian C: Sikap Penduduk Peribumi Bandar Terhadap Penyakit Ringan				
No.	**Soalan**	**Setuju**	**Neutral**	**Tidak Setuju**
7	Risiko untuk mendapat penyakit ringan boleh dikurangkan jika langkah-langkah pencegahan telah diambil. Adakah anda setuju?	3	2	1
8	Dengan memberikan perhatian tambahan, penghidap penyakit ringan boleh disembuhkan dengan lebih cepat. Adakah anda setuju?	3	2	1
9	Penyakit ringan boleh menjadi sesuatu yang serius sekiranya dibiarkan tanpa jagaan. Adakah anda setuju?	3	2	1
10	Anda akan menerima rawatan daripada doktor jika ia adalah percuma dan tidak memudaratkan. Adakah anda setuju?	3	2	1
11	Adakah anda setuju bahawa berjasa baik boleh mengurangkan risiko untuk memperolehi penyakit ringan?	1	2	3
12	Penyakit ringan tidak boleh disembuhkan sepenuhnya kerana anda menghidapnya berulang kali. Adakah anda setuju?	1	2	3
13	Penghidap penyakit ringan boleh disembuhkan dengan lebih cepat jika diwadkan di hospital. Adakah anda setuju?	1	2	3

Bahagian D: Amalan Penduduk Peribumi Bandar terhadap Penyakit Ringan		
No.	**Soalan**	
14	**Pernahkah anda pergi ke klinik / hospital disebabkan penyakit ringan?**	
	☐ Ya (Sila teruskan ke No. 15)	
	☐ Tidak (Sila teruskan ke No. 16)	
15	**Apakah sebab-sebabnya?**	
	☐ Demam	
	☐ Batuk	
	☐ Selsema	
	☐ Sakit tekak	
	☐ Sakit kepala	
	☐ Cirit-birit	
	☐ Kutu kepala	
	☐ Cacing usus	
	☐ Masalah telinga (gatal / sakit / bernanah)	
	○ Lain-lain (sila nyatakan): _____	
16	**Antara yang berikut, manakah tempat yang anda akan pergi jika anda mengalami penyakit ringan?** *(Sila susun pilihan anda mengikut kekerapan. 1 untuk paling kerap.)*	**Susunan (1-3)**
	☐ Klinik kesihatan / hospital kerajaan	
	☐ Klinik swasta	
	☐ Farmasi	
	☐ Tabib tradisional	
	☐ Bomoh	
	○ Langsung tidak mendapatkan rawatan	
	○ Lain-lain (sila nyatakan): _____	
17	**Antara yang berikut, yang manakah mungkin adalah sebab anda tidak pergi ke klinik / hospital?** *(Sila susun 3 pilihan utama anda mengikut keutamaan. 1 untuk paling utama.)*	**Susunan (1-3)**
	☐ Berehat di rumah boleh menyembuhkan penyakit ringan	
	☐ Ubat tradisional boleh menyembuhkan penyakit ringan	
	☐ Kos rawatan terlalu mahal	
	☐ Kos pengangkutan terlalu mahal	
	☐ Terlalu jauh	
	☐ Suntikan mungkin menyakitkan	
	☐ Saya berasa malu	
	☐ Tidak percaya kepada pekerja perubatan	
	○ Lain-lain (sila nyatakan): _____	

18	**Jika anda mengalami penyakit ringan, daripada siapakah akan anda mendapatkan nasihat sebelum pergi ke klinik / hospital?** *(Sila susun pilihan anda mengikut kekerapan. 1 untuk paling kerap.)*	**Susunan (1-3)**
	☐ Pasangan	
	☐ Ibu bapa	
	☐ Anak	
	☐ Kawan	
	☐ Ketua kampung	
	○ Tiada siapa-siapa	
	○ Lain-lain (sila nyatakan): _____	
19	**Jika anda mengalami penyakit ringan, berapa lama anda akan menunggu sebelum pergi ke klinik / hospital?**	
	☐ Serta-merta	
	☐ 1 hari	
	☐ 2 hari	
	☐ 3 hari	
	☐ Lebih daripada 3 hari	
	○ Langsung tidak akan mendapatkan rawatan	
20	**Apakah amalan anda sekarang untuk mencegah penyakit ringan?**	
	☐ Saya sedang mengambil herba dan ubat tradisional.	
	☐ Saya mengamalkan kebersihan diri yang baik sepanjang masa.	
	☐ Saya bersenam setiap hari.	
	☐ Saya melawati Bomoh secara berkala.	
	○ Saya langsung tidak mengamalkan langkah pencegahan.	
	○ Lain-lain (sila nyatakan): _____	
21	**Apakah reaksi anda terhadap ahli keluarga anda yang mengalami penyakit ringan?**	
	☐ Memberi nasihat dan membantu mereka untuk mendapatkan rawatan	
	☐ Menjaga mereka di rumah	
	☐ Jauhkan diri daripada mereka	
	☐ Kuncikan mereka dalam bilik	
	☐ Tidak mengaku mereka sebagai ahli keluarga	
	○ Lain-lain (sila nyatakan): _____	

---------- BORANG SOAL SELIDIK TAMAT. TERIMA KASIH. ----------

APPENDIX E

JABATAN KEMAJUAN ORANG ASLI MALAYSIA
(KEMENTERIAN KEMAJUAN LUAR BANDAR DAN WILAYAH)
TINGKAT 10, 20 & 20M, WEST BLOCK,
WISMA SELANGOR DREDGING,
142 – C, JALAN AMPANG,
50548 KUALA LUMPUR.

JAKOA

Telefon : 03-21610577
: 03-21610994-8(5 talian)
Gombak : 03-61892122
Fax : 03-21621470 (IP)
: 03-61883160 (GBK)
Laman Web : www.jakoa.gov.my

Ruj. Kami : JAKOA.PP.30.032 Jld.27 (37)
Tarikh : 12 J' Akhir 1434KH
04 April 2013

Dekan
Fakulti Farmasi
Cyberjaya University College of Medical Sciences
No 3410, Jalan Teknokrat 3, Cyber 4
63000 Cyberjaya
Selangor
(u/p: Prof. Dr. Rosnani Hashim)

Tuan,

KEBENARAN MENJALANKAN KAJIAN / PENYELIDIKAN

Dengan hormatnya saya diarah merujuk kepada perkara di atas.

2. Sukacita dimaklumkan bahawa Jabatan ini tiada halangan untuk memberi kebenaran kepada pelajar tuan untuk menjalankan kajian bertajuk "**Health Status and Awareness Among Indigenous People In A Remote Settlement,**". Pihak tuan dibenarkan menjalankan kajian di tempat dan pada tarikh yang telah ditetapkan seperti berikut:-

Tempat	:	**Kg. Pos Piah, Sungai Siput (U), Kuala Kangsar, Perak**
Tarikh	:	**31 Mei – 9 Jun 2013**
Penyelidik	:	**Seperti di lampiran**

3. Pihak tuan adalah diminta supaya dapat mematuhi syarat-syarat seperti mana terkandung dalam borang permohonan seperti di lampiran 'Appendix 1'. Di samping itu, pihak tuan juga diminta mengemukakan 2 salinan *hard copy* dan 1 salinan *soft copy* kepada JAKOA Ibu Pejabat ***(Bahagian Perancangan dan Penyelidikan)***

copy to 3/5

Ruj. Kami : JAKOA.PP.30.032 Jld. 27 (7)

4. Pihak tuan boleh menghubungi Pegawai Jabatan Kemajuan Orang Asli daerah Kuala Kangsar untuk mendapatkan maklumat lanjut mengenai perkara di atas.

Sekian,

" BERKHIDMAT UNTUK NEGARA "

" KOMUNITI BERDAYA DESA BERJAYA "

Saya yang menurut perintah,

(SARGI BIN BAKAM)
sargi@jakoa.gov.my
Bahagian Perancangan dan Penyelidikan
b.p Ketua Pengarah
Jabatan Kemajuan Orang Asli Malaysia

s.k - *Pengarah JAKOA Negeri Perak/Kedah*
(No. Tel: 05-2540009)

- *Pegawai JAKOA Daerah Kuala Kangsar*
(No. Tel: 05-5975329)

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