Feeling the PULSE of the Community

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Is the role of fatwa in the Singapore Judicial System diminishing?

Health and Wellness
New challenges in the Malay/Muslim community

Zulm and Chronic Illnesses
Managing chronic illnesses by minimising acts of zulm

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Health vs social repercussions of teenage pregnancies

The Fat Tsunami
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Health is wealth.

Unfortunately, many among us do not spare much effort in practising healthy lifestyle habits, only doing so when we fall ill. We often forget health is an aspect of wealth that is equally important as financial wealth. The Malay/Muslim community is sadly overrepresented among those who suffer from high blood pressure, diabetes and high cholesterol. To make matters worse, many in the community are smokers and obese. This does not bode well for the future of the community. There is a need to look into why the statistics are against us, especially when Islam forbids us from committing such acts of zulm (oppression or cruelty) towards ourselves and our body.

The issue of health is a compelling one and was the focus of AMP’s annual Community in Review seminar held recently. The trends in health and wellness took centre stage then, as it does in this issue of Karyawan. Our cover story gives an insight into the challenges that the community can expect in the future in terms of health issues. This will prove to be useful in charting the steps our community needs to take to tackle these issues in the future.

An oft-discussed issue – teenage pregnancy – is featured as well, discussing if it is a health problem or a social one. The article, by Dr Suzanna Sulaiman and Dr Sadhana Nadarajah, shows the multi-faceted problems faced by pregnant teenagers, beyond pregnancy-related ones. It highlights the importance of educating these teenagers to prevent second pregnancies, which might impede their educational aspirations, in turn resulting in them being unable to support their families, worsening the “cycle of poverty”.

This “cycle of poverty” might also worsen given the current economic downturn. Our community is not spared from the effects of the recession, with many workers getting retrenched and families losing their sole breadwinners. The article by Abdul Shariff Aboo Kassim looks at the vulnerability of Malay/Muslim workers in the workforce and whether efforts from community organisations are adequate to help them pull through the recession.

There are other areas of health that require our attention. For instance, should we look at spending to prevent illnesses as a prudent investment? Also, are Malays becoming the fattest people in Singapore? What can we do to curb these problems? Are we doing enough? This issue of Karyawan wishes to encourage discussion and hopefully bring us closer to a solution to these problems.

We hope you enjoy this issue of Karyawan.

Yang Razali Kassim
Supervising Editor
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The Fate of Fatwa in Singapore

Aidil Zulkifli

The Administration of Muslim Law Act (AMLA) in Singapore provides for the application of Syariah Law to personal matters, where a fatwa (a legal opinion) is issued on the case at hand. However, recent judicial decisions have indicated a pattern of the rejection of fatwa by the Singapore Judiciary. Does this signify the eventual death of fatwa as an accepted legal opinion?

RECENT SINGAPORE High Court decisions reveal a rather disturbing pattern of the rejection, by the Singapore Judiciary, of fatwa issued by the Legal Committee (LC) of Majlis Ugama Islam Singapura or Islamic Religious Council of Singapore (MUIS). A few observations on this trend can be made. It is argued that the continuance of such a trend will eventually sound the death knell for the authority of fatwa in Singapore. Two local judicial decisions have been selected for discussion below. The focus is not so much on the results of the findings, but for the future implications it may have on the applicability of personal shari’a law to Muslims in Singapore.

Fatwa in Islam and in Singapore: A Background
A fatwa is a religious opinion on any point of Islamic Law issued by an Islamic scholar. In the Sunni tradition, a fatwa is not binding except on the author of the fatwa himself. This is to be contrasted with the binding nature of a legal opinion (on the parties but not on later similar cases) issued by a qadi after the adjudication of a case.

Judicial Treatment of Fatwa
Fatwa issued by the MUIS LC rarely feature in local cases until the advent of two recent developments. Any local fatwa issued at the request of a private party can be rejected by a local court for the mere fact that its reasoning cannot be logically defended and it is incompatible with Islamic law as interpreted by the courts. It may also be rejected if it offends basic sense of justice and fairness (a sense that is embodied in a set of judicially-recognised rules called ‘natural justice’ – for example: a defendant’s right to be heard in a case against him). This is the outcome in the 2004 case of Mohamed Ismail bin Ibrahim v. Mohammad Taha Bin Ibrahim in which the High Court implicitly rejected a fatwa passed by the MUIS LC.

The facts in Mohamed Ismail were rather complicated but briefly: the testator passed away leaving behind a will in which it stated that one-third of his estate would be given in a manner known as nuzriah. The testator’s children (plaintiffs) notified the executor of the
In other words, by challenging the MUIS validation of the will, the plaintiffs are suggesting that the fatwa was erroneous. The issue before the court was quite simple: whether the concept of nuzriah is valid under Islamic law. The High Court found that the concept of nuzriah was not founded under Islamic law and found for the plaintiffs. It granted the declaration accordingly after examining the shari’a law on inheritance and hearing expert evidence from both sides. The Learned Mufti himself provided expert evidence on the defendants’ behalf. However, the Court rejected the Mufti’s expert opinion.

This case shows that our civil courts will not hesitate to interpret and apply shari’a law in Singapore. On points of Islamic law, it seems that civil courts are now abandoning the opinions of the MUIS LC in favour of their own determination and interpretation. While certainly the Syariah Court is not empowered to adjudicate on disputes involving administration of the Muslim estate, this situation gives rise to jurisdictional issues pertaining to the development and administration of personal shari’a law.

This is especially so when it is the function and duty of MUIS “to administer matters relating to the Muslim religion and Muslims in Singapore” (section 3(2)(b), the Act). The fact that section 32(7) provides for the request of fatwa by the courts suggests that the MUIS fatwa is to be of some value to the Muslim in his own private life and activities conducted in the public sphere. Since it is unlikely that the Parliament will step in to clarify the extent of the authority of a fatwa, MUIS should implement a more rigorous fatwa-issuing regime by issuing more detailed and reasoned fatwa akin to that of common law judgements so that its reasoning in coming to its conclusions would be clear.

With the greatest respect to MUIS, it is discomfoting to note the exceptionally brief fatwa (a mere three paragraphs) that was offered in the case of Mohamed Ismail, with no reference to supporting authorities or reasoning. This is to be contrasted with the style and format of fatwa issued in the Middle East. It is suggested that a rethink of the format of fatwa issued by MUIS would not only lend credibility to the fatwa in local courts but would aid in the local development of personal shari’a law. Since it is non-binding, the fatwa literature can be “dynamic and flexible, adjusting to changing circumstances and expressing a wide range of opinions on any topic”, as mentioned in the book “Islamic Legal Interpretation: Muftis and Their Fatwas”.

Therefore, a fatwa can have the best of both worlds: the detailed reasoning of a common law judgement and the flexibility that it needs. Such dynamism can be supported by section 32(6) which allows MUIS to publish rulings on any issue on its own accord. For example, while I fully agree with the informed conclusion of the Minister-in-Charge of Muslim Affairs, Dr Yaacob Ibrahim, the issue of whether Muslims can work in the Integrated Resorts would have provided MUIS with an opportunity to utilise the section 32(6) mechanism to issue a fatwa reasoned according to the shari’a. To MUIS’ credit, it did exactly that on the issue of the applicability of the Human Organ Transplant Act to Muslims. All Muslims would benefit from such intellectual dynamism by keeping Islam attuned to changing times.

The weak standing of the local fatwa is demonstrated more recently in April 2009 in the case of Shafeeg Bin Salim Talib v. Fatimah Bte Abud Talib. The deceased died intestate (i.e. without a will) and the High Court had to decide whether the common law right of survivorship in a joint tenancy applies to Muslims. The court decided in the affirmative. The court rejected the fatwa that was issued at the plaintiffs’ request on the basis that the fatwa was not relevant to the issue as it was not a question of Muslim law. While there is much to be said about the reasoning of this case, the implication is that it weakens the fatwa further as a tool of guidance for the Muslim. This case demonstrates that a Muslim may request for a fatwa on a particular issue to arrange his personal affairs according to Islamic law as interpreted by the country’s highest authority on the subject (the Learned Mufti) but the Courts may reject such fatwa.

Further, this case held that the common law right of survivorship in joint tenancy is part of personal shari’a law applicable to Muslims. It is also clear that fatwa is regarded by our courts as “expert evidence” of a type of foreign law but nothing more. However, it is unclear how this ruling gels with section 112(1) of the Act and the “Muslim law” mentioned therein. Whether fatwa should be regarded as mere expert evidence should be legislatively clarified considering the essence and role of fatwa in the spiritual development of Muslims and that shari’a law is not, strictly speaking, foreign by reason of AMLA.

Re-opening the Door of Ijtihad
Fatwa remain to be an integral part of a Muslim’s life as a tool of spiritual guidance in an ever-changing world. Despite arguments that the door of ijtihad is closed in Sunni tradition, the novel issues brought about by fast-paced change forces this door open once again. Therefore, fatwa has become increasingly more important in this age of scientific reasoning.

The art of legal reasoning is not new to Islam—qiyas has been an integral feature of the development of the shari’a. The spiritual development of Muslims in Singapore, and the credibility and authority of the fatwa hinge on our scholars’ ability to provide opinions that are fully debated and reasoned so that it may stand up to public scrutiny. We owe it to ourselves to robustly develop our personal shari’a laws so that the shari’a tradition serves as a model legal tradition.

Aidil Zulkifli is a final year law student at the National University of Singapore (NUS).
A health survey conducted by the Health Promotion Board (HPB) in 2005 showed a worrying trend of poor health among Malays in Singapore. The Community in Review Seminar 2009 was organised to discuss the potential problems that the Malay/Muslim community may face in the near future.

IN 2005, the Health Promotion Board (HPB) released its periodic National Health Survey to monitor the health level of Singaporeans. HPB identified the risk factors that contributed to the major ‘killers’ within the various ethnic communities in Singapore. The results of the survey showed a trend that could be detrimental to the Malay community in the future. This trend, if it worsens, could undermine the community’s ability to contribute to Singapore economically as public resources would be diverted to addressing problems arising from the deterioration of health within the community.

Survey Results
The survey showed that, although there was an increase in the percentage of people participating in regular exercise (see Chart 1), there is still a high level of occurrence of obesity and smoking in the Malay community (see Charts 2 and 3 respectively). Apart from this, there is also an increase in the number of Malays suffering from high blood pressure, high blood cholesterol and diabetes (see Charts 4, 5 and 6 respectively). These health risk and lifestyle factors would increase the probability of the community contracting the major killer diseases.

The Community in Review (CIR) Seminar 2009 organised on 31 January this year by the Centre for Research of Islamic and Malay Affairs (RIMA), attempted to study this trend with a view to devising possible solutions. Health and wellness was chosen as the focus for this year’s CIR because it was felt that this issue has not been sufficiently addressed within the community. The speakers were Dr Zuraimi Dahlan, a General Practitioner; Mr Ameerali Abdeali, President of the Muslim Kidney Action Association (MKAA); Mdm Yang Chek Salikin, Advanced Practice Nurse with the Institute of Mental Health (IMH); and Ms Sofiah Jamil, Research Analyst from the Centre of Non-Traditional Security Studies at the S. Rajaratnam School of International Studies (RSIS), Nanyang Technological University. The speakers raised three challenges that needed to be addressed arising from the trends presented by the HPB survey.
Lack of Awareness

The consensus amongst the speakers was that there is a lack of emphasis by various organisations to communicate the benefits of healthy living to the community. Dr Zuraimi noted that despite the advanced medical facilities that Singapore has, which contributed to Singapore experiencing the lowest infant mortality rate as compared to other nations, he observed that the general population tends to lack the awareness of healthy living. Within the Malay community, the highest rate amongst the major killer diseases is heart disease at 30%. Through his experience as a general practitioner, there were many instances that showed the perceived apathy towards good living. The main reasons given by his patients were more of acceptance of the diseases; ‘berserah kepada takdir’ (leave it to fate), rather than actual efforts to prevent them.

In terms of mental illness, Mdm Yang Chek observed that the barriers facing the Malay/Muslim community are mainly due to personal beliefs, religion and to a certain extent, the lack of promotion and understanding of mental illness amongst the various community organisations. She noted that the community seeks alternative treatments of the spiritual kind as a means to cure such mental illnesses. Most of these patients would visit a spiritual healer or a religious leader such as an imam in the mosque if they or someone they know contracted such an illness rather than a mental health specialist. There exists a certain degree of stigma in the affliction of such mental illness within the community who usually attribute such afflictions to the irrational concept of possession by the unseen. In contrast with what was observed by Dr Zuraimi, the lack of acceptance of mental illnesses was the main challenge facing the community.

Diversion of Community Resources

The plight of families having a member afflicted by chronic diseases was highlighted by Mr Ameerali to illustrate the impact of poor health and unhealthy lifestyle trends facing the community. These families face tremendous challenges, he said, not only from the financial burden of managing and treating a chronic illness, but also decreasing family cohesiveness due to the strain of numerous sacrifices in their daily lives to assist the ailing family member. Thus, there is a need to increase public resources to aid these families especially with the rising cost of healthcare. These families could also suffer some form of mental disorder due to the tremendous stress resulting from the caring of ailing family members.

Mr Ameerali highlighted that due to the high representation of the Malay community in the lower income group, the resources that can be mobilised would be limited. If these unfavourable health and lifestyle trends persist, the community as a whole would suffer. Resources that could be used to uplift the community would be diverted instead
to address such health issues. On the other hand, if these resources were provided by the state, the Malay community could perennially be seen to be economically dependent and not contributing to the economic growth of the nation.

**Awareness vs Actual Positive Behavioural Change**

Ms Sofiah Jamil shared the findings of the Centre for Non-Traditional Studies on the experiences of other regional nations combating the spread of contagious diseases such as HIV/AIDS, Avian Flu and SARS. The experiences of these nations showed strong support from the grassroots in addressing such health epidemics. However, she noted that the main challenge in tackling these epidemics was the same one faced with regard to other health issues – the behavioural change of the individual. Despite massive awareness programmes run by the state and civil society of those Asian countries, the target groups usually remain unmoved due to various reasons such as a lack of resources to implement the recommended changes, compounded by apathy on the part of individuals.

The situation in the Singapore context is no different. Despite massive health education initiatives since the inception of the NHP, the Malay community and other ethnic communities seem not to be moved to change their lifestyles, as shown by the HPB survey results. This inability to change could be attributed to structural barriers rather than personal. For example, one of the ways to prevent diseases is to participate in regular exercise. However, if someone is employed in a low wage blue-collar job and is required to work longer hours to make ends meet, then the person would not have the time to participate in regular exercise. Thus, the challenge facing the community may not be lack of awareness per se, but also the lack of actual positive behavioural change due to such structural barriers.

**Possible Solutions**

To address these challenges, the speakers recommended a concerted effort by various stakeholders to target the most susceptible group – the Malay males, as this group is highly represented in all the health risk factors. In other words, the Malay male is prone to affliction by the major health threats such as chronic heart disease, hypertension and diabetes. Dr Zuraimi called for a three-pronged approach – prevention, regular check-up and health screening. This, he said, needs to be continuously communicated to the community to provide early detection of diseases. Underlying all this is the need to encourage regular exercise. Dr Zuraimi also suggested that community organisations look into the possibility of health insurance for the elderly to meet the increasing health costs.

There are obviously potential future problems if these negative health trends persist. Although the challenges presented by the speakers are not unique to the Malay community, they need to be addressed early with new strategies before the situation gets worse. As it is, the community already has a plateful of problems to deal with, such as growing unemployment and various social issues. It can do without new ones.

Mohd Suhaimi Ismail is a research officer with the Centre for Research on Islamic and Malay Affairs (RIMA), the research arm of the Association of Muslim Professionals (AMP).
Feeling the Pulse of the Community

KARYAWAN

Dr Suzanna and Dr Sadhana discuss the health issues linked to teenage pregnancy. They share real-life cases from the CARE Clinic, a new initiative which helps pregnant teenagers.

TEENAGE PREGNANCY is becoming more prevalent in Singapore. Many, if not all of such pregnancies are unplanned. There are many possibilities why this is occurring at a very young age. In some cases, it is because of peer pressure and in others, because of curiosity. More often than not, it is too late before they realise their mistake. This poses a social problem as many of them will eventually drop out of school once they have a child as they succumb to social circumstances and need to look for a job to support their new family. Others simply lose interest in continuing their education.

On the other hand, teen mothers are perfectly capable of having a healthy pregnancy and baby, with proper nutrition, early prenatal care and good screening for potential problems. However, with inadequate educational qualifications and a lack of skills, the challenge will be affordability as many will be low income earners. Support from the family and community is a must for the young, new family to be able to cope with the demands of early family life.

CARE Clinic
The Reproductive Medicine Department in KK Women’s & Children’s Hospital (KKH) has set up the Clinic for the Adolescent PREgnant (CARE) to cater to the needs of pregnant teenage girls. The CARE

Dr Suzanna Sulaiman & Dr Sadhana Nadarajah

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Clinic intends to identify these at-risk teens and help them cope with their pregnancies by educating them on sexually transmitted diseases as well as contraception. This is aimed at preventing a second pregnancy and thus relieving them from greater financial strain.

The clinic started operations on 10 January 2008, with eight new and twelve return patients every fortnight. With the increase in the number of patients, the clinic started running weekly in March 2008. Referrals are made by polyclinics, specialist clinics in KKH, Ministry of Community Development, Youth and Sports (MCYS), PERTAPIS, other hospitals and the 24-hour Women’s Clinic for single, pregnant girls under the age of 21.

Sexually Transmitted Diseases (STDs)
In addition to the routine pregnancy tests, (Hepatitis, HIV, Syphilis, Full Blood Count and Blood Group), patients of the CARE Clinic undergo tests for Neisseria Gonorrhoea and Chlamydia Trachomatis. These two STDs can cause miscarriage and pre-term labour. If a patient is affected, there may be adverse effects on the babies too.

Transmission of STDs from the pregnant woman to her foetus, newborn or infant can occur before, during or after birth. Certain STDs such as syphilis are able to cross the placenta and infect the foetus which can affect the foetal development. Other STDs including gonorrhoea, chlamydia and hepatitis B can be transmitted to the infant during vaginal delivery.

Sexually transmitted diseases can have devastating consequences to the baby including:
- stillbirth
- low birth weight
- eye infection – conjunctivitis
- pneumonia
- infection in the blood – neonatal sepsis
- neurologic damage such as brain damage or motor function disorder
- blindness, deafness, or other congenital abnormalities
- acute hepatitis
- meningitis
- chronic liver disease
- cirrhosis.

Unfortunately, not all of the effects of STD infections may be apparent at birth. Some of the effects of birth-related STDs may not be detected for months or sometimes, years.

Even though bacterial STDs such as chlamydia, gonorrhoea, and syphilis can be treated and cured by antibiotics, a long-term monogamous relationship is the best protection against STDs. While protection is critical during the entire pregnancy, it is particularly important during the third trimester of pregnancy when an active STD infection can cause the greatest harm to both the mother and baby.

Patients of the CARE Clinic are counselled regarding STDs and contraception by a dedicated staff nurse to ensure they understand the dangers and consequences of STDs on themselves and their babies. They are also encouraged to return to the clinic after delivery for a follow-up consultation.

Recent Data
An initial short review of the clinic was performed from 17 January 2008 to 30 June 2008. A total of 43 adolescent patients were included in the review. It was found that all of them did not plan their pregnancies. 84% of the patients were Malay, 14% were Chinese and 2% Indian. The adolescents were between the ages of 15 and 20. The highest education level of these patients is illustrated in the chart below.

![Chart 1: Distribution of Highest Education Level of Single Pregnant Adolescents (absolute numbers)](chart.png)

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Many of them had dropped out of school and entered the workforce early. By the time they were first seen by the clinic, 65% were unemployed. Thirty percent of them smoked, 7% drank alcohol and 5% took recreational drugs. Forty-nine percent of these adolescents had only one sexual partner, while 51% had more than one sexual partner. When asked if the father of the child was involved, 67% answered in the affirmative.

Social workers work closely with these young patients. They collate the patient’s family tree and history to assess the amount of support the patient gets. They would then alert the obstetricians of any potential social problems. As far as possible, the clinic tries to involve all family members, boyfriends and his family members too.

From the Case Files

**Case #1**  
19-year-old Annie* is pregnant with her first child at 27 weeks gestation. Her highest education level is ‘O’ levels and is unemployed. She does not smoke and stopped consuming alcohol once she found out she was pregnant. Annie stays in a 4-room flat with her parents and sister. Her father has just been retrenched. She is trying to get out of a verbally and physically abusive relationship and hopes to be able to take care of her baby after delivery. She has plans to look for a job after her confinement period.

**Case #2**  
Sarah*, 17, is currently 24 weeks pregnant with her first child. She requested for a termination of the pregnancy at first but changed her mind and decided to continue with the pregnancy. The father of the child disappeared after he was told that she was pregnant. She became sad, easily irritable, uninterested and kept to herself in her room. She was then referred to the Mental Health KKH team by the CARE Clinic to be simultaneously helped to manage the situation. She is an ex-smoker who stopped drinking alcohol when she became pregnant. In her 16th week of pregnancy, she met a new boyfriend whom she plans to marry.

‘This poses a social problem as many of them will eventually drop out of school once they have a child as they succumb to social circumstances and need to look for a job to support their new family.’

**Case #3**  
Roz*, a 19-year-old first-year polytechnic student found out that she was pregnant in the 20th week of her pregnancy. She continued with her studies during her term. Fortunately for her, she was well-supported by her boyfriend who was waiting to begin his National Service (NS). Roz delivered a baby girl in her 36th week of pregnancy. After the delivery, her boyfriend’s mother asked her to stop schooling to take care of the baby. However, she declined as she felt that she would be able to better provide for the child once she completes her diploma. Her boyfriend’s mother then took over the role of the ‘mother’ to the baby and forbade Roz from visiting the baby as long as she refuses to stop schooling.

*Names have been changed

Teenage Pregnancy – A Public Health Issue

The CARE Clinic aims to educate this high-risk group of teenagers on contraception and safe sex as well as the need to prevent repeat pregnancy. A second pregnancy in their teenage years will inevitably reduce the likelihood of their return to school and therefore their chances of acquiring job skills to enter the workforce. It is hoped that the clinic can improve the quality of life for this group of patients as we believe that adolescent pregnancies are not an obstetrical risk, but a public health issue.

Dr Suzanna Sulaiman is a Registrar with the Department of Obstetrics and Gynaecology, KKH. Dr Sadhana Nadarajah is a Senior Consultant from the Reproductive Medicine Department, KKH. They both initiated and run the CARE Clinic, which is open every Thursday afternoon at the D clinic, Basement 1, Women’s Tower of KKH.
Dr Zuraimi Mohd Dahlan

Dr Zuraimi discusses whether socioeconomic background affects the health of a person. Through his experience as a general practitioner, he looks at whether there are specific health issues plaguing the lower socioeconomic group.

The Link between poor lifestyle, dietary habits and poor health is well-known. For example, smoking causes lung cancer, an unbalanced diet causes obesity and other health complications, and sexual promiscuity could lead to sexually transmitted infections. But what about the link between socioeconomic factors and health? Are those in the lower socioeconomic group more prone to poor health? If so, how can they mitigate the situation and manage their healthcare costs?

Smoking and the Lower Socioeconomic Group
Smoking seems to be more prevalent in the lower socioeconomic group. This is also true for the Malay/Muslim community. People who smoke tend to pick up the habit from a young age – some as early as 9 years old. Young females within the community are also picking up this habit. The proportion of young female smokers nationally aged 18 to 29 increased from 5.2% in 1998 to 6.6% in 2004, according to the National Health Survey 2004 by the Health Promotion Board. Of this, 17% were Malay females. Despite intensive public health education drives, the number of young Malay female smokers bucks the trend, increasing instead of decreasing. This can be attributed to the weakening of social and cultural constraints which previously discouraged Asian women from smoking. Often, there is also a lack of good role models at home and they are influenced by their male counterparts.

Sexual Promiscuity
Early sexual promiscuity, that is, experimenting with sex at an early age, at times as early as 10 years old, has a negative effect on the child. Exposure to friends who indulge in active sex, exposure to pornography early in life and lack of proper sexual education and guidance may result in the child experimenting with sex early in life. Sexual promiscuity amongst the young is closely linked with dysfunctional families. If a single mother, single father or caregiver (for example, a grandparent) of the child is bogged down with work and no one is at home to guide the child when the child comes home from school, the child may turn to other sources for love and guidance. Unfortunately, these sources tend to exploit them rather than help them.

The best way to avoid these problems is to provide proper sexual education, guidance, love and to practise sexual abstinence. Muslim children should be told that Islam forbids pre-marital sex; that sex is to be avoided until they are married when they are mature enough to shoulder the responsibility of being sexually active.
Prevalence of Particular Diseases in Certain Communities

There are certain diseases that are more pronounced in the lower socioeconomic group. Diseases like tuberculosis, scabies, head lice, fungal skin infections, poor dentition, obesity, chronic ear infection and poorly controlled chronic illnesses are more likely to occur in this group. These diseases arise from poor hygiene, overcrowding and lack of proper early treatment. The good news is that all these illnesses can be easily treated. Hence, access to affordable healthcare for this group of people is essential.

Lower Socioeconomic Group and Health – A Case Study

I once encountered a family of five who was still living with their parents in a four-room flat. The mother brought one of her children to see me because the child suffered breathlessness to the point of near collapse.

When questioned why she delayed seeking treatment for her child, she replied that she did not have enough money to visit a doctor even though both she and her husband, in their early 20s, were working. The fact that this couple married very early in their adulthood and had three children early in their marriage likely placed a great strain on their finances. This could be mitigated if they made an effort to upgrade their skills and increase the family’s earning power. I do not doubt that with sound financial planning and having clear priorities in life, this family would be able to overcome their financial problems, ensuring that emergency medical treatment can be sought when required.

The *tidak apa* or easy-going attitude they had towards health was also worrying, especially since the father of the child was puffing away on a cigarette outside while the mother saw me. A chronic daily smoker can save hundreds of dollars every month if he stops his smoking habit, considering current high cigarette prices. That extra cash can then be put aside to pay for medical treatment for his family members.

Lower vs Higher Income Groups

While the lower socioeconomic group seems to be at a higher risk of poor health, the middle class is not spared either. They too have their own specific health problems. These are often attributed to life’s affluence and excesses. Common diseases are obesity, diabetes and gout. These arise from too much food and too little exercise. However, those in the lower income strata face more challenges given the increasing healthcare costs. Even though there are government subsidies in place, there is still a need to take proactive action to ensure that healthcare costs are managed.

Managing Healthcare Costs

While it is generally inexpensive to maintain health in Singapore, given the government’s various subsidies, there is still a need to prepare ourselves in the event the need to treat serious and chronic illnesses arises:

Practising a Healthy Lifestyle

First, a healthy lifestyle should be inculcated from young so as to avert or delay the onset of lifestyle-induced diseases or preventable diseases such as those caused by smoking, high cholesterol levels and dangerous sexual practices. This includes eating a balanced meal three times a day, getting enough rest and exercising at least three hours a week.

Obtain Medical Insurance

Second, everyone should obtain an affordable basic medical insurance (term or life) against death, permanent disability and chronic illnesses as this would help them hedge against a sudden requirement for funds when they are diagnosed with life-threatening illnesses. Policies offering accident and hospitalisation coverage and income protection may also be considered.

Spending Now for the Future

When you go to the clinic, several types of costs will be incurred such as consultation and investigation fees and for the medication. If your doctor is unable to diagnose your problem, you will be referred to a specialist for further assessment, which may cost you more initially. However, if your illness is resolved early, you would be able to save money in terms of medical expenses in the long run. Delaying treatment can sometimes prove to be costly as higher costs might be incurred when complications set in. Therefore, it would be prudent to put health as your top priority from the start.

The answer in managing your healthcare costs lies in proper planning just as you would when it comes to marriage, having children and purchasing big-ticket items like housing and a car. A portion of your monthly income should therefore be set aside for healthcare expenses that you might incur in an emergency or in the future.

Socioeconomic factors can affect health but if the individual is well-informed and proactive in disease prevention, it should not be a major disadvantage.
CONTAINING THE COST OF HEALTHCARE

Dr Nur Farhan Mohd Alami

With advances in medical technologies, the cost of healthcare is set to rise. How do we mitigate these costs? Dr Nur Farhan discusses whether prevention is better than cure in this case.

WHILE BIRDS being culled grabbed headlines and our attention during the Avian influenza outbreak, civet cats were blamed for SARS and pigs for the Nipah virus and the latest H1N1 influenza virus. In reality, not many of us will die from virus or bacteria in a pandemic but from three chronic conditions: cancer, heart disease and stroke. These diseases account for more than 60% of deaths among Singaporeans in 2006 according to data from the Ministry of Health (MOH). Unfortunately, no creature can be blamed for obesity, unhealthy lifestyles, lack of exercise, tobacco use and poor nutrition, all of which contribute as risk factors to the above three leading causes of death. The burden on healthcare costs lies mainly in managing chronic diseases such as diabetes, hypertension and high cholesterol, among many others.

Cutting Healthcare Spending Through Disease Prevention
In Singapore, our healthcare spending is at about 3% of Gross Domestic Product (GDP). Advances in medical technologies, introduction of new drugs and medical procedures will continue to push up costs in the years ahead. It is thus important that strategies be adopted to help lighten the predictable impact of these cost drivers and the burden of chronic diseases on overall healthcare costs. In the case of the US, this was also recognised by President Barack Obama who has made healthcare reform a cornerstone of his agenda. A better care of chronic illness is part of the plan for change and is expected to save US$2 trillion over the next 10 years.
The key to safeguarding oneself from ballooning healthcare costs is prevention. What this means is primary prevention before the onset of disease; secondary prevention, which focuses on early detection through screening; and tertiary prevention which focuses on good disease management. Looking after ourselves before a disease occurs or primary prevention is an investment into the future that no health insurance policy can measure up to. As how Prophet Muhammad S.A.W had explained: “Surely your body has rights over you” (Narrated by Imam Tarmizi). Here, the rights of the body include exercise, a balanced diet and avoidance of tobacco use.

Primary Prevention
According to data from the Ministry of Health in 2007, Malay men had the highest prevalence of daily cigarette smoking (29.9%), compared with Indian men (22.4%) and Chinese men (20.5%). While the link between smoking and heart disease, high cholesterol levels, cancer and chronic lung disease is well-established and known to many, there is generally a lack of concern as most see these diseases affecting smokers as well as non-smokers alike. The more sinister effects of smoking would be that of reduced immunity of the smoker, causing frequent days off work and income lost and paying for outpatient care. When the smoker has a family, the children are not spared either. Children living in households with a smoker tend to have higher rates of asthma than households without smokers. Costs of caring for an asthmatic child may not only include medication, devices to administer medication and doctor consultation fees, but hospitalisation and even intensive care unit stays, which can potentially drive a family into debt.

Another not often talked about factor is the effect of smoking on male and female fertility. Defective sperm quality is a significant cause of subfertility. It is known that cigarette smoking affects semen quality. Studies have also shown delayed conception in heavy smokers, both male and female, as well as poorer outcomes in smokers undergoing assisted reproduction procedures. While the causes of subfertility are varied; dumping the ashtray and cigarettes should be the first step rather than spending six to ten thousand dollars on a cycle of in vitro fertilisation (IVF) which has a success rate of 30-40%.

Secondary Prevention
Secondary prevention focuses on early prevention through screening. Our primary disease prevention programmes include screening programmes for breast and cervical cancer and for diabetes, hypertension and hyperlipidemia (excessive amounts of fat in the blood) among persons older than 50 years. Early prevention through screening for cervical cancer for example, has decreased deaths and disability from the disease dramatically. The cost of a Pap Smear test is a mere S$15 while the cost of cervical surgery and radiation for an advanced cervical cancer can run into thousands of dollars.

Screening for diabetes should be done routinely for anyone who is above 50 years old or anyone else who has a positive family history of diabetes.
Feeling the Pulse of the Community

Unfortunately with the epidemic of obesity developed countries are facing, the age of the diabetic is getting lower and lower. With the emergence of diabetes as what TIME magazine labelled as the Asian epidemic, one in three Singaporeans above the age of 60 will have diabetes. Early detection prevents complications setting in.

There is a condition called the metabolic syndrome or what was previously called syndrome X. This condition describes a constellation of diseases such as hypertension, diabetes, high cholesterol and obesity occuring together. Once a person is diagnosed with hypertension, which will affect one in 3 Singaporeans, he or she should be screened for diabetes and high cholesterol simply by administering a blood test which costs less than S$20. Many people shy away from screening or blood tests as living in denial of potential illness is preferred to knowing one has an underlying illness. This is not cost effective as basic and cheap medications can be used to treat these common chronic conditions as compared to when the complications of these diseases set in which will then require costly medicine.

For example, high cholesterol is a known risk factor for a heart attack. It is unfortunate that high cholesterol is only detected after a heart attack has occurred. Putting costs of hospitalisation and consultations aside, the cost of a tablet which thins the blood in a patient post-heart attack costs as much as S$3 per tablet and this can add up to thousands of dollars per year on medications alone. Also, once irreversible damage has occurred in the heart or in the brain as in after a heart attack or stroke, no advancement in medical science has managed to revive the function of dead cells.

Tertiary Prevention
Tertiary prevention involves managing the illness well before complications set in. The government is aware that the performance of the healthcare system is far from perfect in managing chronic diseases. Health Minister Khaw Boon Wan, in a speech on 14 October 2008 made on end-of-life issues, said: “While I think we deserve at least an A- for acute care, I can only score a C for our care of chronic diseases. Too many Singaporeans are still ignorant of their chronic diseases; fewer still come forward to have their chronic diseases managed regularly and treated consistently. As a result, too many end up with unnecessary complications requiring intensive acute care.”

Empowering Family Doctors
Various programmes and initiatives have been put into place to strengthen the primary healthcare system in managing these chronic illnesses. For example, the Direct on Target or DOT programme empowers family doctors with tools that aid them in monitoring and controlling chronic illnesses as well as providing direct access to hospital care and facilities when complications set in. Family doctors play a central role in controlling chronic diseases.

The Role of The Individual in Disease Management
While so much more has to be done to improve the healthcare system, the onus still lies in the individual as the patient to AIM to manage their disease control – A: Aim to keep a record of their condition, I: Increase their knowledge on the condition, M: Make an effort to see their doctor and follow advice.

There is a hadith of the Prophet Muhammad S.A.W. which states that for every illness there is a cure. While we know that not all diseases have a known cure, prevention itself is an effective antidote for several diseases. The way forward in managing ballooning healthcare costs would be, simply put, to prevent the onset of disease. The way to do it is by maintaining a healthy lifestyle, to actively participate in screening programmes to catch the disease early and to take control of one’s illness when it happens.
MUCH HAS been written and discussed about health issues in recent months. From the recent H1N1 flu pandemic that spread across four continents and claimed more than 150 lives, to China’s milk contamination scandal and the local cases of food poisoning right on our doorstep, each of these unforeseen incidents has provoked a profound sense of insecurity. A young child’s cough in a crowded train is enough to prompt other passengers to move away from the little person they apparently suspect to be the carrier of some unknown virus. In newspapers, online forums and pulpits, religious teachers, vegetarians and others are quick to depict the flu as an example of the truth of God’s eternal warning: Pork is Dangerous. Call it ‘Swine’, to be sure. Wash thy hands and purify thy soul. Follow the news and hoard face masks. Be responsible and all will be well.

Let me come clean. I am not discounting the present efforts by moral entrepreneurs and state agencies to make us sentient or sensitive to the predicament at hand. Cynicism and indifference of those sitting in the ivory towers of the academe have no real place in a world suffering from a perpetual battle for existence. But it strikes me as rather remarkable that, whilst so much has been done by way of campaigns, fines and legal measures to decrease human morbidity, very little has been spoken about enhancing our intellectual health, of nurturing the minds to think critically about the food we eat, our personal hygiene, our physical well-being and the circumstances that led to our uncritical attitudes to life.

**Intellectual Health**

Why, one may ask, did the dozens of people who knew that the food that they were consuming was clearly spoiled seem bent on having it re-cooked? Why do sickly people who were carriers of deadly viruses choose to flout confinement orders? Why do religious groups debate at length upon the proper name of a disease or speculate on whether the punishment from God has come asunder when what is severely needed are worldly and practical solutions to remedy the problems that besiege their very lives?

Misfortune and destiny notwithstanding, the answers to these questions are not easy to find. I would attribute these problems to unhealthy minds which inadvertently affect our actions, choices and movements and, hence, our bodily health. Any man, says Mahatma Gandhi, “is but the product of his thoughts. What he thinks, he becomes”. This pearl of wisdom from one of India’s greatest sons is pertinent in these troubled times. The provenance of these words could be safely traced to the Prophet of Islam – Muhammad – whom Gandhi was known to have personally admired. Born in an age when ignorance held sway and illiteracy was the norm, Muhammad’s teachings urge us to cultivate our intellect through study so that we can fully understand any problem we might encounter. It follows that the health of any given community is contingent upon the state of the individual and the collective mind.

**Begin with the Intellect**

Dr Syed Khairudin argues that the key to good health begins with intellectual health. Can we improve our health by using our intellect to make dietary decisions?
At a time when most of his people believed that all sicknesses were caused by the forces of magic and accidents, Muhammad taught: “There are cures for all diseases.” Responding to the outbreak of an epidemic in his time, Muhammad counselled his listeners to be guided by their heads rather than their hearts. Muhammad issued instructions which amounted to a quarantine order, saying: “Refrain from entering the site nor should anyone who is there leave until the disease has subsided.” He knew that diseases and pandemics could be more swiftly neutralised if people would use their intellects to think rationally about these threats to public health and act accordingly.

Muhammad’s teachings provided the impetus for the rise of an enormous body of medical knowledge in the years to come. In thinking through the spirit and principles governing the enormous body of medical knowledge in the years to come. A branch of medicine termed Al-Tibb Al-Nabawi (The Prophet’s Medicine) was formalised and enshrined in commentaries written by Ahmad b. Ali ibn Hajar al-Asqalani (d. 852/1449) and Abu Muhammad Mahmud Ahmad al-‘Ayni (d. 855/1452).

The overarching aim of this system of medical knowledge is to raise awareness of the importance of health and suggest how the body could withstand the ravages of disease and old age. This was in keeping with one of the goals and objectives of Islamic law (Maqasid al-Shariah) which states that the education of the individual is essential in safeguarding the community’s interests. Fazlur Rahman, in his book, Health and Medicine in the Islamic Tradition: Change and Identity, said that the practitioners of Al-Tibb Al-Nabawi placed a premium on the cultivation of intellectual health as the first step in the promotion of physical health. Simply put, healthy minds mean healthy bodies.

History of Medicine
Yet this was just the beginning of a long history of medicine in the Muslim world. Driven by Muhammad’s injunction to be relentless in the formulation of new knowledge, jurists and philosophers questioned the comprehensiveness of Al-Tibb Al-Nabawi in resolving other chronic ailments that engulfed Muslims and non-Muslims alike in the Muslim world and beyond. Muhammad was, after all, a Prophet rather than a medical expert, and he relied on the expertise of specialists to resolve worldly problems that were outside of his divinely-endowed knowledge. Muslim scientists drew upon the knowledge they gathered from Hellenistic, Indian, Iranian and Greek medicine. By translating and developing the best out of the sciences that had developed in other civilisations, physicians such as Hunayn ibn Ishaq, Ali ibn Sahl Rabban al-Tabari, Ibn Sina and Şerafeddin Sabuncuoğlu pioneered new advances in the fields of experimental anatomy and physiology, pulsology and sphygmology, child development and pediatrics, therapies, and toxicology, among many other areas.

They worked in highly advanced hospitals and universities and wrote volumes of encyclopedias and treatises that lay the foundations of the intellectual edifice of modern medicine. The Mind was the chief driving force of these developments in medicine, which led to the creation of a flourishing civilisation of thinking men and women who were conscious of self-preservation by scientific means. In medieval times, life expectancies were longer in the Islamic world than in Christendom. Muslims were so concerned with purity that the culture of public baths in the Roman Empire was adopted and improvised in Muslim Spain and Syria and transplanted back to European lands as discussed by Maya Shatmiller in the book ‘Labour in the Medieval Islamic World’.

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Lest I be misunderstood as a romanticist, let me state some bitter truths which we are often unprepared to confront. Because the men of knowledge in our midst are intellectually unhealthy and had forgotten the manifold contributions of our noble forebears, we have spent useless ink and engaged in lengthy, hair-splitting debates on naming diseases (“Swine flu” versus “Influenza A” or “H1N1”) rather than trying to better understand these diseases. Wouldn’t it be more productive for us to learn from the rich legacy of scientific inquiry that we have inherited, so as to save precious lives?

“It’s the Intellect, stupid”
Because our minds have been conditioned that we ought to eat whatever is put on our plates, we seldom think about the effects of certain foods on our health. Such decisions may prove fatal. Above and beyond these problems, our health is endangered by the demands of our highly industrialised, capitalist and elitist society that even sick people must go out and work every day for the fear of impending poverty. Have we ever considered the intellectual health of our leaders who perpetuate a system that places economic interests before the self at the risk of our intellectual health?

Bill Clinton may have won his first presidential election back in 1992 with the relatively simplistic slogan of ‘It’s the economy, stupid!’ It is perhaps timely that we update Clinton’s slogan and argue that the key to finding the cure to flu bugs and other diseases, as well as contaminated foodstuffs that threaten health around the globe, is to be found not so much in the economy as in our own minds.

‘It’s the intellect, stupid!’ This applies to Muslims as much as to anyone. Start thinking.

Dr Syed Khairudin Aljunied is Assistant Professor at the Malay Studies Department, National University of Singapore (NUS). His views are personal and do not reflect the position of the department or NUS.
Feeling the Pulse of the Community

In the latest Singapore National Health Survey by the Ministry of Health (MOH), Malays were found to have the highest proportion of fat people in this country. An alarming 19.1% of our population are categorised as clinically obese. This is followed by the Indians at 13.4% while the Chinese were far off the mark with an obesity rate of only 4.2%.

However, there is a far more worrying statistic. Between 1998 and 2004, the obesity rate amongst Malay males within the community grew at an astounding 47%. This means that the number of obese Malay men approximately doubles every six years. Just how did we arrive at this situation if we have been so careful of what we eat?

THE MALAY Obesity Epidemic is currently our society’s most pressing concern and it is bound to get uglier if left unattended.

“Beware! Mak Joyah’s Delicious Ice Cream contains emulsifier number E12345. This emulsifier may not be Halal. Please forward this to as many Muslims as you can for the safety of their religion!”

Sounds familiar? If you have an email address, chances are you are guilty of forwarding something similar at one point of time or another. I have lost count the number of emails I have received over the years that warned me to look out for cakes, creams, drinks and every other imaginable food stuff with possibly forbidden ingredients.

When it comes to food, Singaporean Muslims are a discerning lot indeed. We have equipped ourselves to read labels very carefully, scrutinising every ingredient for anything that may seem out of the ordinary. When something is amiss, or when an eating establishment is doubted to be ‘Halal’, word on these possibly forbidden foods will be disseminated widely within the community in a very short time.

This is a good habit. It pays to be mindful of what you are consuming for the overall health of your mind and body. Scrutinising what you eat is a culture that should be encouraged within the community and preserved for future generation of Muslims.

But if we are so discerning of what we eat, why is it that many of us in the Muslim community are now walking around with big bellies?

Recent data and media reports on the state of health of Singaporeans have not been in favour of the Malay community. With one of the highest rates of obesity, are we at risk of being the fattest people in Singapore? Ridzwan discusses possible ways to combat this worrying problem.

The Fat Tsunami

Muhd Ridzwan Rahmat

In the latest Singapore National Health Survey by the Ministry of Health (MOH), Malays were found to have the highest proportion of fat people in this country. An alarming 19.1% of our population are categorised as clinically obese. This is followed by the Indians at 13.4% while the Chinese were far off the mark with an obesity rate of only 4.2%.

However, there is a far more worrying statistic. Between 1998 and 2004, the obesity rate amongst Malay males within the community grew at an astounding 47%. This means that the number of obese Malay men approximately doubles every six years. Just how did we arrive at this situation if we have been so careful of what we eat?

The Concept of Halalan Tayiban

A Muslim’s main dietary guideline comes from the Quran in the form of verse 168 of Surah Al-Baqarah whose meaning states:

“Oh you people, eat of what is on earth that is ‘Halalan Tayiban’ (lawful and good).”

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This is a commandment for Muslims to not only ensure that the food we eat is permissible in source and substance, but also good and nutritious for the body. This commandment is intuitive to the teachings of Islam which has always forbidden us to cause harm to our bodies.

Unfortunately, while Muslims have been diligently ensuring that our food is ‘lawful’, it seems that we have largely ignored the requirement for it to be ‘good’. While we have been diligent in ensuring that our dishes do not contain ‘Haram’ additives or emulsifiers, we have been less careful in taking note of the amount of saturated fat and cholesterol that they deposit in our body. While we have been diligent in ensuring that our dishes are free from alcohol, we have ignored other harmful substances such as trans-fat and sweeteners that have contributed to the increasing trend in obesity in the community.

The Fat Tsunami and the Potential Problems
The Malay Obesity Epidemic is a storm brewing on the horizon. Left unattended, it will manifest over our heads in the very near future as a tsunami that will devastate our society in more ways than one.

A community with a large obese population is a community that is economically and socially less able. Obesity will present an array of physical impairments such as lethargy that will prevent many in our society from carrying out beneficial deeds for their families and ultimately, for our people.

Obesity has also been blamed for taking the bliss out of families. Experts have pointed out how sexual and psychological anxieties between husband and wife can develop from an unchecked bout of obesity in either one of the partners. These nuptial complications may prove to be detrimental to the overall well-being of a family.

But most importantly, obesity brings about a host of chronic medical problems like diabetes, high blood pressure, heart disease and kidney failure. We cannot afford to have a large population of medically unfit individuals who will continue to drain the financial resources of the community in the future.

Change Has to Come
There has to be urgent and decisive action by everyone in the community, especially at the grassroots level, to raise awareness and eliminate some long-entrenched habits that have placed our society on the current trajectory.

There has to be a shift in paradigm with regards to our eating habits. Harmful foods like thick gravies, fried delicacies, meaty dishes and sweet beverages have long been ingrained in the minds of our children as an acceptable source of nourishment. When they grow up, these detestable eating habits continue as a form of lifestyle.

This mental conditioning cannot continue. There has to be a conscious effort to start educating our young on the value of nutrition and the detrimental effects on our well-being if we choose to disregard it. The concept of Halalan Tayiban from the Quran must be strictly observed at the dinner table, with its concept clearly explained to our youngsters for them to carry into adulthood.

There has to be a change in lifestyle with regards to exercise. Our Malay families cannot continue to just sit idle by the beach on weekends, barbequing chicken wings while families of other races are whizzing by in their running shoes. There has to be greater involvement of the media, mosques and self-help groups towards promoting an active lifestyle within the Muslim community.

In line with the vision and concept of Khairah Ummah, Muslims have been taught to develop ourselves as the best example for all mankind, not only in terms of spirituality, but in terms of how we lead our lives on this earth as well. This is the vision that we need to strive for when we organise our lifestyle and dietary habits.

Unfortunately today, what we are about to experience is a tsunami of an increasing number of fat individuals in our community who may be draining the country’s resources in the form of medical liabilities. Action needs to be taken, and it needs to be taken collectively – and fast.

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Zulm is a Quranic term referring to oppression, injustice or cruelty. The concept of zulm refers not only to oppression towards other created beings but also towards oneself. One commits an act of zulm, if, by one’s action, the end result is damage to oneself or others. The action of the zalim individual consists of acts of transgression (fusuk). Examples of transgressions are unjustified killing, consumption of intoxicants, adultery, usury and gambling – in other words, transgressions of boundaries as set by Allah in the Holy Quran. The Quran states that zalim individuals have only themselves to blame for their acts of transgression and oppression –

"Nowise shall We be unjust to them: but it is they who have been unjust to themselves." (Surah Al-Zukhruf, 43:76)

Where then does zulm come into the discussion of chronic illnesses?

Zulm Illnesses

In fast-paced urban Singapore, chronic illnesses are very common. Examples include hypertension, diabetes, hypercholesterolemia, obesity, coronary heart disease, stroke, asthma, chronic obstructive lung disease, chronic liver disease and chronic kidney failure. These illnesses take up a significant amount of the country’s healthcare expenditure.

In the Malay/Muslim community, increasing affluence and the halal certification of most fast food outlets have led to increasingly unhealthy eating habits (for example, eating out at McDonald’s) and a more sedentary lifestyle (for instance, many children and adolescents now spend more time surfing the Internet or SMSing from their handphones instead of playing outdoor games during their leisure time). This increasingly unhealthy lifestyle has certainly contributed to worrying trends in the community. Examples include the high prevalence of obesity and kidney failure when compared to other communities.

In Singaporean society, success is measured in terms of wealth, and being afflicted with a chronic illness is often viewed as a major disadvantage, as ‘health is wealth’.

The Quran, however, describes a different viewpoint –

"Whenever We sent a prophet to a town, we took up its people in suffering and adversity, in order that they might..." (Surah Al-Ahzab, 33:55)
The preceding verse explains that humans are made to suffer in order that they may learn humility. Without suffering (for example by being afflicted with an illness), the soul will not improve in character. In other words, having an illness is indeed a mercy from Allah such that the sufferer remembers his human limitations and constantly seeks Allah’s help and guidance. He will continue to ‘test’ each believer with suffering and adversity, in order to select those deserving of Paradise as inferred from Surah Al-Baqarah, 2:214 – “Or do ye think that ye shall enter the Garden (of Bliss) without such (trials) as came to those who passed away before you? They encountered suffering and adversity, and were so shaken in spirit that even the Apostle and those of faith who were with him cried: “When (will come) the help of God?” Ah! Verily, the help of God is (always) near!”

An oft-quoted story of a believer suffering from a chronic illness is that of Prophet Ayub. Although his illness caused him much suffering, Prophet Ayub’s patience, perseverance and constant remembrance of Allah, followed by obedient execution of Allah’s instructions, resulted in successful resolution of his illness.

Instead of healthy acceptance (ridha’), coupled with a resolve to change his lifestyle to minimise the impact of this illness to his health, the zalim diabetic continues with his previously unhealthy lifestyle of overeating and lack of exercise.

hand a little grass, and strike therewith: and break not (thy oath).’ Truly We found him full of patience and constancy. How excellent in Our service! Ever did he turn (to Us)” – (Surah Sad – 38:41-44).

Allah however also reassures us that each person will not be given a burden greater than what he can bear – “On no soul doth God place a burden greater than it can bear.”

In societies where the consumption of alcoholic beverages is accepted and even encouraged, the incidence and prevalence of chronic illnesses related to alcohol consumption is higher. These include alcoholic liver disease, alcoholic heart failure and alcoholic dementia. Another example is chronic obstructive lung disease resulting from prolonged and sustained cigarette smoking – an illness that results in massive destruction of lung tissue causing the sufferer to often experience breathlessness. Yet another devastating illness is HIV-AIDS, a deadly disease with no hope of a cure that is more prevalent among promiscuous individuals.

Mdm Z is recently diagnosed to be HIV-positive. This was discovered during her routine antenatal check-up. It transpired later that her husband had been HIV-positive all along without realising it. Theirs was an arranged marriage. He is a businessman who used to make frequent business trips to Bangkok during the years he was single. He admitted to having unprotected sex with prostitutes.

In the above example, the husband’s transgressions have resulted in him getting the virus and passing it to his wife, an innocent victim of zalim.

In terms of responding negatively towards an illness, a very obvious example is diabetes. When the news is broken to the zalim individual that he has diabetes, he falls into a state of disbelief that it could affect him and later, to a sense of hopelessness and despair. Instead of healthy acceptance (ridha’), coupled with a resolve to change his lifestyle to minimise the impact of this illness to his health, the zalim diabetic continues with his previously unhealthy lifestyle of overeating and lack of exercise. These continued acts of self-oppression ultimately result in many complications such as coronary heart disease, stroke, blindness, leg amputations and kidney failure. The ridha’ individual, on the other hand, realises that this illness is indeed a wake-up call for him to change in the direction of adopting a healthy lifestyle. The ridha’ individual takes diabetes as a mercy from Allah to help him change for the better.

How Zulm Comes About

Zulm plays a central part in chronic illnesses in two ways: Firstly, the oppressor commits acts that lead to the development of a chronic illness. Secondly, the oppressor shows a negative attitude when afflicted by the chronic illness; instead of viewing the illness as a source of strength, the zalim individual falls into despair.

There are many examples of chronic illnesses that originate from acts of zulm.
In the Malay/Muslim community, increasing affluence and the halal certification of most fast food outlets have led to increasingly unhealthy eating habits (for example, eating out at McDonald’s) and a more sedentary lifestyle (for instance, many children and adolescents now spend more time surfing the Internet or SMSing from their handphones instead of playing outdoor games during their leisure time).

Mr M had been losing weight and feeling very weak. After seeking help from traditional Malay healers without much success, he finally consulted a doctor who diagnosed him with diabetes and started him on medications. He was advised to adopt a healthier lifestyle that included better diet management, exercise and cessation of smoking. His condition improved initially. Unfortunately Mr M frequently missed his follow-up sessions with the doctor due to his lack of financial resources. He also found it very hard to give up smoking or to give up his favourite Malay dishes like mee rebus and laksa. His doctor urged him to visit the nearest polyclinic where the cost of treatment is much more affordable. He went to seek treatment a few times but eventually gave up because he could not tolerate the long queues. A year later, Mr M was again brought to the polyclinic by his wife and daughter because he had been experiencing transient episodes of weakness in his right arm and leg. While waiting for his number to be called, Mr M collapsed suddenly, unable to move the right side of his body or speak. He had suffered a stroke.

This example reflects the continued acts of zulm the individual inflicts upon himself where he ends up in a situation worse than before.

The Role of Ridha’ in Healthier Lifestyle

Another common chronic illness in the Malay/Muslim community is asthma, which is eminently treatable with modern medicine. Often, this illness first manifests itself during early childhood. As asthmatics enter adolescence, their condition improves with many of them seldom experiencing asthma attacks. Unfortunately, despite prior warnings to never take up smoking, one often sees asthmatics who start smoking in their late teens and start to experience frequent asthma attacks again. Smoking then becomes an act of zulm that results in the illness making a comeback.

In conclusion, a chronic illness as ordained by Allah towards an individual produces different results, depending on the response of the sufferer. In the ridha’ individual, it leads to a journey towards a healthier lifestyle and a positive outcome. In contrast, the zalim individual continues in the crooked path of self-oppression and ultimately self-destruction. There is still much to be done to raise awareness amongst the local Malay-Muslim community. Meeting the dual challenge of prevention against a chronic illness or battling a chronic illness is the duty of every Muslim individual in order to become more productive, contributing citizens.

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“Kak Timah, kita datang nak siram.”
(Sister Timah, we have come to ask you to pour water).

**AS A** child growing up in the 1970s, I did not understand why there were visitors who came to Gedung Kuning, our home, to ask Nenek (grandma) to *siram* or pour water over their hands and legs. These visitors were women, girls or boys and sometimes men. Nenek would always encourage them to consult a Western doctor. Some did but many preferred to *siram*.

**The Practice of Siram**
I quietly observed Nenek. She brought these visitors to the open washing area near the toilets. There, she filled up a big basin of water. She then asked for their full name and the part of the body which was injured or fractured. Nenek then recited some prayers from the Quran and blew on the surface of the water. She scooped the water with a small pail and poured the water onto the injured parts thrice. Nenek’s patients would then have to come for a *siram* ‘session’ for two consecutive days.

Nenek tried not to have physical contact with the men she treated. So, Nenek would fill up three water containers (one for each day) and gave them instructions on how to *siram*. Then Nenek gave her patients *param* (small flattened balls of herbal medicine) which must be mixed with water until it becomes a paste and applied onto the injured parts. Among some of the ingredients to make *param* were *cekor* or *kencor* (a local flower known as ‘resurrection lily’), *jintan putih* (cumin) and *buah pala* (nutmeg). Nenek would grind all the ingredients, mix them with *tepung beras* (rice flour) and roll them into small balls. She would flatten the balls so that their shapes resemble a fifty-cent coin. She then dried them under the sun at Gedung Kuning. When the sky turned dark, I would help Nenek bring the *param* in.

Nenek’s patients would sometimes offer to pay Nenek for her services but she always refused. She said she was *ikhlas* (sincere) in helping them. They just needed to give her two items: some *asam* (tamarind) and some *garam* (salt). I remembered asking Wak Lah, my uncle, why
Wak Lah said that in Malay culture, those ingredients signified the hope of getting well being granted (“biar masin permintaan untuk sembuh”). Furthermore, those ingredients often used in Malay cooking were also food items the poor could afford to buy.

The ‘Healing Power’ of Siram

Nenek once told me how the neighbours asked her mother, Hajah Aisah, to cure their child who had high fever. The helpless Hajah Aisah told them to seek medical attention at the hospital. But they refused. Perhaps poverty led them to seek alternative forms of treatment or simply because of the trust they had in the Gedung Kuning family. That night, Hajah Aisah gave the boy some water to drink. She had blessed the water with recitations from a surah (chapter) from the Quran. Miraculously, the boy’s fever subsided and the ever grateful neighbours thanked Hajah Aisah. Her ‘fame’ as a healer soon spread to the residents of Kampung Gelam.

A young colleague who used to live in Kampung Gelam affectionately talked about how Nenek used to siram him all the time. Being an avid soccer player, he was injured on multiple occasions and he would ask Nenek to heal his broken bones. Of course Nenek always reminded him to consult the doctor. My brother Hadi and I were also Nenek’s patients who benefited from the siram and param treatment. According to Nenek, the treatment is a form of usaha (attempts) to seek cure; she believed in balancing traditional cure and western treatment. To emphasise her conviction of all forms of usaha, Nenek trusted the Western-trained surgeon and underwent surgery to cure her breast cancer.

Hajah Aisah, Nenek and Emak (Mother) have since passed on, leaving only Wak Lah who knew the siram method of healing. Wak Lah told me that one must be pure in thoughts and intention before one can master the skill. Our family did not pass on this knowledge to others for fear of abuse. Somehow, I am glad they turned away offerings of money (although some patients were very insistent they accept the money) unlike some medicine men who profited from others’ illnesses.

I can picture sceptics reading this story shake their heads in disbelief as they ponder on how one could “cure” an injury which requires an orthopaedist’s attention. Perhaps the act of siram has a psychological effect on Nenek’s patients. After all, when they believed that the siram was effective, their faith could have actually been the healing power. Perhaps the ingredients of the param somewhat reduced their swelling and pain, and mended some broken bones in the process. A doctor once commented that scientifically, certain psychological states such as contentment and hope release chemical substances in the body. These substances will assist the body in battling ineffective agents and produce a general sense of well-being in the patient.

As far-fetched as the siram and param treatment sounds, Man has yet to discover much of the mysteries of the world of traditional medicine and of silent healers.

Hidayah Amin is the author of Gedung Kuning, Memories of a Malay Childhood (‘Siram and Param’ is one of the 29 historical narratives in the book). She is also a member of the Board of Directors of AMP and the Board of Management of Young AMP.
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The current economic recession leaves Malay workers vulnerable to retrenchments. Abdul Shariff looks at whether the efforts by the Malay/Muslim organisations have been effective in helping the retrenched reenter the job market. What more can be done?

**NEWS EMANATING** from the authorities about the employment market in Singapore has been somewhat mixed.

In 2008, the Ministry of Manpower (MOM) reported that 16,880 workers were made redundant, most of whom were laid off or released from contract in the last quarter of 2008 as businesses reeled from the onslaught of the worst global recession in decades.

Earlier this year, Marina Bay Sands and Resorts World at Sentosa announced that a total of 20,000 jobs will be rolled out by early 2010.

Commenting on a report released by MOM on April 24, 2009, Manpower Minister, Mr Gan Kim Yong noted that 45,000 jobs would be available this year and the next. The report also showed that 70% of residents who were retrenched in the third quarter of 2008 found jobs by December, an improvement compared to the preceding three-month period when only 60% of the retrenched were rehired.

However, in his May Day message, labour chief, Mr Lim Swee Say, called on Singaporeans to brace for tough times ahead as the downturn has yet to bottom out and the wave of retrenchments seen in the first quarter of 2009 was only the first of more to come. This at once quelled optimism that the job market is weathering the economic turbulence well.
What is certain is that, in the first quarter of 2009, more jobs had been shed than created. The 8,500 and 10,300 jobs created in the construction and services sectors respectively could not offset the 19,900 jobs lost in the manufacturing sector, resulting in a net loss of 1,000 jobs.

In January, Careerlink centres operated by the Workforce Development Agency (WDA) and its Distributed Careerlink Network (DCN) partners, comprising the Community Development Council (CDC) and National Trades Union Congress (NTUC), attended to 7,447 job seekers. According to data taken from the Singapore Department of Statistics, 4,501 of them were given job referrals, of which a mere 798 were placed.

The reality therefore is that jobs are scarce.

Malays Susceptible to Retrenchment, Unemployment
The dramatic rise in retrenchments among the educated and skilled class known as PMETs (Professionals, Managers, Executives and Technicians) – from 840 in the third quarter of 2008 to 3,570 in the fourth – gives the impression that the employment crisis is most felt by them. On the contrary, while layoffs rose the fastest for PMETs as the last quarter of 2008 approached, a total of 6,320 low-skilled workers who were production and transport operators, cleaners and labourers were retrenched, compared to 5,820 for PMETs, according to the Labour Market Survey by MOM. This is despite the fact that PMETs form 51% of the workforce, much larger than the former, which constitutes only 21%.

Data released by the Manpower Research and Statistics Department of MOM in November 2008 showed that lower-skilled workers were more susceptible to unemployment in 2007 and 2008 (as at June). Service and sales workers (6.6%), cleaners, labourers and related workers (5.3%) and clerical workers (5.0%) had unemployment rates that were significantly above the norm (3.6%).

Compared to the Chinese and the Indians, a larger proportion of the Malays in the workforce are lower-skilled workers. In the 2005 General Household Survey (GHS 2005), it was reported that 36.9% of Malays were production workers, cleaners and labourers while 38.9% held clerical, sales and services jobs (Chart 1). Going by the unemployment statistics, it seems the Malays are vulnerable to unemployment.

In March this year, MP for Pasir Ris-Punggol GRC, Dr Ahmad Magad said that an estimated 30,000 Malay workers faced retrenchment. He noted that in 1998 when the economy was affected by the Asian financial crisis, two in five workers who were retrenched were Malays. Prospects look bleaker this year because, compared to the first quarter of 1998 when 7,130 workers were retrenched, 10,800 workers were laid off in the first quarter of 2009. This surpasses the previous highest quarterly retrenchment figure of 8,590 in the last quarter of 2001 when the economy was battered by the September 11 terrorist attacks and the bursting of the dot-com bubble.

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A possible underlying cause of the susceptibility of Malays to retrenchment could be that 75.1% of Malays have lower secondary and below secondary education, as opposed to 58.7% for the Chinese and 53.1% for the Indians, as General Household Survey 2005 shows. In 2008, the non-seasonally adjusted average unemployment rate, as reported by MOM, for those with lower secondary education was highest (4.3%), followed by those with primary and below qualifications (3.5%). The rates for those with polytechnic diploma (2.7%) and degree (2.7%) were the lowest.

It could be argued that the Malays will not be as badly affected by the current crisis as was the case with the 1998 and 2001 crises. As the Manpower Ministry’s April 24 report disclosed, in 2008, degree holders – a category where Malays are underrepresented – were most vulnerable to retrenchment. They constituted 30.9% of those who were retrenched. The below secondary group came next at 24.5%, followed by the lower secondary group at 18.2%. The re-employment rate of graduates retrenched in the third quarter of 2008 was also the worst for all education levels. Only 61.7% were re-employed by December. In contrast, those with secondary and below secondary education did better with re-employment rates of 64.3% and 71% respectively. This information, however, has to be viewed with caution because the sharp deterioration in the economy started only in the fourth quarter of 2008. The full impact of the economic recession, reflecting the vulnerability of residents, may not have shown up in the data as yet.

Moreover, the fact remains that 42.7% of those who were retrenched in 2008 were in the lower secondary and below secondary groups, where Malays were overrepresented. In previous downturns, the lower educated had to bear the brunt of the recession. Those in the vulnerable zone were residents with primary and below (during the 1997-98 Asian financial crisis) or below secondary (following the September 11 attacks on the US in 2001) qualifications.

Furthermore, the constitution of the Singapore workforce is changing. Between 2006 and 2008, most of the new jobs taken up by locals were in PMET positions. PMETs enjoyed continued employment gains across all major sectors and now form 51% of the workforce. Correspondingly, the proportion of production and related workers declined from 30% to 24% and clerical, sales and service workers from 29% to 25%. This, according to MOM, is partly reflective of the improvement in the educational profile of the resident labour force. Hence, whether the impressive re-employment rates of the less educated are sustainable in the long run is questionable.

The overrepresentation of Malays in the secondary and below secondary categories raises the question of whether the improving educational profile of the non-Malay workforce would cause the Malays to be left behind in the long run.
Addressing the Plight of Malay Workers

Malay/Muslim organisations (MMOs) have various programmes to assist the unemployed and the retrenched to find jobs. The Job Ready programme by Yayasan Mendaki targets 4,000 jobseekers, more than 50% of whom would be the newly retrenched and aims to offer 9,000 training places this year. Another programme by Mendaki, Job Steady, is working to create awareness among low-skilled workers about the availability of training programmes, such as those under the Work Skills Qualification System (WSQ). The Micro Business Programme by the Association of Muslim Professionals (AMP) equips individuals from low-income families with entrepreneurial skills to enable them to start home businesses as a source of alternative income.

While the programmes offered by MMOs are useful, consideration has to be given to the distinct characteristics of the Malays in the labour force and a long-term view has to be taken to enable the Malay community to cope with future crises. The overrepresentation of Malays in the secondary and below secondary categories raises the question of whether the improving educational profile of the non-Malay workforce would cause the Malays to be left behind in the long run.

The educational attainment of the resident labour force partly contributed to the increase in PMET positions in the workforce with the non-PMET ones declining. On the one hand, a growing number of Malays have at least three ‘O’ level and five ‘O’ level passes. This allows them to pursue Higher NITEC and polytechnic courses respectively and apply for PMET positions. On the other hand, comparing the trends of the workforce by occupation between 2000 and 2005, the share of Malay PMETs actually fell from 23.4% in 2000 to 21.2% in 2005. In contrast, the proportion of PMETs for the Indians rose from 43.3% to 46.8% and that for the Chinese from 46.2% to 47.3%.

Some may attribute the decline in the number of Malay PMETs to the entry of new non-Malay residents into the workforce. Comparing the data between 2000 and 2005 for number of resident working persons aged 15 and over, the proportion of Malays in the workforce declined from 11.5% to 11.2%. The same went for the Chinese where the proportion fell from 80.2% in 2000 to 78.9% in 2005. Only for the Indians and other races was there an increase from 7.1% to 7.7% and 1.2% to 2.2% respectively. In terms of education, only 25% of Malays in 2000 had upper secondary qualifications and above, which is the educational attainment of the vast majority of PMETs. However, this increased to 34% in 2005. This 9% increase is larger than that achieved by the Chinese (7.7%) but less than that accomplished by the Indians (12.4%). Correspondingly, the number of Indian PMETs rose by 3.5% while there was a smaller increase for Chinese PMETs (1.1%). For some reason however, the share of Malay PMETs fell by 2.2%. Relevant bodies should attempt to identify the factors that contributed to the decline in the number of Malay PMETs despite improved educational attainment and more PMET jobs being available.

The Malays have a relatively young population, as depicted in Chart 2 by the broader base of the age pyramid of the Malays. As such, encouragement should be given to younger Malays who have dropped out of the formal education system and who are economically active with at least secondary education to acquire professional or trade certificates so that they stand a chance of moving progressively into PMET positions. MMOs should come up with initiatives targeting such youths – whether or not they are employed. MMOs should also create awareness about the availability of alternatives to formal academic qualifications like the ‘O’ levels. Initiatives such as these may help to accelerate change in the occupational profile of Malays in the workforce.

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WHAT IS “Islamic”? How do we consider something to be “Islamic”? How can we “Islamise” aspects of our life? Is it by comparison with a glorious “Islamic” past that is to be treated as a sort of a standard? Can we say that we have “Islamised” a building simply by assimilating certain “Islamic” physical aspects, say a *mussolah*, within the premises? Is there an “Islamic” science or an act of “Islamising” science? What about “Islamising” schools?

There are primarily two schools of thought associated with the notion of Islamisation. The first is spearheaded by the late scholar of Islam, Ismail Faruqi and his International Institute of Islamic Thought (IIIT). The second is initiated by Syed Muhammad Naquib Al-Attas using the International Institute of Islamic Thought and Civilisation (ISTAC) as his propagation centre. Because Al-Attas is considered the original father of the movement, this article will focus on his ideas.

The Islamic Metaphysical Worldview
At the very heart of this concept of Islamisation is the concept of an Islamic metaphysical worldview. As an analogy, a worldview is a spectacle or window through which one sees the world. As such, one’s outlook and perception of life is very much dependent on the worldview through which one lives his or her life, and this perception is dynamically shaped by one’s education and environment. A worldview gives meaning and purpose in our actions; it gives the answers to questions dealing with why and how we exist. It defines what ethical or moral values that we should partake in, and what type of behaviour or actions we should consider as right or wrong. Relating back to Islamisation, the Islamic metaphysical worldview is found in our *aqidah* (theology and cosmology), *tasawwuf* (psychology) and *syariah* (jurisprudence) derived from the teachings of the Quran and the Sunnah.

Because a worldview determines how one sees the world, information is interpreted in the light of one’s worldview too. Hence, value is attached to knowledge that one receives, because the information is processed by the knowledge-giver first before it is passed down to the recipient. This knowledge, together with the value attached to it, is then assimilated into one’s mental framework and worldview.

The Epistemological Challenge of Secularism
Due to the impact of worldviews (in particular the secular worldview) and the values attached to knowledge that would impact one’s perspective on life, Al-Attas views the fundamental crisis of the modern-day ummah to be epistemological in nature – that is, having its roots in the very conception of knowledge.
This is brought about by the contents of their education, as opposed to it being political or economic in nature. In other words, the problem is not just about a lack of knowledge. Rather it is also related to the definition of knowledge, its hierarchies, its sources and authorities. The loss of ability to differentiate between what is knowledge and what is not knowledge has led to confusion instead of enlightenment.

With this, Al-Attas can be regarded as the modern day Al-Ghazālī, who also similarly argues about the epistemological challenge faced by the medieval Muslims with the onslaught of Greek philosophy. The difference is that this time around, the Muslims are faced with the challenge of secularism, which he defines as the modern day manifestation of Greek philosophy.

Al-Attas identifies the “confusion of knowledge” brought about by modernist interpretations of Islam as the centre of this problem. This leads to a “loss of adab” and subsequently the “rise of false leaders” that would consciously or unconsciously propagate the ongoing “confusion of knowledge” and vehemently defend this vicious cycle using their power.

What Al-Attas means by adab is related again to the concept of worldviews, because a worldview arranges information and knowledge into ‘places’ in the mind. As such, adab according to Al-Attas is the recognition and acknowledgement of the right and proper places of things, the acquisition of good qualities and attributes as well as actions to discipline the mind and the soul, and the performance of correct and proper action as opposed to erroneous and improper ones. Adab therefore implies the knowledge and right methods of knowing which should preserve Man from errors of judgement and disgrace, and by which the condition of being in the right and proper place is actualised. The proper knowledge which produces these requisite actions is wisdom (hikmah), resulting in justice (‘adl) in the individual self as well as in the state, society and natural environment.

‘This act of knowing and the discipline in constantly putting things in their proper places is called adab. The condition brought about by the loss of adab; by playing improper roles or being ignorant of one’s proper place is defined as an injustice (zulm).’

The Eagle Does Not Fly at the Level of the Sparrow

In a nutshell, Al-Attas asserts that everything has a place that is relative to one another. He is often quoted saying that “eagles do not fly at the level of the sparrows”. Hence the ignorant is not at the same level as the learned. The word of God is not the same as the word of Man. This act of knowing and the discipline in constantly putting things in their proper places is called adab. The condition brought about by the loss of adab; by playing improper roles or being ignorant of one’s proper place is defined as an injustice (zulm). As such, Al-Attas calls for the reformation of the educational philosophy and institutes of the Muslims based on the metaphysical worldview of Islam. In line with the reformation of the philosophy of education,
Al-Attas calls for sincerity in the pursuit of knowledge as well as the recognition of the proper authorities of knowledge. In the same light, Al-Attas argues against the levelling down of the classical scholars to the same level as that of the modern day scholars. He believes that the traditional scholars are closer to the truth and hence regards the *tafsir* as a more reliable science as opposed to a modern hermeneutic approach to the Quran.

### The Proper Place Of Language

Another salient feature of the Al-Attas concept of Islamisation is his careful analysis and usage of language, because language is a projection of one's worldview. In other words, language being the vehicle or medium which expresses the meaning of things is ultimately tied to the worldview from which it is developed. Hence, Al-Attas calls for the careful definition of terms, and as such, define specific terms using Quranic terminology as understood by the classical scholars. Science according to the Islamic worldview is not the same as that which is understood by the secular West. Science defined by the Islamic worldview is the pursuit or unveiling of *haqiqah* or of truth and reality as described in our *aqidah* and *tasawwuf*. With this given definition of science, the existence of paradise and hellfire is scientific because they are both true and real, though confined to the non-empirical spiritual dimension.

There is no dualism between science and religion; dualism only exists in the West due to its secularisation experiences; it has no roots in Islam. In fact, Al-Attas argues that there exists a unity and harmony between science and religion within a *Tauhidic* framework. In other words, science as understood from the Islamic worldview is but a means to acknowledge the Omnipotence and Magnificence of the One God. Science is not an alternative way to the truth; science is in unity with religious truth.

The same goes for other terms like justice which is somewhat equated to equality in the West but is not understood in the same way from an Islamic perspective. The Muslim world’s understanding of democracy is different from the West, because the concept of *syura* does not treat the learned’s vote and opinion the same way as that coming from the ignorant. Thus Al-Attas seeks a redefinition and reconceptualisation of terms coming out of other worldviews in the Muslim’s attitude towards learning knowledge from other worldviews, as well as the correct and accurate usage of terms in expressing the meaning of things. In addition, Al-Attas states that the Islamisation process begins with the Islamisation of languages where Quranic terms, which reflect the metaphysical worldview of Islam, are incorporated into languages.

### Islamisation is Anti-West?

Contrary to some claims that the concept of Islamisation is anti-West, it is helpful to recall that Al-Attas calls for the recognition of the proper authorities of knowledge. This means that since the West is at the forefront of science and technology and hence, the current authorities in that field, Muslims are urged to learn from the West. The only catch is that the Muslim should possess the metaphysical worldview necessary to filter out those theories that are not in line with our *aqidah* and *tasawwuf*. In fact, the pursuit of knowledge does not just stop at the reinterpretation of secular knowledge; the Muslim should also possess the ability to form new theories and solutions that support the Islamic metaphysical worldview. And lastly, the Muslim should realise that the ultimate purpose for knowledge is spiritual and immaterial in nature, not one that is done for employability sake only.

### Food for Thought

With the given definition of “Islamic” and “Islamisation”, are our madrasahs, while incorporating Islamic rules, regulations and rituals, free of the secular dualism and dichotomy of *duniawi* and *ukhrawi* sciences? Can they be considered as a truly Islamic-learning environment?

*Hasanul Arifin is Vice President of the National University of Singapore Muslim Society (NUSMS). His views are personal and do not represent those of any group or organisation.*

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