

**K. Juliet A. Bedford**

GOMBAK HOSPITAL, THE ORANG ASLI  
HOSPITAL

Government healthcare for the  
indigenous minority of Peninsular  
Malaysia

*Gombak Hospital is a paradox for the Malaysian government. As the only government-run hospital for the Orang Asli, the indigenous minority of Peninsular Malaysia, this discrete medical service seems to contradict the government's policy of Orang Asli assimilation. This article explores the development of the Hospital and the Medical Division of the Department of Orang Asli Affairs, from its inception during the Emergency (1948–1960) when it formed part of the British hearts and minds campaign, to today in the climate of indigenous assertion. The historical detail is drawn from newly sourced primary material, particularly the unpublished diaries of Dr J. Malcolm Bolton. The medical service for the indigenous peoples of the peninsula is compared to the services in Sabah and Sarawak, where treatment of indigenous communities is incorporated into the wider rural healthcare services. The paradox of assimilation versus indigenous assertion dominates the provision of healthcare at Gombak Hospital and reflects the place of Orang Asli within contemporary Malaysia.*

Gombak Hospital, the hub of the Medical Division of the Department of Orang Asli Affairs (Jabatan Hal Ehwal Orang Asli, henceforth referred to as JHEOA) is an awkward paradox for the Malaysian government. The Medical Division represents the schism between the government's desire to assimilate the Orang Asli into mainstream Malaysian (specifically Malay) society, and their assumed interest in responsibly providing for the Orang Asli as the indigenous minority of Peninsular Malaysia. This article explores the paradox, by focusing on the role of Gombak Hospital in relations between the government and Orang Asli through comparison of the hospital at its inception to the institution it has become today. In one sense, Gombak Hospital may be seen as a case study that provides empirical evidence of the state of Orang Asli existence within contemporary Malaysian society. Yet Gombak Hospital is more than representative, for it actively contributes to the paradox Orang Asli face. This becomes more obvious when comparisons are drawn between the Orang Asli and the

indigenous groups of Sabah and Sarawak with respect to the differences in biomedical healthcare provision to which they are exposed.

The historical details presented are drawn, in part, from newly sourced primary material, particularly the unpublished diaries of Dr J. Malcolm Bolton.<sup>1</sup> My account also draws upon oral histories (including life histories) and patient narratives gathered during 18 months anthropological fieldwork conducted at Gombak Hospital (2004–2005). The ethnographic analysis is grounded in a broader discussion of indigenous peoples' health and healthcare provision in light of the United Nations Decades of the World's Indigenous Peoples and its Declaration on the Rights of Indigenous Peoples, adopted by the United Nations General Assembly in September 2007 (UN 2008).

### The Orang Asli in Malaysia

In Malaysia, ethnic identity remains the dominant ideological framework. It is key to the country's governing structures: its constitution, government, politics and economics. It also figures prominently in public discourse, whether in the world of big business and industry or in the lives of ordinary people, influencing where one lives, eats, shops, goes to school, one's religion and primary language. Despite the populist view that Malaysia's 'remarkable economic and social success is at risk from the increasingly separate lives its three main races are living' (*Economist* 2006: 25), national rhetoric continues to espouse Malaysia's pride at being a 'multi-ethnic' country that successfully weaves together social and cultural threads from its Malay, Chinese and Indian communities; hence the country's branding as 'Malaysia: Truly Asia'.

Against this backdrop, the Orang Asli have emerged as the indigenous minority of the peninsula. According to the JHEOA, there are 18 distinct ethnic groups that come under the generic name Orang Asli, 'Original Man', the name conceived by the British colonial administration as an etymologically responsible translation of aborigine (Benjamin 2002: 17). At the end of 2004, the Orang Asli numbered 149,723 (JHEOA 2004: 8).<sup>2</sup> Given their marked inter-group differences, the range of development pressures and living conditions to which they are exposed, in addition to their social and cultural variations, the majority of anthropological work to date has, understandably, used a particular group (however delineated) as the primary unit of research. This has resulted in the publication of a steady stream of compelling and scholarly monographs (including Dentan 1968; Endicott 1979; Karim 1981; Howell 1989; Gianno 1990; Roseman 1991; Lye 2004). In recent years however, the community has adopted the generic name Orang Asli in

<sup>1</sup>I am grateful to Malcolm Bolton and his sister Barbara Richmond for allowing me unprecedented access to his diaries. After Bolton's death in 2006, his diaries were deposited at Rhodes House in the Bodleian Library, Oxford.

<sup>2</sup>Sourcing reliable statistical data on the Orang Asli remains difficult and figures quoted should be regarded as indicative and not accurate. The JHEOA's census enumerates only the settlements and communities that come under its administration. The national census does not record Orang Asli separately from Malays, but brackets them together under the label *bumiputra*. The 2004 data I present is the most up-to-date statistics available. The 2005, 2006 and 2007 data has not yet been officially authenticated and the JHEOA have remained unable to provide me with more recent population figures.

self-identification as it forges an identity as the indigenous minority of Peninsular Malaysia. Rather than focusing on the specificities of component groups, my approach concentrates on the macro community as it has emerged as a distinct entity in relation to the nation state (see also Nicholas 2000; Nah 2003, 2004; Endicott and Dentan 2004). In this context, 'Orang Asli' is a widely shared representation that advocates a particular aspect of their existence, that of an emerging and contemporary community postulated, as Karim (2001: 13) has pointed out, on a sense of 'unity within diversity'.

As a community, their minority status in Malaysia is undisputed. Numerically they represent a tiny fraction of the peninsula's population (0.58%). In 1991, their literacy rate was about 30%, compared with the national rate of 86%. In 2004, 76.5% of Orang Asli lived below the poverty line, compared to 6.5% of other Malaysians; their average life expectancy at birth was 53 years, compared to the national average of 71.5 years; their average infant mortality rate was 51.7 deaths per 1000 births, compared to the national average of 16.3 deaths per 1000 births (figures extracted from Nicholas 2004, 2005; Nicholas and Baer 2007).

For both Orang Asli and other Malaysians, the indigenous status of the Orang Asli is more controversial than the fact that they are a minority within the peninsula. There is also continuing debate in the anthropological literature concerning the label 'indigenous', its use as a descriptive category and its relevance in international law (Bowen 2000; Colchester 2002; Kuper 2003, 2005a, 2005b; Kenrick and Lewis 2004; Barnard 2006; and with particular regard to Asia, Barnes et al. 1995). The United Nations has yet to develop a formal definition of 'indigenous peoples', but its Working Group on Indigenous Populations (WGIP) uses a working definition that emphasises four essential principles: priority in time, with respect to the occupation and use of specific territory; the voluntary perpetuation of cultural distinctiveness; self-identification, as well as recognition by other groups and by state authorities, as a distinct collective; an experience of subjugation, marginalisation, dispossession, exclusion or discrimination, whether or not these conditions persist (Kenrick and Lewis 2004: 5).

The Orang Asli satisfy these key requirements. International groups, including the International Working Group for Indigenous Affairs (IWGIA), regard them as indigenous and, crucially, the Orang Asli assert themselves as the indigenous peoples of Peninsular Malaysia. Whilst not yet fully engaged with the Fourth World forum (in contrast to indigenous groups in Sabah and Sarawak), there are signs that the Orang Asli are becoming more politicised and, through non-governmental organisations like the Center for Orang Asli Concerns (COAC), are beginning to forge links to the global discourse of indigenous peoples.

Within Malaysia however, notions of 'the indigenous' are further complicated by the concept of *bumiputra*. Meaning 'sons of the soil', this model recast the political and economic structure of the country and became the cornerstone of post-colonial state building (Reid 2001, Shamsul 2001). As enshrined in Article 153 of the Constitution, it affords the Malay extensive and special privileges. To Malay indigeneity based on the absolute rights of the *bumiputra*, the assertion that the Orang Asli are the truly indigenous peoples of Peninsular Malaysia is both problematic and an embarrassment.<sup>3</sup> With this

<sup>3</sup>See Hooker (1978: 172–85; 1996) and Rachagan (1990) for detailed discussions of the legal and constitutional position of the Orang Asli in Malaysia, and Nah (2006) for a summary of the historical background to issues of their indigeneity.

in mind, the JHEOA has a mandate to integrate the Orang Asli into mainstream Malaysian society through their assimilation (or ‘ultimate integration’) into the Malay section of the population (JHEOA 1961:2).

The idea of Orang Asli assimilation took on greater economic significance with the introduction of the New Economic Policy in 1971, which emphasised the eradication of hardcore poverty whilst reducing relative poverty. It targeted an economic share for the *bumiputra* with affirmative action, and came to form part of the then Prime Minister Dr Mahathir’s Vision (*Wawasan 2020*) to achieve fully industrialised nation status for Malaysia by the year 2020. The aim of raising the socio-economic indicators of the Orang Asli to equate with that of other Malaysians should be considered inherently positive. However, by emphasising market-orientated activities as progressive, traditional subsistence, epitomised by the Orang Asli, came to be regarded as fundamentally backward. As Nicholas (2000: 47) stresses,

The state regards the lifestyles of the Orang Asli and attachment they have to their territories as impediments to modernisation. The antagonism is further intensified if the state perceives that it cannot modernise effectively if it were to tolerate indigenous minority culture in its midst.

It seems contradictory, therefore, that the government maintains a distinct medical service run specifically for the Orang Asli, the Medical Division of the JHEOA. Since the integration of Orang Asli education into the Ministry of Education in 1995, this Medical Division is the government’s only service provider to be organised according to ethnic criteria and is the only state-run medical service that is not under the auspices of the Ministry of Health. The Orang Asli community is the sole recipient of a discrete government-run medical service. Whilst Orang Asli are entitled to receive free treatment at any mainstream government clinic, the Medical Division caters almost exclusively for the Orang Asli. The flipside to this positive discrimination is that the community, already a minority numerically, socially, economically, politically and culturally, is further marginalised by a healthcare system which is outside the mainstream provision of the Ministry of Health. In addition to these inequities, the standard of Orang Asli health remains far below the national average and the community carries an increased burden of illness and disease. The disparities in both health status and healthcare provision continue to set the Orang Asli apart from the rest of the population, in direct contrast to the call for assimilation. However, the historical precedent for such a service remains influential, as we shall see below.

### The Medical Division and its colonial legacy

It is widely accepted that the establishment of healthcare services specifically for the Orang Asli was a consequence of British policy during the Emergency (1948–1960), a period of insurrection by the Malayan Communist Party (MCP) aimed at overthrowing the British (Bolton 1968; Carey 1976; Nicholas 2000; Endicott and Dentan 2004; Nicholas and Baer 2007). It should also be considered, however, in the context of the wider colonial endeavour that had set a precedent for utilising medicine as a tool of empire (Headrick 1981) ‘to serve non-medical goals of a society’s dominant groups’

(Morsy 1996: 31). The centrality of medicine in imperial rule has been well demonstrated. Arnold (1988: 2), for example, identifies disease and medicine,

as a site of contact, conflict and possible eventual convergence between western rulers and indigenous peoples, by illustrating the contradictions and rivalries within the imperial order itself, by identifying the importance of medicine and disease to the ideological and political framework of empire, and by drawing attention to the role of medical agencies and practices in shaping the impact and identity of colonial regimes.

All these motives, from the military to the commercial aspects of statecraft, may be identified in colonial Malaya and as Manderson (1996) makes clear, medicine was appropriated as a politically expedient way to consolidate and legitimate imperial rule. Due to the nature of colonial concern, medical intervention was necessarily selective and concentrated on areas considered vital to the administration. This value-laden system, where medicine was used only when it could sustain practical returns, led to the general neglect of large sectors of the population with whom the administration had little contact, including the rural Malays and the Orang Asli.

Whilst missionaries working amongst the Orang Asli long appreciated medicine as a profitable tool in terms of establishing contact and gaining influence (Favre 1865; Means and Means 1981) the British colonial government had few formal links with the indigenous groups of the peninsula before World War II. There was no coherent policy regarding their jurisdiction and any active involvement was carried out in a disparate fashion at the local levels of state or district (Nagata 1997). What minimal contact there was came through small-scale trade and research interests, but the administration assumed no responsibility for them. The groups endured as discrete communities largely because they lived outside the realms of direct rule by inhabiting what was regarded as the distant interior of the peninsula. Change came when the government's internal security agenda provoked recognition of the aboriginal groups and forced an administrative policy concerning the Orang Asli to be devised on a national scale. As Harper (1997: 28) asserts, the Emergency caused 'a traumatic period of consolidation of colonial authority which dragged the Orang Asli into wider political conflicts and exposed them to new pressures'.

In 1950, the Department of Aborigines (the precursor to the JHEOA) was established with the central objective of countering the MCP guerrilla position with the Orang Asli. Under Richard Noone, a member of the Federation Intelligence Committee who was appointed Adviser of Aborigines in 1953, the Department was transformed into an effective unit with offices in many states and a large body of both administrative and field-based staff. These enhanced resources gave credence to the Department that embarked upon an ambitious exercise of social intervention and manipulation (cf. Hack 1999). The 'hearts and minds campaign' of General (later Field Marshall) Sir Gerald Templer (High Commissioner 1952–1954) required the administration, for the first time in strategic planning, to cross into the interior, into the domain of the Orang Asli, rather than bring Orang Asli out to the administration. The most immediate way in which this occurred was with the establishment of jungle forts in key areas where there were thought to be appreciable numbers of both Orang Asli and Communist guerrillas. The forts, manned by the Police Field Forces,

a paramilitary body trained in jungle warfare, made government presence felt in a tangible and permanent way.

In theory, the Department was responsible for all matters concerning the Emergency administration of the Orang Asli, yet its primary aim remained to break the hold of the MCP. About this the government was quite candid. Williams-Hunt, Noone's predecessor as Adviser of Aborigines, was commissioned by Templer to write *An introduction to the Malayan aborigines* (1952), intended as a practical guide to British Security Forces involved in jungle warfare against the MCP. In his foreword Templer asserts that 'without some understanding of the background and outlook of these fascinating people, it is impossible to make use of them on operations'. In his foreword to Holman's *Noone of the Ulu*, written after he had left Malaya, Templer is even more forthright stating 'Let me be quite frank. The only reason why I directed that something must be done about the aborigines of Malaya was that they had become a vital factor in the Emergency' (Holman 1958: ix). One of the most effective ways in which the Department began to gain the confidence of the Orang Asli was through the provision of welfare services at the jungle forts. In a letter to Oliver Lyttelton, the Secretary of State for the Colonies, dated 3 November 1952, Templer declared that 'a contest is going on between us and the communists over gaining the confidence of the Sakai [the exonym used prior to Orang Asli]. We're both very hot on Sakai welfare' (Cloake 1985: 257).<sup>4</sup>

A significant factor in the fostering of relations with Orang Asli was the provision of an adequate supply of medicine and increased access to simple healthcare through the expanded network of jungle forts. In line with the long-established tradition of manipulating healthcare, the British administration used medicine effectively in the hearts and minds campaign as 'a demonstration of their benevolent and paternalistic intentions, as a way of winning support from a newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony than could be derived from conquest alone' (Arnold 1988: 16). Noone (JHEOA 1959: 9) asserted that 'one of the most powerful weapons in the battle for the control of the aboriginal peoples was, and still is, the ability to cater adequately for their medical needs'.

Initially the healthcare offered to Orang Asli through existing medical channels was limited and problematic. The scarcity of resources hindered anything but the most trivial of services and issues of access and location were major impediments. According to Leary (1995: 46) Williams-Hunt accused the Department of Health of being unhelpful and was critical of its officers who 'felt it was incumbent on sick Aborigines to make their own way to a hospital rather than be serviced by staff in the field'. The jungle forts therefore provided crucial access to groups in the interior and offered a potential network through which medical welfare could be administered.

---

<sup>4</sup>Malay ruling class ideas about the Orang Asli, the impression that they are backward, lazy and harbour negative, even deviant traits, are derived, in part, from notions of the Sakai. It was never a term of self-reference and is inherently pejorative. Repeatedly they were referred to by comparison with the dominant population and there emerged an assumption, still in evidence today, that the Sakai represented an early stage of Malay development, a pre-civilised society that had not yet progressed into the modern era. For comparison with the Australian colonies and their relations with aboriginal Australians see McGregor (1997).

In 1955, the Department of Aborigines secured the employment of two doctors as Medical Officers for the Department, Dr Hans E. Lichtenstein (1955–1957) and Dr Malcolm J. Bolton (1955–1972). They were responsible for providing medical services to the forts, and were to treat any Orang Asli in the vicinity in addition to the police and military personnel stationed there. Both doctors were appointed by the Department of Health and seconded to the Department of Aborigines. According to Bolton, the Department of Health, which was very short of Medical Officers and no longer permitted to employ doctors from overseas, was strongly opposed to the appointment of two expatriate Medical Officers for the care of the Orang Asli and the Police Field Force. Their opposition was overruled as the appointments were ‘regarded as a priority in the fight in the jungle against the Communist insurgency’ (Bolton, Diary, 14 December 1955).

The doctors shared their workload geographically, using the peninsula’s north-south mountain range as a dividing line, and used pioneer aeroplanes (and later helicopters) to access the remote forts. Bolton nicknamed their monthly tours the ‘Fort Express’. Each fort was visited in rotation and one tour would often take in excess of four days, moving between the forts by air, boat and foot, weather permitting. In addition it was assumed, although not made explicit in their contracts, that the doctors had a medical duty to treat Orang Asli elsewhere in the peninsula, including those who did not live close to a jungle fort and were considered outside the reach of the existing medical services.

When Lichtenstein left Malaya in 1957, Bolton assumed responsibility for the whole peninsula and all the jungle forts. By this time, a small cottage hospital, designated for the treatment of tuberculosis patients, had been built at Gombak, the research station of the Department of Aborigines. In April 1957, Bolton moved to Kuala Lipis to establish the headquarters of the Medical Division of the Department. His aim to provide a stable medical service depended upon opening a medical centre accessible to Orang Asli, especially those from deep jungle areas and Kuala Lipis was well situated for this purpose. In addition to treating Orang Asli as in- and out-patients, the ‘Aborigine Medical Centre’ administered to Department staff and their families and to the police of Kuala Lipis District. Bolton also trained the Medical Orderlies of the Police Field Force. These six-week courses enabled the Medical Orderlies stationed with police platoons in the jungle to assist in the treatment of Orang Asli at the forts and helped foster good community relations. The first police Field Force medical training course was held from 9 to 18 August 1957. In addition to the seven police undergoing training were three Orang Asli (two Semai and one Temiar). That July, Bolton had received permission from Noone to train a small number of Orang Asli as Medical Field Staff. This important development underpinned Bolton’s perception that to be effective, the Medical Division had to involve Orang Asli as healthcare providers, rather than just administer to them as patients. In line with this, another of Bolton’s major innovations was the *bomoh* (traditional healer) training course.

Described in detail in his diary, the first course was held from 22 to 29 September 1957 and included 17 *bomoh* from the Temerloh district of Pahang. In the mornings, the participants received lectures on the use of certain drugs, dressings and hygiene, and in the afternoon were taken to see the facilities of Kuala Lipis, including the District Hospital and Dental Clinic (where, according to Bolton [Diary, 22 September 1957] two *bomoh* fainted whilst watching a dental extraction!). At the end of the course, each *bomoh* was presented with a badge and box containing a bottle of Acriflacin lotion

for wounds, cotton wool, bandages, a sling and medicines with which to treat their community upon returning home. The medicines were stored in colour-coded containers for ease of administration – red for chloroquine, blue for aspirin, yellow for vitamins. The presentation of this medical box, further to its practical importance, served as a visible sign of the Division's medical authority.

Twenty-four *bomoh* courses and several revision courses were held between 1957 and 1961 and around 300 *bomoh* were trained. Whilst there was no guarantee that upon return to the village the medicines would be used, or used correctly, the courses forged stronger ties between the Medical Division and the Orang Asli. The *bomoh* became acquainted with the Department and its staff in a safe environment that allowed them to see the workings of the Medical Centre and encouraged them to seek the biomedical healthcare available. In an insert to his diary (September 1957) Bolton concludes,

the trained *bomoh* were very valuable to us at a time when we had limited daily contact with Orang Asli and limited funds. They acted as envoys who told their communities that we were there to give them medical help and also they introduced us when we visited their community.

At the end of the Emergency, Bolton transferred to Gombak and secured an increased allocation of funds from the government's Second Five-Year Plan (1961–1965) to develop the Division's capacity and capability. The small hospital at Gombak was extended, new buildings erected and a proper sanitation system introduced. English lessons were given to the staff and occupational therapy to the patients. The film unit from the British High Commission came out from Kuala Lumpur to screen films fortnightly and Bolton, with his growing staff, continued to give health lectures in Malay, Temiar and Semai languages. On 10 April 1961, Bolton wrote in his diary that 'the number of cases of aborigines treated at medical posts is double what it was this time last year and the number of hospital admissions continues to rise'. From Gombak, Bolton continued to oversee the medical Centre at Kuala Lipis and perform the monthly round of fort visits. In addition he introduced new healthcare programmes including maternity training at a special maternity unit at Gombak, vaccination programmes for all Orang Asli including MMR (measles, mumps and rubella) and tuberculosis screening using a portable X-ray machine. By 1962 he had compiled a register of all Orang Asli tuberculosis and leprosy patients and had started collaborating on various research projects.

From this period of rapid expansion onwards, Gombak has remained the hub of the Department's Medical Division. When Bolton left Malaysia in 1972, it was a 400-bed hospital, seeing about 350 patients a day and admitting around 34,000 annually. There were 139 jungle medical posts that administered up to 62,000 new treatments in 1972 and the Medical Division boasted a staff of 528 persons, 475 of whom were Orang Asli (Bolton 1973b: 1124). The provision of and access to healthcare for all Orang Asli, including those living in the interior, was at that time superior to the services experienced by Malays living in rural areas, a remarkable feat considering the marginalised status of Orang Asli in comparison to the Malay population.

The two decades after the end of World War II saw the (indigenous) minorities of Southeast Asia emerge as politically relevant communities and in the same period as the

JHEOA was being established in Malaya, neighbouring countries developed comparable systems for the administration of their minority groups. A major component of such administration was increasing the internal security of these countries and their border regions in response to the perceived threat of Communism. In Thailand for example, the Ministry of the Interior controlled the mountainous upland areas through the Department of Public Welfare and in 1951 established the first committee 'in charge' of the hill tribes. In 1964, the Thai government approved the development of the Hill Tribe Research Centre (HTRC) with the aim of collecting and disseminating information about the 'target' population. According to Gillogly (2004: 122) the HTRC stated in 1971 that Thai development and planning measures must be,

aimed at increasing the involvement of the rural people in the life of the nation in such a way that they will not feel the need to resort to violence in order to attain a secure and satisfying way of life for themselves or their offspring.

These sentiments of assimilation are similar to those expressed in the JHEOA 1961 'Statement of Policy regarding the Administration of the Orang Asli in Peninsular Malaysia', and also echo the approach adopted by the Commission on National Integration in the Philippines. The Philippine Commission was set up following Independence in 1946, and was authorised by a 1957 Act of Congress to 'effectuate in a more rapid and complete manner the economic, social, moral and political advancement of Non-Christian Filipinos' (Eder and McKenna 2004: 61). In all of these administrative schemes, provision of services including education and medicine were used as incentives for the population.

The complex military situation during the Emergency ensured that not all Orang Asli could be contacted or welfare extended to all areas. Yet medicine, in line with its utilisation in other colonial settings, was deployed to great effect in the campaign where and when it was practical to do so. Tactics born in Malaya were then developed in the fight against Communism in Vietnam and Laos and veterans from the Emergency went on to play important roles elsewhere in Southeast Asia (Aldrich 2001; Busch 2002; Varsori 2003).<sup>5</sup> Noone, following his success in Malaya with the Orang Asli and the Senoi Praaq (his paramilitary-styled group of Orang Asli jungle soldiers), was appointed as an adviser on aborigines to the Southeast Asian Treaty Organisation in 1961, and in 1962 was heavily involved with the hill tribes of Vietnam, particularly the Montagnard. Similarly, Robert Thompson, the Permanent Secretary of Defence in Malaya (1957–1961) was then appointed head of the newly established British Advisory Mission to South Vietnam and in 1969 became a special adviser to US President Richard Nixon (Thompson 1966; Beckett 1997). Alongside the military development of jungle guerrilla warfare, medicine continued to be used as an 'apolitical avenue through which favourable influence may be maintained' (Neel 1968) and according to Leonard Friedman (1960), a psychiatrist for the United States Special Forces, medicine was used to

---

<sup>5</sup>McFaddon (2005) goes so far as to argue that lessons learnt from the British success in the Malayan Emergency should be incorporated in the development of America's Joint Interagency Task Force to combat the threat of Al-Qaeda inspired terrorism. See also 'After smart weapons, smart soldiers' (*Economist*, 25 October 2007).

develop 'mutual trust' and so contribute to the 'solution of the South Vietnamese insurgency' (Paul 1978: 277).

### Gombak Hospital

Despite the confidence instilled via the deployment of medicine, in Southeast Asia, only Malaysia established a health service specifically for its indigenous minority on the peninsula (but not for the indigenous communities in Sarawak and Sabah, as discussed below). Gombak Hospital with its network of healthcare services remains the flagship of the JHEOA. Both national and international delegations frequently visit Gombak to be guided around the facilities that are heralded by the government as a model of effective healthcare for their indigenous population. Yet both the providers and receivers of healthcare at Gombak openly question the true effectiveness and even the continued existence of the JHEOA Medical Division.

Today the Division continues to rely upon the framework of hospital and outstations that was, in essence, devised half a century ago. Whilst it provided unprecedented access to the interior of the peninsula during the Emergency and post-Emergency eras, the network was designed to infiltrate areas of specific importance to that period. The demography and requirements of the Orang Asli communities have evolved since then, but the framework has not and the pattern of delivery now has limited relevance in terms of access to the most needful communities.

Whilst the network may remain intact, the motivation and ethos driving the Medical Division and delivery of healthcare has changed dramatically. Bolton ensured that the Medical Division actively engaged Orang Asli as providers of healthcare and fostered education and employment opportunities in roles other than as patients. He concluded that 'without doubt the key to the success of the medical service for the aborigines has been the recruitment and training of aborigines in medical duties' (Bolton 1968: 819). One of the Division's strengths lay in the fact that it did not just provide services to the Orang Asli but functioned for and with the community. Hence, Gombak was known as the Orang Asli Hospital. The name persists yet the community's involvement has diminished. Since the early 1990s there has been no official government recruitment of Orang Asli health workers and, reflecting the JHEOA overall, the staff body at Gombak has become increasingly Malay dominated.

Because of its orientation and location, the hospital is widely considered to be an isolated backwater of the medical profession in Malaysia. It rarely attracts high-calibre medical staff, and the majority of non-Orang Asli employed claimed ignorance of the hospital prior to their secondment. In contrast to the apparent dedication to healthcare delivery in Bolton's era there has developed, according to one critical doctor, an atmosphere of 'institutionalised laziness' in which the hospital is continually devalued.

In Bolton's era, patients and *pengiring* (accompanying relatives or friends) were encouraged and the hospital regarded them as 'an excellent captive audience for health education lectures and for initiating preventative health measures amidst otherwise relatively inaccessible communities' (Bolton 1973a: 74). Practical instruction was provided on a wide range of subjects including malaria and tuberculosis, maternal and child healthcare, family planning and personal hygiene. There was a playgroup and

school for children and the sewing and cooking classes were attended by both male and female patients. Such activities are no longer afforded priority at the hospital and have been reduced to two hourly sessions each week at which attendance rates are very low and patients have little incentive to participate. The organisation of educational or practical activities is not integrated into any job description at the hospital and no one person will assume responsibility for the programme. The nursing staff consider even minimal involvement in the morning sessions to be an additional burden. The Sisters encourage patients to attend, but their lack of enthusiasm and marked absences are often interpreted as a lack of interest and laziness. Whilst these attitudes are apparent in some patients, others informed me that they would find practical classes including reading, writing, cooking and sewing to be beneficial. They intimated that if they could learn useful transferable skills they would attend the sessions, especially if they were consulted as to their form and content. As there is no positive dialogue between patients and the hospital authorities, this seems unlikely.

If the government wanted to achieve positive development through Gombak Hospital, then offering a sustained programme of education and vocational skills to patients would be an effective measure. Structured activities would provide patients with positive tasks to accomplish and may help to abate some of the lethargy and depression that is common on the wards where there is little to occupy the time. By encouraging participation in this way, the patients could purposefully engage with their surroundings and would regain some legitimate agency within the hospital environment. In addition, basic skills could be improved and through the training of individuals, the flow of information from the hospital to the family unit and into the village group upon returning home would be of benefit to the whole community.

The lack of structured education is most problematic when children are at the hospital for a prolonged period of time, either as patients or *pengiring*. Whilst the government's policy is that all children should attend school, this is not implemented at the hospital. This sets a bad example and is considered unsatisfactory by patients and staff alike, yet in the context of poor school attendance rates by Orang Asli generally, it is not regarded as remarkable and there is no impetus to remedy the situation.

For Bolton (1973a: 71) it was imperative that the Orang Asli,

be encouraged to lead as normal and active life as possible while they are at the hospital. Most cook their own food for which they are provided with rations . . . The patients are free to fish, hunt, gather jungle produce, or just wander.

As the JHEOA evolved, however, the Medical Division adopted an increasingly authoritarian stance towards its patients, and influenced by the government's paternalistic attitudes, in-patients became regarded by the hospital authorities as wards of care. Today, official policy states that patients are not allowed to leave the immediate vicinity of the hospital grounds without permission. In the case of long-term admissions, patients are deprived of their livelihood and with their movements restricted, are forced to be dependent upon the hospital. Some derive a small income from making traditional handicrafts that are sold through a collective. Others have salaried jobs in Gombak or Kuala Lumpur and several *pengiring* are contract gardeners and refuse collectors. Although such employment is technically not permitted, its existence is an open secret amongst the nursing staff. In one case a doctor even arranged employment for

the young husband of one of his patients. The same doctor informed me that the hospital authorities were frightened they would be held responsible for any accident or trouble involving a registered patient outside the hospital's domain. This situation is a vicious circle for the patients. Through the hospital's paternalistic policies, the patients and *pengiring* are dependent on the hospital's services, but by relying solely on the food, clothing and amenities provided, they are accused of being lazy and criticised for accepting 'hand-outs'. Yet, to do anything else, they must contravene hospital rules.

The difficulties caused through lack of education and employment opportunities for *pengiring* has given momentum to an argument amongst the hospital's more senior staff that the attendance of friends and family should be actively discouraged. They suggest that Orang Asli patients are now 'developed' enough to deal with periods away from their communities. There is a sense that the prolonged presence of *pengiring* is, according to one doctor, an attempt to 'take advantage of the hospital's generosity'.

### Provision of healthcare to indigenous minorities – Sabah and Sarawak compared

The delivery of healthcare to the Orang Asli is, in some ways, similar to the delivery of healthcare to indigenous peoples across the world. It is ubiquitous that this delivery comes predominantly from the government (public) sector, is constrained by limited resources and socio-economic barriers, must be provided to disparate communities that are discrete and difficult to access, and, over the last 50 years or so, has become increasingly and intricately linked to national and international policies of 'development'. The identification of themes that dominate the perceived 'plight' of indigenous peoples (an enduring lack of representation; legal territory rights; control of indigenous knowledge; sustainability; heritage etc.) have led some commentators to suggest that it may be more illuminating to compare indigenous groups with other indigenous groups, rather than with non-indigenous peoples.

Stephens et al (2005: 12) argue that due to their unique relationship with the nation states in which they live, 'indigenous peoples are not merely another population group with ill health' but one that deserves special attention. In 2006, *The Lancet* turned its attention to indigenous peoples by publishing a series of commissioned articles on 'Indigenous Health' (Anderson et al. 2006; Montenegro and Stephens 2006; Ohenjo et al. 2006; Stephens et al. 2006). The series emphasised the social determinants of health and healthcare inequalities (Marmot 2005), stressing the structural barriers that prevent improvements in generalised health status and in effective and accessible healthcare delivery by mainstream services. More importantly, however, the authors confirmed through their analyses of health indicators from around the world, that indigenous peoples have consistently lower standards of health than the rest of the population within a given country. Reliable disaggregate data relating to the health of indigenous groups is limited, yet throughout the information available, consistent patterns emerged, for as Brown (2003) argues, their 'health problems and needs . . . are not unknown even if they are not clearly defined by health and demographic data'. Indigenous people generally have higher morbidity and mortality patterns than other populations groups, a substantially lower life expectancy and elevated infant and child mortality rates. They also have disproportionately high levels of communicable and

vector borne diseases including malaria, tuberculosis, yaws, leprosy and diarrhoeal disease as well as high levels of cancer, respiratory disease, stroke and diabetes. In 2002, for example, the Orang Asli community had an incidence rate of 1.06 per 10,000 population for leprosy and 10.3 per 10,000 for tuberculosis, compared to the national incidence of 0.06 and 5.9 respectively.<sup>6</sup>

Whilst it is possible to trace broad historical and social trajectories that have contributed to the disadvantages indigenous peoples currently face, local particularities must also be accounted for. In addition to the generalised features of embedded structural inequities that lead to an indigenous community's poor standard of health and health services, ethnology shows that localised specificities play an important role in shaping the pattern and method of healthcare provision. Within Malaysia, the health status of both the Orang Asli and the indigenous peoples of Sabah and Sarawak remains far below the national average, yet the delivery of healthcare to the Orang Asli is, in important ways, markedly different from the services found in Sabah and Sarawak.

East Malaysia has a greater proportion of 'interior territory' with less infrastructure than the peninsula. Sarawak is similar in size (124,449 km<sup>2</sup>) to the peninsula (131,587 km<sup>2</sup>) and Sabah two-thirds its size (74,398 km<sup>2</sup>), yet according to the 2000 census, the peninsula boasts 79% of the national population, Sabah 11% and Sarawak 10%. There are an estimated 133 people per square kilometre in the peninsula, 34 people per square kilometre in Sabah and 18 people per square kilometre in Sarawak.<sup>7</sup> Outside the main urban centres the population is of low density and uneven distribution, making the per capita cost of healthcare provision high and the delivery of basic services logistically difficult. Whereas the Orang Asli make up around 0.6% of the peninsula's population the indigenous communities constitute 60% and 50% of the populations of Sabah and Sarawak respectively.<sup>8</sup> The communities are also dealt with differently from the Orang Asli in Malaysia's Constitution (Rachagan 1990). The designation 'native of Sabah and Sarawak' is used as their term of reference and the indigenous groups of Sarawak (although not those of Sabah) are listed by 'tribal' name.<sup>9</sup> Whilst marginalised in similar ways to the indigenous groups inhabiting the peninsula, the 'native groups' of Sabah and Sarawak have not been collected under a generic label (such as Orang Asli) and, numerically at least, are not a minority.

The major difference in the provision of healthcare lies in the institution responsible for delivery. As discussed, for the Orang Asli, the Medical Division of the JHEOA established during the Emergency remains the main provider of healthcare from the government sector, although the Ministry of Health has assumed responsibility for certain areas

<sup>6</sup>These figures were obtained from the Tuberculosis and Leprosy Control Unit in the Disease Control Division of the Malaysian Ministry of Health.

<sup>7</sup>Figures based on the 2000 Population and Housing Census of Malaysia. For details refer to the Department of Statistics Malaysia <<http://www.statistics.gov.my>> and the World Fact Book of the Central Intelligence Agency <<http://www.cia.gov/library/publications/the-world-factbook/geos/my.html>>

<sup>8</sup>International Working Group for Indigenous Affairs <<http://www.iwgia.org/sw18358.asp>>

<sup>9</sup>In Sarawak there are officially 28 groups listed, but according to the International Working Group for Indigenous Affairs, 37 groups and sub-groups are known, and in Sabah more than 30 groups are recognised. <<http://www.iwgia.org/sw18358.asp>>

and services. Sabah and Sarawak, which joined the peninsula in 1963, six years after independence, to form a new Federation of Malaysia, lack an equivalent of the JHEOA operating within their state boundaries (the JHEOA is unconcerned with the indigenous groups of Malaysia outside the peninsula). Like the Orang Asli, the communities in Sabah and Sarawak first received biomedical healthcare from missionaries, explorers, colonial administrators or the military. Baer (2006: 64) asserts that many Kelabit received medical attention from the British troops stationed in their areas from 1945 to 1952. However, a specific medical division to service the indigenous population was never established. Today, healthcare services are provided by the national Ministry of Health and the state health departments, with supplementary funding from the state governments which function with greater autonomy than those of the peninsula which fall under the autocratic gaze of Kuala Lumpur.<sup>10</sup>

No published research has analysed the overall provision of healthcare to the indigenous peoples of Sabah and Sarawak specifically, but several works focusing on the provision of healthcare within the state more generally, show them to be engaged with mainstream rural healthcare services. In *Vital signs, health in Borneo's Sarawak* (2006) Baer conducts a similar study to her *Health, disease and survival* (1999), which was a comprehensive review of Orang Asli health. There, she mentions biomedical healthcare provision only briefly and in relation to poor health outcomes and malpractice rather than to provide any details of delivery. In her more recent Borneo work however, Baer does include a chapter, 'Health Services', which provides a short summary of mobile and static clinics, dentistry and health promoter volunteers. Khoo (2007: 189) discusses healthcare services in Sarawak in more depth and states that the health-seeking behaviour of the indigenous population is 'not hugely different from others'. Khoo (2007: 189) concludes that,

a discussion about health care provision for indigenous groups in Sarawak translates largely into issues relating to rural health delivery in a context of a large area with a relatively small – and lower income – population and difficult communications.

The methods of healthcare delivery described by Baer and Khoo are similar to those discussed by Chandler (1989) in relation to Sabah.<sup>11</sup> District hospitals, rural clinics, village clinics, dental clinics, mother and child clinics, mobile clinics and flying doctor services are all in operation. In Sarawak, the flying doctor service was established in 1973 and now covers 175 locations and 70,000 persons (Khoo 2007: 195). As in the peninsula, and Sarawak, where visits are announced over public radio services in the vernacular, the flying doctor service in Sabah also operates on a monthly basis and is similarly limited by resources and scheduling disruptions due to the weather conditions. In Chandler's analysis (1989: 115–16), this helicopter-based service offers inadequate provision for the people living in the most remote areas of Sabah whom she found dissatisfied with the service. Yet, despite its 'inappropriateness' in terms of accessibility, provision and annual operating costs, Chandler concludes, as I do for the peninsula (Bedford 2007), that its visibility renders it a useful tool for the government.

<sup>10</sup>For details of the Sarawak Health Department see <<http://www.sarawak.health.gov.my>> and for the Sabah Health Department see <<http://jknsabah.gov.my>>

<sup>11</sup>I am not aware of a more up-to-date study of healthcare in Sabah.

Another similarity in provision is the role of health volunteers. In the peninsula, this strategy has only recently been re-implemented among Orang Asli, perhaps as compensation for the reduction of professionally trained Orang Asli medical staff, but as Nicholas and Baer (2007: 131) conclude, 'the programme to train village-level Orang Asli Health Volunteers (*Sukarelawan Kesihatan*), although an excellent idea, has unfortunately yet to achieve its desired goals'. Khoo (2007: 195) and Lubon (2006) assert that the programme of Village Health Promoters in Sarawak was started in 1981 whereas on their website, Sarawak Health Department cites 1983, the date also quoted by Baer (2006: 70). According to the latter, the *Wakil Kesihatan Kampung* are unpaid representatives (*wakil*), either male or female, who have been selected by their village to provide basic health needs. The representatives undergo simple training at their rural clinic, which then dispenses medical kits to the trainees. According to Baer (2007: 71), by 2001 over 2900 *wakil* had been trained and were administering to more than 1,500 villages. The Ministry of Health asserts there are 2,500 trained Village Health Promoters that reach nearly 2,000 villages and service over 300,000 people in Sarawak (Lubon 2006). Reporting for UNICEF, Lubon (2006) quotes Dr Narimah Awin, Director of the Family Health Development Division of the Ministry of Health suggesting that,

the Village Health Promoters, in effect, are internal agents for change, serving to motivate, organise and mobilise their own communities. Since they come from within the communities themselves, they serve as ideal, trusted entry points to build partnerships and to encourage the communities to take responsibility for their own health and well-being.

However, Khoo (2007: 195) argues that the programme 'has not functioned well, especially in more remote areas, as provisioning them is a problem and Village Health Promoters are all volunteers without any incentive scheme. Thus, irregular contact and communications has resulted in a decline in their activity after an initial spurt'. In contrast to the generally negative attitude of medical staff working with Orang Asli that I witnessed, Baer and Chandler both claim that despite the hardships of being employed in remote areas and under limiting conditions, the staff in Sarawak and Sabah were diligent workers. Baer (2006: 65) attests to their 'praiseworthy dedication' whilst Chandler (1989: 109) concludes that all the health workers to whom she spoke 'believed in their work and were conscious of the important role they played in providing health care services... There appeared to be a high level of job satisfaction'. The contrast with counterparts at Gombak is stark. Nicholas and Baer (2007) suggest that the medical staff at Gombak have become condescending caregivers with devaluing attitudes that permeate the way they dispense medicine. They state that 'it is not uncommon to hear JHEOA doctors attributing their 'sacrifice' to serve the Orang Asli to their 'pity' for the people' (Nicholas and Baer 2007: 131).

The most noticeable disparity between the rural health services of East and West Malaysia lies in overall evaluation. Commentators remain critical of healthcare services in the peninsula (Chee and Barraclough 2007), especially concerning the inequalities of provision associated with the Orang Asli (Nicholas and Baer 2007) where the quality of service is poor, the coverage limited and there is only minimal community

participation.<sup>12</sup> Chandler's analysis of healthcare in Sabah suggests that the quality is acceptable, the coverage is partial but satisfactory and that there is some community participation. At the opposite end of the spectrum is Khoo's positive evaluation of healthcare in Sarawak, in which he claims that the quality of service is very good and that the state enjoys comprehensive coverage that benefits from flexibility of delivery and positive community participation. Despite areas of concern, particularly child under-nutrition and the rise of malaria, Khoo (2007: 196) asserts that 'the provision of facilities and services and the policies and practices adopted have resulted in outcomes that are amongst the best in the developed and developing world'. He concludes that overall 'Sarawak is a model of how a publicly financed healthcare system can achieve near-universal coverage for basic healthcare and preventive services – with hugely positive outcomes' (Khoo 2007: 187). In this model, the treatment of indigenous communities is incorporated into the wider rural healthcare services.

The period of fieldwork I conducted at Gombak Hospital bridged the two United Nations Decades of the World's Indigenous Peoples and in September 2007, the month after celebrating 50 years of independence, Malaysia voted to adopt the United Nations Declaration on the Rights of Indigenous Peoples (UN 2008). Part 5 Article 24 of the Declaration relates to health and healthcare provision. It states that indigenous peoples have the right to their traditional medicine and health practices, including the right of protection of plants, animals and minerals used in medicine, and that indigenous peoples shall also have access to all medical institutions, health services and medical care without discrimination. Paragraphs 35–41 of the Second International Decade of the World's Indigenous People (UN 2005) appertain directly to health and recommend that targeted policies, programmes, projects and budgets for indigenous health problems are adopted in strong partnership with indigenous peoples.

*The Lancet* series also stressed that the active participation of communities in the arenas of service development, management and delivery is crucial if sustained improvements are to be achieved. Yet, as Garrett (2007: 16) asserts, 'virtually no provision exists to allow the world's poor to say what they want, decide which projects serve their needs, or adopt local innovations'. Stephens et al. (2006: 2026) suggest 'indigenous peoples might continue to be ignored by international health policy simply because they do not fit into the predominant lens of public health utilitarianism that has predominated in the creation and action of health policy'. Whilst this may be true, increasing the capacity of primary healthcare services is unlikely to yield substantial gains in indigenous health without the community's active participation at all levels.

Under Bolton, the Orang Asli did actively participate in the Medical Division and its targeted healthcare provision was adopted in strong partnership with the community. Today, the reverse is evident. At a time when there is increasing vigour to the international calls for effective capacity building for indigenous peoples' health and wellbeing, with an emphasis on self-determination and participation, current policies of the Malaysian government are actively reducing the number of medically trained Orang Asli who provide healthcare to their community and limiting the opportunities for the community's involvement. Their stance is in direct contrast to the Second

<sup>12</sup>The inclusion of an Orang Asli orientated article (Nicholas and Baer 2007) in Chee and Barraclough's (2007) edited volume on healthcare in Malaysia suggests (in addition to an Orang Asli sympathetic editor) that indigenous healthcare is becoming increasingly visible.

International Decade of the World's Indigenous Peoples. The Medical Division of the JHEOA could be working effectively towards achieving the above goals, yet there is little evidence that Gombak is being used constructively or its developmental potential maximised. The political will for using the hospital as a platform for the Orang Asli is lacking and the Division now functions at a relatively diminished capacity.

### The Orang Asli Hospital

The diversity of indigenous peoples in Malaysia can be seen in their varied cultural and political histories. The Orang Asli and indigenous groups of Sabah and Sarawak occupy discrete places within the nation state and have particular relations with both state and federal governments. This has given rise to the distinct patterns of healthcare provision evident across East and West Malaysia. The fact that indigenous groups have been integrated into rural healthcare services in Sabah and Sarawak ensures that indigenism is conceived of in ways different to those found on the peninsula where ethnic identity remains a forceful (and often negative) dimension in healthcare provision.

The Ministry of Health is poised to assume control of Gombak as a district hospital but although the idea of assimilating Orang Asli healthcare into the mainstream has been mooted for some years, to date no definitive action has taken place and, for the time being at least, Gombak looks set to remain under the auspices of the JHEOA. The Orang Asli Hospital is seen by some (Orang Asli and non-Orang Asli alike) as a relic from a previous era that emphasises, maybe even contributes to, the marginalisation of the community. For others it is an enduring institution that contributes to Orang Asli identity and is a positive symbol of indigenous assertion. The quantity and quality of the healthcare provision and whether there remains the need or demand for a specialised service is only part of the debate.

Whilst I do not suggest that a pan-Orang Asli identity was moulded and maintained through the provision of a separate medical service based at Gombak alone, I have shown that healthcare provision is an arena that continues to be fundamental in the construction of 'the Orang Asli' and that biomedical provision, in this regard, is an area that previous scholarship has overlooked. Other researchers have mentioned Gombak Hospital and its network of services in passing, often representing the Medical Division as a negative government institution that continues to practice neo-colonial policies, where medicine is used as a means of control (in a Foucauldian sense) and where medical practices are sub-optimum. In my analysis I have aimed to demonstrate that whilst there is much evidence to substantiate these claims, the 'Orang Asli Hospital' represents far more to, and about, the indigenous community. According to the experiences of in-patients at the Hospital, the importance of healthcare provision through Gombak and the Medical Division of the JHEOA must not be underestimated for, as I was told in no uncertain terms by Orang Asli throughout the peninsula, 'Gombak Hospital means more than just healthcare'.

Bolton (1973: 71) asserted that the hospital was 'a compromise between the requirements for adequate medical care on the one hand and needs of these [Orang Asli] patients on the other'. Today this compromise is no longer in the foreground of the services. Instead, the paradox of assimilation versus indigenous assertion, of mainstream versus marginalisation, dominates the provision of healthcare at Gombak

Hospital. The continued existence of the Medical Division and its discrete medical service ensures that this paradox persists for both the Orang Asli and government.

## References

- Aldrich, R.J. 2001. *The hidden hand: Britain, America and cold war secret intelligence*. London: Murray.
- Anderson, I., Crengle, S., Kamaka, M.L., Chen, T.H., Palafax, N. and Jackson-Pulvar, L. 2006. Indigenous health in Australia, New Zealand and the Pacific. *Lancet* 367: 1775–85.
- Arnold, D. 1988. *Imperial medicine and indigenous societies*. Manchester: Manchester University Press.
- Baer, A. 1999. *Health, disease and survival*. Subang Jaya, Malaysia: Center for Orang Asli Concerns.
- Baer, A. 2006. *Vital signs: health in Borneo's Sarawak*. Philips, ME: Borneo Research Council.
- Barnard, A. 2006. Kalahari revisionism, Vienna and the 'indigenous peoples' debate. *Social Anthropology* 14 (1): 1–16.
- Barnes, R.H., Grey, A. and Kingsbury, B. (eds). 1995. *Indigenous peoples of Asia*. Ann Arbor, MI: Association for Asian Studies.
- Beckett, I.F.W. 1997. Robert Thompson and the British Advisory Mission to South Vietnam, 1961-1965. *Small Wars and Insurgencies* 8: 43–4.
- Bedford, K.J.A. 2007. Gombak and its patients: provision of healthcare to the Orang Asli (indigenous minority) of Peninsular Malaysia, D.Phil thesis. University of Oxford.
- Benjamin, G. 2002. On being tribal in the Malay world. In G. Benjamin and C. Chou (eds), *Tribal communities in the Malay world*. Singapore: Institute of Southeast Asia Studies, pp. 7–76.
- Bolton, M.J. 1955–1962. Diaries. Unpublished.
- Bolton, M.J. 1968. Medical service to the aborigines in West Malaysia. *British Medical Journal* 2: 818–23.
- Bolton, M.J. 1973a. Family-centred hospital treatment in the aboriginal people of West Malaysia. *Community Health* 5 (2): 70–4.
- Bolton, M.J. 1973b. A training-orientated medical programme in West Malaysian aborigines. *Medical Journal of Australia* 2 (25): 1122–5.
- Bowen, J.R. 2000. Should we have a universal concept of 'indigenous peoples' rights? *Anthropology Today* 16 (4): 12–16.
- Brown, A. 2003. Health issues. Summary presentation at Indigenous Peoples and Socioeconomic Rights Expert Workshop, Commonwealth Policy Studies Unit, London, 20–21 March 2003.
- Busch, P. 2002. Killing the 'Vietcong': the British Advisory Mission and the Strategic Hamlet Programme. *Journal of Strategic Studies* 25 (1): 135–62.
- Carey, I. 1976. *Orang Asli: the aboriginal tribes of Peninsular Malaysia*. Kuala Lumpur: Oxford University Press.
- Central Intelligence Agency. World Fact Book. <<http://www.cia.gov/library/publications/the-world-factbook/go/es/my.html>> Accessed 15 November 2008.
- Chandler, G. 1989. Access to health care in the interior of Sabah. In P. Cohen and J. Purcal (eds), *The political economy of primary health care in Southeast Asia*. Canberra: Australian Development Studies Network, ASEAN Training Centre for Primary Health Care Development, pp. 101–23.

- Chee, H.L. and Barraclough, S. (eds). 2007. *Health care in Malaysia: the dynamics of provision, financing and access*. London: Routledge.
- Cloake, J. 1985. *Templer, tiger of Malaya: the life of Field Marshal Sir Gerald Templer*. London: Harrap.
- Colchester, M. 2002. Indigenous rights and collective conscious. *Anthropology Today* 18 (1): 1–3.
- Dentan, R.K. 1968. *The Semai: a non-violent people of Malaya*. New York: Holt, Rinehart and Wilson.
- Economist. 2006. Putting the malaise into Malaysia, 2 December.
- Economist. 2007. After smart weapons, smart soldiers, 27 October.
- Eder, J.F. and McKenna, T.M. 2004. Minorities in the Philippines: ancestral lands and autonomy in theory and practice. In C. Duncan (ed.), *Civilizing the margins: Southeast Asian government policies for the development of minorities*. Ithaca, NY: Cornell University Press, pp. 56–85.
- Endicott, K. 1979. *Batek Negrito religion*. Oxford: Clarendon Press.
- Endicott, K. and Dentan, R.K. 2004. Into the mainstream or into the backwater? Malaysian assimilation of Orang Asli. In C. Duncan (ed.), *Civilizing the margins: Southeast Asian government policies for the development of minorities*. Ithaca, NY: Cornell University Press, pp. 24–55.
- Favre, P. 1865. *An account of the wild tribes inhabiting the Malayan Peninsula, Sumatra and a few neighbouring islands, with a journey in Johore and a journey in the Menangkabaw states of the Malayan Peninsula*. Paris: Imperial Printing Office.
- Friedman, S. 1960. American medicine as military-political weapon. *Military Medicine* 131 (10): 1273–77.
- Garrett, L. 2007. The challenge of global health. *Foreign Affairs* 86 (1): 14–38.
- Gianno, R. 1990. *Semelai culture and resin technology*. New Haven, CT: Connecticut Academy of Arts and Sciences.
- Gillogly, K. 2004. Developing the ‘hill tribes’ of northern Thailand. In C. Duncan (ed.), *Civilizing the margins: Southeast Asian government policies for the development of minorities*. Ithaca, NY: Cornell University Press, pp. 116–49.
- Hack, K. 1999. British intelligence and counter-insurgency in the era of decolonisation: the example of Malaya. *Intelligence and National Security* 14 (2): 124–55.
- Harper, T.N. 1997. The politics of the forest in colonial Malaya. *Modern Asian Studies* 31 (1): 1–29.
- Headrick, D. 1981. *The tools of empire: technology and European imperialism in the nineteenth century*. New York: Oxford University Press.
- Holman, D. 1958. *Noone of the Ulu*. London: Heinemann.
- Hooker, M.B. 1978. *The personal laws of Malaysia: an introduction*. Kuala Lumpur: Oxford University Press.
- Hooker, M.B. 1996. The Orang Asli and the laws of Malaysia: with special reference to land. *Akademika* 48: 21–50.
- Howell, S. 1989. *Society and cosmos: Chewong of Peninsular Malaysia*. Oxford: Oxford University Press.
- International Working Group for Indigenous Affairs. <<http://www.iwgia.org/sw18358.asp>> Accessed 15 November 2008.
- Jabatan Hal Ewhal Orang Asli (JHEOA). 1959. The long term administration of the aborigines. Kuala Lumpur: Federation of Malaya, Medical Division of the Department of Orang Asli Affairs. Unpublished report.

- Jabatan Hal Ewhal Orang Asli (JHEOA). 1961. *Statement of policy regarding the administration of the Orang Asli of Peninsular Malaysia*. Kuala Lumpur: JHEOA.
- Jabatan Hal Ewhal Orang Asli (JHEOA). 2004. *Data maklumat asas*. Kuala Lumpur: JHEOA.
- Karim, W.J. 1981. *Ma'Betisèk concepts of living things*. London: Athlone Press.
- Karim, W.J. 2001. Constructing emotions and world of the Orang Asli. In R. Rashid and W.J. Karim (eds), *Minority cultures of peninsular Malaysia*. Penang: Academy of Social Sciences, pp. 13–26.
- Kenrick, J. and Lewis, J. 2004. Indigenous peoples' rights and the politics of the term 'indigenous'. *Anthropology Today* 20 (2): 4–9.
- Khoo, K.J. 2007. Health care in Sarawak: model of a public system. In H.L. Chee and S. Barraclough (eds), *Health care in Malaysia: the dynamics of provision, financing and access*. London: Routledge, pp. 187–207.
- Kuper, A. 2003. The return of the native. *Current Anthropology* 44 (3): 389–402.
- Kuper, A. 2005a. *The reinvention of primitive society: transformations of a myth*. London: Routledge.
- Kuper, A. 2005b. Indigenous people: an unhealthy category. *Lancet* 366: 983.
- Leary, J. 1995. *Violence and the dream people*. Athens, OH: Ohio University Center for International Studies.
- Lubon, L. 2006. Village health promoters bringing care to rural communities in Malaysia. UNICEF Report <[www.unicef.org/infobycountry/malaysia\\_34164.html](http://www.unicef.org/infobycountry/malaysia_34164.html)> Accessed 15 November 2008.
- Lye, T.P. 2004. *Changing pathways: forest degradation and the Batek of Pahang, Malaysia*. Lanham, MD: Lexington Books.
- McFaddon, E.M. 2005. Contemporary counterinsurgency operations: history as a guide to assist in the development of the Joint Interagency Task Force. *Comparative Strategy* 24: 361–78.
- McGregor, R. 1997. *Imagined destinies: aboriginal Australians and doomed race theory, 1880–1939*. Melbourne: Melbourne University Press.
- Malaysia, Department of Statistics <<http://www.statistics.gov.my>> Accessed 15 November 2008.
- Manderson, L. 1987. Health services and the legitimation of the colonial state: British Malaya 1786–1941. *International Journal of Health Services* 17 (1): 91–112.
- Manderson, L. 1989. Political economy and the politics of gender: primary health care in colonial Malaya. In P. Cohen and J. Purcal (eds), *The political economy of primary health care in Southeast Asia*. Bangkok: Australian Development Studies Network and the ASEAN Training Centre for Primary Health Care Development, pp. 76–94.
- Manderson, L. 1990. Race, colonial mentality and public health in early twentieth-century Malaya. In P.J. Rimmer and L.M. Allen (eds), *The underside of Malaysian history: pullers, prostitutes, plantation workers*. Singapore: Singapore University Press, pp. 193–213.
- Manderson, L. 1996. *Sickness and the state: health and illness in colonial Malaya 1870–1940*. Cambridge: Cambridge University Press.
- Marmot, M. 2005. Social determinants of health inequalities. *Lancet* 365: 1099–104.
- Means, P. and Means, N. 1981. *And the seed grew*. Singapore: [privately published].
- Montenegro, R.A. and Stephens, C. 2006. Indigenous health in Latin America and the Caribbean. *Lancet* 367: 1859–69.
- Morsy, S.A. 1996. Political economy in medical anthropology. In C.F. Sargent and T.M. Johnson (eds), *Medical anthropology: contemporary theory and method*. London: Praeger, pp. 21–40.

- Nagata, S. 1997. The origin of an Orang Asli reserve in Kedah. In R.L. Winzeler (ed.), *Indigenous peoples and the state: politics, land and ethnicity in the Malayan Peninsula and Borneo*. New Haven, CT: Yale University Southeast Asia Studies, pp. 84–97.
- Nah, A.M. 2003. Negotiating indigenous identity in postcolonial Malaysia: beyond being 'not quite/not Malay'. *Social Identities* 9 (4): 511–33.
- Nah, A.M. 2004. Negotiating Orang Asli identity in postcolonial Malaysia, MA thesis. National University of Singapore.
- Nah, A.M. 2006. (Re)Mapping indigenous 'race'/place in postcolonial Peninsular Malaysia. *Geografiska Annaler, series B* 88 (3): 285–27.
- Neel, S. 1968. The medical role in army stability operations. *Military Medicine* 132 (8): 605–8.
- Nicholas, C. 2000. *The Orang Asli and the contest for resources*. Copenhagen: International Workgroup for Indigenous Affairs.
- Nicholas, C. 2002. Organising Orang Asli identity. In G. Benjamin and C. Chou (eds), *Tribal communities in the Malay world*. Singapore: Institute of Southeast Asia Studies, pp. 119–36.
- Nicholas, C. 2004. Mahathir and the invisible Orang Asli. In Bridget Welsh (ed.), *Reflections: the Mahathir years*. Washington: John Hopkins University Press, pp. 220–30.
- Nicholas, C. 2005. Acting on the knowledge: seeking recognition for Malaysia's Orang Asal. Keynote address, National Conference on Communities, Cultures and Change in Malaysia – Indigeneity, Identity and Social Transformation, School of Social Sciences, Universiti Malaysia, Sabah, 6–7 December.
- Nicholas, C. and Baer, A. 2007. Health care for the Orang Asli: consequences of paternalism and non-recognition. In H.L. Chee and S. Barraclough (eds), *Health care in Malaysia: the dynamics of provision, financing and access*. London: Routledge, pp. 119–36.
- Ohenjo, N., Willis, R., Jackson, D., Nettleton, C., Good, K. and Mugarura, B. 2006. Health of indigenous people in Africa. *Lancet* 367: 1937–46.
- Paul, J.A. 1978. Medicine and imperialism. In J. Ehrenreich (ed.), *The cultural crises of modern medicine*. New York: Monthly Review Press, pp. 271–86.
- Rachagan, S.S. 1990. Constitutional and statutory provisions governing the Orang Asli. In T.G. Lim and A.G. Gomes (eds), *Tribal peoples and development in Southeast Asia*. Kuala Lumpur: University of Malaya, pp. 101–11.
- Reid, A. 2001. Understanding *Melayu* (Malay) as a source of diverse modern identities. *Journal of Southeast Asian Studies* 32: 295–313.
- Roseman, R. 1991. *Healing sounds from the Malaysian rainforest*. Berkeley, CA: University of California Press.
- Sabah Health Department. <<http://jknsabah.gov.my>> Accessed 15 November 2008
- Sarawak Health Department. <<http://www.sarawak.health.gov.my>> Accessed 15 November 2008.
- Shamsul, A.B. 2001. A history of an identity, an identity of a history: the idea and practice of 'Malayness' in Malaysia reconsidered. *Journal of Southeast Asian Studies* 32: 355–66.
- Stephens, C., Nettleton, C., Porter, J., Willis, R. and Clark, S. 2005. Indigenous peoples' health – why are they behind everyone, everywhere? *Lancet* 366: 10–13.
- Stephens, C., Porter, J., Nettleton, C. and Willis, R. 2006. Disappearing, displaced and undervalued: a call top action of indigenous health worldwide. *Lancet* 367: 2019–28.
- Thompson, R. 1966. *Defeating communism insurgency: experiences from Malaya and Vietnam*. London: Chatto and Windus.

- United Nations. 2008. *United Nations declaration on the rights of indigenous peoples*. Geneva: United Nations.
- United Nations Permanent Forum on Indigenous Issues. 2005. *Fourth session: the millennium development goals and indigenous peoples*. New York: United Nations Permanent Forum on Indigenous Issues.
- Varsori, A. 2003. Britain and US involvement in the Vietnam War during the Kennedy administration, 1961–63. *Cold War History* 3 (2): 83–112.
- Williams-Hunt, P.D.R. 1952. *An introduction to the Malayan aborigines*. Kuala Lumpur: government Press.