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EDITORIAL

Medical Education and Practice in Malaysia, Quo Vadis?

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As of June 2016 there are 28 medical schools [1] in both private and public sectors in Malaysia offering more than twice as many programs [2] with yearly graduates of about 4500 including those that graduated from overseas. This magnitude is beyond the usual capacity of Ministry of Health (MOH) that is entrusted to accord preregistration training posts to the graduates as the whole process of allocation to available places in public hospitals nationwide is painfully slow. It is already a tragedy having to wait 6 months on average for a placement but words that a delay for up to a year can occur is totally unacceptable when the actual training places available at grade DU41 preregistration house officers is said to be more than the graduate number [3]. Delay can be detrimental to the training itself because waiting is a waste of talent and potential, a disincentive to a young aspirant, tacitly is a testimony of system failure and deprives the public of highly trained graduates to serve in our healthcare system that ironically suffers from chronic and ever growing wait but yet we have excess medical graduates. Some of them have taken a simple and quick route out of the mess by migrating to our neighbours near and far, not entirely their faults, but their thresholds to despair seem very low indeed. The need for a speedy and right solution to the delay is long overdue and this is nothing more than what the public and the young doctors deserve.

How did we get to this? Not unexpectedly but the magnitude stemmed from the unusually large number of *Sijil Pelajaran Malaysia* (SPM; Malaysia Certificate of Education) leavers that opted to study medicine, in part made easy by the many medical schools in the country and those that have been accredited abroad. This was augmented by the constant reminder of the need for more doctors, parental or hype pressure perhaps for whatever reasons, and also the ease with which scholarships were available to study medicine. The principle driver for the whole mess was money initiated by those who wish to make profits under these "fortunate" circumstances [4]. The resulting deluge of medical graduates clogged the system up and unfortunately created many of the unnecessary challenges that we face today. Paradoxically despite this excess our doctor population ratio is still lower than the Organization for Economic Cooperation and Development (OECD) average and our more prosperous neighbour in the south. These veiled and unscrupulous drivers are addressing the gap in ratio with such a speed that it strains the system to almost breaking point and had somewhat ruffled both Ministry of Higher Education (MOHE) and MOH.

The doctor number that we need should ideally be planned or rather managed at this point and this can only be done by addressing all the factors that had led us to this. For a start we should look at the basic question of what the country needs in the future (2020 and beyond) and then work backwards. This sounds simple enough but in practice this is where the challenge lies. Two ministries MOH and MOHE are both looking at the issue albeit with different focus but inevitably with some overlapping jurisdiction. The MOH concerns with the nation's health issues and MOHE deals with medical education and consequently doctor number, although seemingly separate but in actual fact they will converge. Whatever the number of medical students approved at Malaysian Qualifications Agency (MQA) / Malaysian Medical Council (MMC) or sponsored by *Jabatan Perkhidmatan Awan* (JPA; Public Services Department) /MOHE the final tally in five years will be the medical graduates that will have to be allocated to training places. Too many medical

graduates too soon appear to be the main problem and therefore it is high time that we try to regulate the number that goes into training. Immediate actions are required too to restore public confidence in the light of unsympathetic media comments. This includes policies that require hard choices such as derecognizing some foreign medical schools in the archaic list of schedule 2 and introducing the right to practice examination for those who have graduated from abroad. Both can regulate number and consequently emphasize quality.

The next challenge is the specialist number now that doctor number at lower grades will address the gap in ratio in time. Although a lot has improved but by most estimates the number of specialists must double to take up the challenges of a developed nation status and we need to add to this the question of disparity (uneven number by specialty) and geographical mal-distribution, unfortunately the issues remain despite numerous incentives introduced by MOH over the years. An easier question of churning up specialist number can be addressed rather immediately because we have a robust, economical, and internationally respected system within our midst that is the Master in Medicine (MMED). But when the issue of increasing the specialist number is debated, the discourse mystically takes a pathetic course to the times when postgraduate medicine began in the country in the 60s, a return to our colonial ancestry for training opportunities and supervision. When postgraduate medicine first started we indeed relied heavily on the hospitals in the United Kingdom (UK) and their college exams but these are things of the past. Except for stated and specific niche areas for training and education, or occasional exception, by and large we have existed and trained our specialist independently from the system in the UK for more than three decades. For the record, to date more than 8000 specialists have graduated from MMED system and for a rapidly growing Malaysia this number is huge. Especially so for the surgical based specialties that are the most challenging to train and in all domains the surgeons have been at par with the very best in the world. In fact from our own survey, MMED trained specialists are the backbone of doctors that service the public hospitals and clinics in Malaysia.

Despite this apparent regression, the universities that offer MMED are in the process of institutionalizing the training pathway and system to maintain the quality and improve the process further. Steps are taken to formalize the training pathway via MQA and MOHE to reinforce public perception of the system and in preparation for soon to be implemented trade and economic liberalization in ASEAN. For practical purposes the MMED system essentially has two types; one that is based on the presence of the faculty's own teaching hospital and the other on the absence of one and thus reliance on the state hospital as the faculty's affiliated teaching hospital. Both models have achieved success and maintained the quality and competency required by a robust comprehensive assessment system that includes standardized examinations attended by a wide selection of examiners in the country and abroad. In the next 5 years or so, the training environment to some extent the MMED will undergo a significant change with the completion of another 7 teaching hospitals and the incorporation of a consortium of university teaching hospitals. With an estimated number of nearly 10000 tertiary care beds at peak activity this will provide an excellent opportunity to train more specialists and partake in subspecialty training. This includes research and teaching activities that will enhance the return on investment to the public.

Based on the cumulative years of experience and a much more organized MQA the future of medical education for both undergraduate and postgraduate looks very promising indeed but the main lingering issues in both must be addressed. For undergraduate medicine the need to maintain a robust and stringent control on quality is paramount and data shows that the emphasis of this is mainly on graduates from some foreign medical schools because the local ones are subject to very stringent accreditation exercise and compliance audit, therefore quality is assured. Another strategy to achieve this is the introduction of fitness to practice examination for foreign medical school graduates. Both will help control number. The main issue that is affecting postgraduate education is the need to institutionalize the MMED for the future and the creation of teaching hospitals consortium by working closely with MQA and MOHE. This will ensure the best deal for the public. The future is in our hands.

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ORIGINAL ARTICLE

Factors Associated with Homelessness and its Medical Issues among Urban Malaysians: A Qualitative Research

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ABSTRACT

Introduction: Homelessness continues to exist in our country even though we hear of various initiatives that have been put in place to solve this ongoing issue. The objectives of this study are, first, to explore factors that lead to homelessness, second, to determine the associated medical conditions and third, to shed light on the views of homeless individuals regarding their future perspectives. **Methods:** This study employed the use of a qualitative research method in analysing the experiences of 24 homeless individuals. It will detail the causes that have led to the respondents' homelessness and their future plans. **Results:** From the research conducted, it was found that the factors that lead to homelessness are family disorganization, job loss and underemployment, not having a place to call home and attitude problems. The future plans of the 24 respondents can be divided into several broad themes – finding a job, finding their families, finding a better shelter home and seeking for knowledge, while some had no obvious plans. Most of the 24 individuals had no knowledge of their own medical conditions. **Conclusions:** Initiatives from people with authority or organizations dedicated to working on issues of homelessness are not enough to prevent this condition from occurring. People who are homeless must themselves be willing to change their attitudes while family members must care and be responsible for their own families. Health awareness is very important and the occurrence of communicable diseases such as tuberculosis can be prevented if more attention is given to health.

KEYWORDS: Homeless adults, urban homeless, medical issues, homelessness factors

INTRODUCTION

Homelessness has long been recognised as a global phenomenon, affecting poorer populations in both the developed and developing worlds [1]. According to the United Nations Centre for Human Settlements (UNCHS) in 1996, the number of homeless people worldwide is estimated to be between 100 million and one billion [2].

Although Malaysia has been categorized as a developing country, the statistics about homeless people within the country is alarming and needs to be given due attention by local citizens. Based on a study by the Jabatan Kebajikan Masyarakat (JKM) in 2010, the latest statistics of homeless people in Malaysia indicates that there are 1,646 homeless people with 1,387 of them in Kuala Lumpur; 150 in Georgetown, Penang; 99 in Johor Bharu, Johor and 10 in Kuching, Sarawak [3].

Amore et al. defined this particular group of people more specifically understood as those "living in severely inadequate housing due to a lack of access to minimally adequate housing" [4]. This definition is re-emphasised in a recent study describing that poverty and material deprivation are now widely accepted in concepts of homelessness due to the 'enforced lack' criterion [4]. In other words, homelessness denotes a

standard of housing that falls significantly short of the relevant adequacy threshold in one or more domains [5].

Springer et al. also denotes a quality oriented definition developed by the European Federation of National Organizations, working with the Homeless (FEANTSA) [1]. "The Observatory has developed a four-fold classification of housing situation which can be used to both define the condition of homelessness and evaluate its extent:

- rooflessness (i.e. sleeping rough);
- houselessness (i.e. living in institutions or short-term & 'guest' accommodation);
- insecure accommodation; and
- inferior or substandard housing"

In Malaysia, there is no official definition of homelessness. Affairs of the homeless are lumped under the category of displaced and marginalised groups which fall under the broader umbrella of the Ministry of Women, Family and Community Development (MWFCD) with enforcement duty mandated to the Social Welfare Department (SWD). Currently, the running of MWFCD is guided by four major policies, the National Social Policy, National Policy on Women, National Policy for the Elderly, and National Social Welfare Policy. None of these policies have direct bearing to houseless and homeless persons, which implies that thus far, this type of marginalised group have not been receiving much attention [6].

The state of homelessness occurs in the virtue of many factors. The factors that influence homelessness can be categorized into two components, individual factors and structural factors. Individual factors include poverty, adverse early childhood experiences, mental health and substance misuse problems, personal history of violence and association with the criminal justice system. Structural factors that promote homelessness include the absence of low-cost housing, unemployment, lack of opportunities for low-skilled workers and income support [7]. According to Alhabshi and Manan [6], additional factors that can cause homelessness are drug abuse, alcohol addiction and gambling. Other contributors include unemployment, poverty and a lack of affordable housing [8].

These views can be reinforced based on previous JKM findings from 1,387 homeless people in Kuala Lumpur. The research showed that: 46.6% of them were jobless; 17.7% had low income; 10.5% were poor, old and alone; 4.8% were drug abusers; 4.4% were neglected; 2.2% had mental issues; 1.9% was houseless; 1.0% were runaways or had family problems and 10.5% had other issues [3].

Homeless people are often connected with a variety of health problems due to their improper hygiene and personal care. According to Lebrun - Harris et al. [9], individuals who are homeless are recognised to have worse physical and emotional health statuses compared to the general population, even when communities from more deprived neighbourhoods are taken into consideration. Medical conditions that usually occur among homeless people are infectious diseases, cardiovascular and metabolic diseases, psychiatric disorders, drug and alcohol abuse and tobacco use. The categorization of the different types of infectious diseases and their rate of infection are as follows: Scabies infection (4-56%), followed by Hepatitis C (4-36%), Hepatitis B (17-30%), Bartonella quintana (2-30%), HIV (0-21%) and Tuberculosis (0-8%) [10]. Research has also shown that the homeless population has a high rate of morbidity and mortality from cardiovascular diseases [7]. Almost 30 studies have shown that mental disorders have a higher prevalence among homeless people compared to the general population. Furthermore, tobacco use is common amongst the homeless population and they generally have a high rate of smoking-related diseases [11].

Therefore, the aim of this study is to understand the factors associated to homelessness and its medical conditions. Secondly, it is to explore their future plans and perspectives. This present study is especially important in understanding the medical and social issues related to homelessness and how their condition may affect society as a whole.

METHODS

Sample

This is a qualitative study conducted at the Pusat Sehenti Desa Bina Diri Sg Buloh. We conducted semi-structured interviews with 24 homeless adults (18

males, 6 females) aged more than 20 years old. The majority of respondents (n = 14) were Malays, and the rest were Chinese, Indians and also Indonesians. Demographic details of the respondents are described in Table 1.

Data Collection

Interviews were conducted in a large treatment room and also in the male and female dormitories under supervision. Study procedures were explained to the respondents in detail. In order to be eligible for the study, adult respondents must be above 15 years of age and are capable of understanding and answering the questions given to them. In the context of this study, homeless residents are defined as those who were taken by the Malaysian Social Welfare Department (Jabatan Kebajikan Masyarakat Malaysia) off the streets and placed in shelters (Musolla or Mosque), because they had been pushed out of their homes, were runaways, had drifted out of their family of origin, had no money or were jobless.

All interviews were audio-taped and lasted from anywhere between 3 to 20 minutes, completed within a period of 3 days (Monday, Wednesday and Friday) with an interval of 1 day each. Respondents were briefed about the purpose of the interview to minimise inconvenience before they were asked 3 open-ended questions. These questions focused on prior living situations and how they ended up as residents at the centre, maltreatment or related medical conditions and their future plans:

1) Were you suffering from any medical illnesses prior to admission to this place? Have you acquired any new illness since you were here? Can you elaborate more?
2) How did you end up in this place?
3) Can you tell us your future plans after being discharged from here?

Respondents were randomly chosen from the centre after they were briefed on the study details by the researchers. Each interview was transcribed verbatim. To preserve confidentiality, the names of all respondents have been changed. All respondents gave informed consent and this study was approved by the University's Ethics Board Committee.

Data Analysis

After the interviews were transcribed, each one was carefully read through to gain a deeper sense of the data as a whole. As the interest of the study is geared towards the medical status and conditions of the homeless, we excluded data that did not achieve the criteria targeted. From the interview, three major themes were identified based on the objectives: (a) medical conditions of the homeless, (b) factors leading to homelessness and (c) their future perspectives or plans. After these three broad themes were identified, the process of focused coding began which included searching the coded interviews for particularly telling excerpts and grouping them according to themes. This was done via ongoing discussions between members of our team and re-reading of the transcripts [12].

Symptoms and complaints such as headache, lethargy and any history related to medical conditions were coded under the first theme. Incidences of family disorganization, for example negligence, abuse and divorce, which is one of the factors that lead to homelessness was coded along with other factors like job loss, no home, etc. Similar coding was also done for the third theme under future perspectives or plans. All the coding was then tabulated for ease of summarisation and analysis.

RESULTS

Sample Characteristics

The qualitative sample included 18 males (75.0%) and 6 females (25.0%). The respondents' ages ranged from 23 to 83 years old (M = 52.96 ~ 53 years). The racial differences show that a majority, 14 were Malays (58.4%), while the rest were made up of 5 Chinese (20.7%), 4 Indians (16.7%) and 1 Indonesian (4.2%). In terms of religion, all homeless Malays are Muslim and some Chinese and Indians are either Christian, Hindu or Atheists. However, out of the 24 respondents, only 14 of them met all the requirements of the interviews. The other 10 were unsure of what medical illnesses they previously had or were currently having.

Table 1 Socio-demographic characteristics and related medical condition of subjects

Age (years)	Gender	Race	Associated medical conditions
56	Male	Malay	Stroke
65	Male	Chinese	Hypertension Post trauma (accident) on support
50	Male	Malay	-
38	Female	Malay	-
50	Male	Indian	Arthritis Post trauma (accident) on wheelchair
62	Male	Chinese	-
52	Male	Indian	Post trauma (accident)
35	Male	Malay	-
35	Male	Malay	-
54	Male	Indian	Post trauma (accident)
61	Male	Malay	-
60	Male	Chinese	-
68	Male	Malay	Diabetic Headache
23	Male	Malay	Headache (on painkiller) Back ache
37	Female	Chinese	-
50	Female	Chinese	-
74	Male	Malay	Diabetes Mellitus
63	Male	Malay	-
83	Male	Malay	Diabetes Mellitus
57	Male	Indian	Asthma Migraine
35	Female	(Indonesian)	Mental illness (Schizophrenia)
60	Male	Malay	Diabetes Mellitus
75	Female	Malay	Chronic cough
28	Female	Malay	Diabetes Mellitus Hypertension

Three major themes emerged from the interviews that are important in understanding the medical conditions of homeless adults, the reasons behind their homelessness and their future perspectives. The first theme addresses their medical conditions, which provides an overview of the health status of homeless urban Malaysians in the country. The second theme investigates in detail the factors that contribute to homelessness, in order to better understand the reasons behind the rise of the number of homeless people, especially in the urban areas of Malaysia. Finally, the third theme explores their future perspectives and plans.

Associated Medical Conditions

Motor Vehicle Accident (MVA)

Injury from the aftermath of an accident is the most prevalent and common medical illness among the homeless residents (n = 6). According to one of the resident, a motorcycle ran over his legs causing them to break. He had a hard time adjusting to his life and later following the accident he developed arthritis.

Another homeless resident complained that his body and back are in pain (body and back ache) and swollen from an accident he experienced previously. Not only that, the accident had also affected his legs and they are painful. He was healthy and strong in the past but the accident had changed his life entirely. Majority of them had some concern about their current health status as it plays a significant role in their future career development.

Diabetes Mellitus

Diabetes Mellitus especially type 2 is another frequent medical illness among the homeless residents. Out of 14 respondents who met the set criteria, about 4 of them were plagued with this illness. A resident explained that he had polyuria and nocturia, a medical term to explain frequent urination during the day and night as a consequence of having diabetes mellitus.

Another diabetic respondent claimed that he knew he had diabetes even before coming to the centre but later found out from the centres' doctors that he had developed hypertension. When asked about treatment compliance, he gave excuses telling that his medication had gotten lost during a massive cleaning activity (gotong-royong) as one of the centre's cleaners had misplaced it. During the interview, it was observed that his left leg was swollen, red and there was also a sign of pus indicating an inflammation, a common symptom which may be associated with leg infection and diabetic foot ulcer.

According to a study by Hwang and Bugeja [13], type 2 diabetes had been diagnosed in 86% of their study participants, with 62% of them being on oral agents alone and 28% taking only insulin medication. Overall, 72% of the participants reported experiencing difficulties in managing their diabetes: the most common problems were related to diet (type of food at shelters and the inability to make dietary choices, reported by 64%) and scheduling and logistics (inability to get insulin and diabetic supplies when needed and the inability to coordinate medications with meals, reported by 18%).

Others

Other less common complaints were of headache, migraine, back ache, asthma, cough with itchiness and one of the residents was also found to have a mental illness. These associated symptoms usually precede an

underlying medical illness like diabetes mellitus, hypertension and others. Table 2 categorises the medical conditions of the respondents of this study and the codes which correlate to each condition.

Table 2 Associated medical conditions of the homeless residents of Pusat Sehenti Desa Bina Diri

Medical conditions	Coding
1) Motor Vehicle Accident (n = 6)	
• **Injuries**	*"I involved in a motorcycle accident 6 months ago… I pass out. I did not have any job for 6 months. My legs are damaged and I lost 4 teeth… Doctor said I cannot work for 3 months."*
	"The motorcycle hits my legs… I suffered broken bones in my legs… and I also have arthritis"
	"Look at this. My body, because of the accident…" (shows a part of his body)"My legs, painful. But I force myself to walk. My body aches, my back too and swelling, pain, my legs are painful because of the accident. Before that, I don't have any health problems"
2) Diabetes Mellitus (n = 4)	
• **Type 1 with medication**	*"I have diabetes mellitus since I was 5 year old.*
	When I was pregnant I have high blood pressure.
	I know I have diabetes, high blood pressure, and proteinuria (When asked about treatment) Yes, I am in insulin therapy and on high blood pressure medication".
• **Type 2 with medication**	*"I used to have fever during the flood attack in the past… But now I always pee during the night and day and the doctor say that I have diabetes but I am not in any medication".*
• **Without medication**	*"I have diabetes before coming here. When I came here, I was told by the doctor that I have high blood pressure… My medication was lost during the massive cleaning activity (gotong royong) organise by the centre. The cleaner misplaced my medication".*
3) Others (n = 4)	
• **Headache and migraine**	*" … I am having headache...yes the doctor did give me a painkiller"*
	"Ever since I live here, I always experience headache at night. It was okay in the morning but at night… I cannot sleep".
• **Asthma**	*"I have migraine and asthma before coming here and I'm blind since I was 10 years old...* *I do sometimes experience asthma but only occasionally".*
• **Cough and itchiness**	*"I have cough event occasionally and itchiness before and after coming here".*

Factors Leading to Homelessness

It is believed that the medical conditions of the homeless residents may play a major contributing factor in causing their current state of homelessness. There are however various other contributing factors to their homelessness, as explained in the following sections.

Family Disorganisation

Relational Brokenness and Negligence

We discovered that a majority of the residents were homeless due to conflicts in their family (n = 10). Those that were left out and ignored, without being provided supportive relationship are considered as having relational brokenness and negligence. It is the most common cause of family disorganization affecting over 70% of total negligent cases. Their family, relatives and friends no longer have the ability or willingness to help and support them, thus answering the question of why most of them are deeply hurt and lonely. They felt unwanted, unloved, and couldn't do anything about it but only laughed it away.

One of the residents explained how negligence was the cause of her homelessness. "My daughter doesn't want to take care of me and my husband… and since I ended up here, I could not contact her as I don't know her phone number" and "I've been living alone since the death of my spouse… I have two children… they rarely come home". Another elderly resident went on to say "I was trying to find a house... my children house... they live in KL. So I sleep on the street... They (government) found me and put me here..." They just silently accepted the fact they have been mistreated by their own flesh and blood. Instead of feeling enraged, they tend to forgive and forget. Based on these insights, one gets a sense that the situation revolves more around unwantedness and less about homelessness per se.

Divorce

Our investigations also revealed that divorce was one of the causes of family disorganisation, causing homelessness in 15% of the cases. Divorce costs and the associated lowering of the family's total income may result in one of the spouses becoming homeless. Usually, the father is affected, but sometimes it is the mother and the children or at times, everyone involved. According to one of the female residents, she started to find a job because of the divorce to earn a living.

Professor Tony Warnes, director of the Sheffield Institute for Studies on Ageing, based at Sheffield University and co-author of the Economic and Social Research Council (ESRC) said that relationship breakdown is a very prevalent contributory cause of homelessness (S. Womack, 2004). Parents who have split or divorced are at a higher risk of an unstable financial status, as many are underemployed at wages that cannot sustain their lives, eventually causing them to become homeless.

Child Abuse

In our findings, there is one isolated case (n = 1) in which the factor that led to homelessness was child abuse. Child abuse and domestic violence are significant contributors to the reasons behind the number of children and women sleeping on streets worldwide. According to a research published by Busch-Geertsema and Fitzpatrick [14], many homeless youths leave home after years of physical and sexual abuse, strained relationships, addiction of a family member and parental neglect. The article continues to further exclaim that disruptive family conditions are the principal reason that young people to leave home.

Due to some difficulties such as being a bit slower and non-fluency of language coupled with childish characteristics, Arip, the youngest resident at Pusat Sehenti Desa Bina Diri, often gets wrong assumptions thrown upon him, even by his own family. Busch-Geertsema and Fitzpatrick [14] also concludes that battered women who live in poverty are often forced to choose between abusive relationships and homelessness as a result of domestic violence. These studies and findings contribute to our discovery that child abuse and domestic violence are some of the risk factors that can cause homelessness.

Job Loss and Underemployment

The current downturn of Malaysia's economy, means that many Malaysians are barely getting by financially. With unemployment rates remaining high, it has become harder to find a stable job and income. Some are underemployed with minimal wages that cannot sustain them while most have been laid off and job cuts have left them to struggle under desperate circumstances (n = 7). Majidi is an example of a homeless man who previously works as a cleaner but due to the termination of his work contract, he was not able to cope with the society.

Others were unemployed due to medical illnesses, age exceeding over 65 years old, loss of identification card and some had even experienced bankruptcy. We excluded about 5 of the elderly residents from this as they were suffering from debilitating illnesses, mainly stroke.

In Jamaluddin's case, he claimed that he was rejected from employment because he is a disabled person and the rejection had nothing to do with the condition of his health. Contracting an illness and being physically disabled is actually a real concern putting many at risk of poverty and homelessness. A majority of the residents, over 50%, were in need of medical attention due to various health problems. Chronic illnesses including schizophrenia, multiple personalities, stroke, hypertension and diabetes were common among the residents. Most of them, felt that it was unfair for them to have the illnesses that made it difficult for them to get a job, some even lose jobs. However as a rare occurrence, one of the resident aged 61, managed to get a job but was terminated due to sabotage by his colleagues, which caused him to lose a work project thus resulting in his homelessness.

No Place to Call Home

Natural Disaster or Fire

Natural disasters such as earthquakes, floods or landslide and even fire renders housing inhabitable (n = 2). These disasters often cause current housing situations to become untenantable as repairs are often simply not possible due to high costs, especially for those who are from a very low income background. This quite often leads to homelessness. Upon interviewing, the residents showed how upset they were about losing

their house and wandered if they could "find a place to call home again".

Poverty

Poverty is a leading worldwide factor affecting homelessness. It is a major contributor which not only affects parents but also children, especially those in female-headed and working families. Many of those that are struggling with extreme poverty ignore the importance of medical care, food and housing just to survive on a daily basis.

It was previously suggested that poverty and homelessness are inextricably linked. Poor people are frequently unable to pay for housing, food, childcare, health care and education [14]. This is due to the limited resources that they have and difficulty in making choices. Usually, it is housing that they first give up on since the maintenance of a house is expensive. In addition to this, there is evidence of growing shortage of affordable rental houses, which are safe and stable. The reduction in the value and availability of public assistance makes it harder to live a normal life. A resident clarified that she is determined to overcome poverty even had to pick up trash at one point in order to make a living.

Attitude Problems

Addictions

Probably the most common stereotype of chronically homeless people is that they are drug, alcohol and gambling addicts, when in fact the relationship between addiction and homelessness is complex and controversial. Crane et al. [15] found that 32% of the subjects described themselves as having heavy drinking or alcohol problems. 21% of the subjects believed that alcohol problems contributed to them becoming homeless, as a result of either marital breakdown or eviction due to rental arrears, while illegal drug use was reported by 9% and gambling problems by 15%.

In this case, investigations on the homeless residents showed that people who gambled and abused drugs and alcohol in Malaysia are also at a higher risk of becoming homeless (n = 3). This was further reinforced by the statement of 3 residents who used to be gamblers, drug and alcohol abusers as mentioned in Table 3. Some of them showed great remorse for what they had done and would like to start life anew.

Others

The rest of the subjects came to the shelter not as homeless residents but to give a helping hand, some were just lonely and kept coming for fun (n = 3).

Table 3 matches the factors that contribute to homelessness with the appropriate codes for each one.

Future Perspectives and Plans of the Residents of Pusat Sehenti Desa Bina Diri

Everyone has their own future plans and goals to achieve in life; the homeless are not exempted from this. Future planning is important as it will pave the way towards successful achievements. A few of the residents of Pusat Sehenti Desa Bina Diri have goals that they hope to achieve when they leave the centre. Their goals are mostly to have a better life from what they experienced and going through. There are about 4 consistent future plans of the residents, which are: finding a job that suits them, finding their long lost families, finding a shelter home for continuum of care and seeking new knowledge. However it is quite a setback to see the majority who do not have future plans, goals in life and do not even bother taking care of their future. The reasons are explained below:

Find a Job

Based on our interviews with the residents of Pusat Sehenti Desa Bina Diri, about 33% of them expressed their desire to find a suitable job for their future prospects. They knew by having a stable job, stable pay check, they can start afresh. They can apply for loans, and possibly secure savings to find and afford their own home or at the very least a better house than before.

Moreover, when they are employed they are in a better position to start their own business. They could easily gain trust of other members in society. Due to this reasons, the elderly residents of the centre had also planned on getting jobs that are more suited for their age and capabilities. Table 4 denotes some of the quotes from interviews with the residents, regarding their desires to gain employment.

Table 3 Factors leading to homelessness among residents of Pusat Sehenti Desa Bina Diri

Factors	Coding
1) Family disorganisation (n = 10)	
• **Relational brokenness and negligence**	*"I have been treated in a hospital… no one visits me… I have no family… the hospital sent me here."*
• **Divorce**	*"… What can I say, this is sabotage. Someone sabotage my project". He then continues with the story of the sabotage, which eventually lead him to bankruptcy.*
• **Child abuse**	*"My mother don't want me... they (family) don't want me." He paused and continues with "... I even got beaten up by my brother in law..."*
2) Job loss and underemployment (n = 7)	
• **Medical illness**	*" I was rejected because I was a disabled person"*
• **Sabotage**	*When I was pregnant I have high blood pressure.*
• **Age over 65 years old**	*"They refuse to take me… I am too old they said".*
• **Loss of identification card**	*"My friends forced me to take alcohol. I got drunk. My identification card, motorcycle, wallet, all went missing…"*
3) No place to call home (n = 3)	
• **Natural disaster or fire**	*"At that time there was flood in my village, my house destroyed even my children, I don't know where they are".*
	"I used to have a house... and I live with my husband... but months ago ... the house was destroyed by fire".
• **Poverty**	*"I was wandering around Masjid India, picking up trash to be sold… It was harsh. Then I seek help from the government, and they brought me here".*
4) Attitude problem (n = 3)	
• **Addictions (gambling, alcohol, drug)**	*"It had been 20 years that I did not go home... I'm a gambling addict... so l left the house".*
	"I'm volunteering to come here… I used to be a drug abuser since I was 15 until 23, then I decided to change".
5) Others (n = 1)	
• **Non-homeless**	*"I came here just for fun, I was having fun when wandering around the city, and then my sister brought me here".*
	"I am here to help those that are too sick... To help them clean, bath and wash their clothes... I volunteered to help here".

One of the residents wanted to find a job so that he could get married, "I want to find a job…". He then continues with "I want to work at a bookstore… After that I like to find a spouse". Thus it shows that the residents understood that by having a career or job, they can be accepted by the society, move on and start afresh. They know that being jobless renders them to poverty and homelessness and they could not provide the basic necessities for their family. Most of them don't want to dwell in being jobless for too long.

Find a Family

Based on our findings, around 21% of the n = 24 wanted to find their long lost families. The reason for this is because they need moral and emotional support from their family members. From our observations, the Pusat Sehenti Desa Bina Diri only provides residents with physical support and there is a lack of emotional support and tender loving care. Family is important for the development of a good emotional status because emotional connections within family members are often deeper than that with outsiders. Support from family members is the most important tool to elevate the residents' motivation to start a new life.

According to Sivantha, he wants to find his family because he would like to seek their forgiveness of his past problems. Prior to become a homeless person, he used to be a heavy alcohol drinker and this had caused problems to his family. He was then thrown out from his house. A quote from the interview with him expresses his desire to reunite with his family, "It all depends on my family. If they accept me, I will stay with them. If they don't accept me, any shelter home is good enough."

From this, it is clearly shows that all of them believed that having a family are vital. Although they

were neglected, abused, and mistreated, it did not stop them from thinking of going back to their family and get reunited.

Find a Better Shelter Home

About 4.2% of the findings which we obtained from interviews with the residents of Pusat Sehenti Desa Bina Diri were regarding finding a better shelter home to stay in the near future, such as the old folks' homes. They knew that they could not stay in the centre forever. Old folks' homes are known to provide better care and support for weak and disabled people.

Seek New Knowledge

During the interview, there was one individual who wanted to seek and deepen her knowledge on her religion. She hopes that she will have the chance to understand more, especially after she is used to being a drug abuser. She wanted to change her life and become a better person.

No Future Plan

However, from the interviews done, most of the residents of Pusat Sehenti Desa Bina Diri have no future plans. They do not bother having 'future goals', 'life goals' as how most people do nowadays. About 37% from the n = 24 have no thoughts of improving their current state of life. It was like they had never questioned themselves 'what to do in the future?' This is probably because they could not find hopes and purpose in living, they have no one to serve, no one to look after and were ashamed of their previous life. Some took it as a punishment for not being a reliable person to provide for their loved ones. However, there are some that chose to stay away and reject society because they too were rejected. They just do not believe in other people and are not even bothered getting any support or care.

The other reason for their lack of plan is probably because they were hoping others to make plans for them. They could not decide on their own and chose to follow the path given because of their low self-confidence, fear of failure and disappointment.

Lastly, it is probably associated with medical illness. Either physically or mentally challenged, they could not cope in the current state and what more, in future. Some are just not capable of thinking. One of the residents who is suffering from mental illness said, "I don't know what to do, I am just having fun".

Table 4 Future perspectives of the residents of Pusat Sehenti Desa Bina Diri Sg Buloh

Future perspective	Coding
1) Find a job	
	" If I can go out from this centre, I want to rent a room and find a job that suit my age",
	"If I can go out from this centre, I want to have my own business and wanting to sell used item such as sofa".
	"I want to find a job and place to stay".
2) Find their long-lost families	
	"I want to find my family".
	"When I can get out from this place, I want to go back to my family".
	"I want them to send me home back".
3) Find a new shelter home	
	"After this, I want to be sent to a shelter home."
4) Seek new knowledge	
• **Religious knowledge**	*"I want to become more pious, and want to learn more about my religion".*
5) No future plans	
• **No hope in life**	*"I don't know what to do. I don't want to find my family…I am ashamed of my life".*
	"I don't want to disturb anybody including my family. I wish I die".
• **They want others to make plans for them**	*"I'll wait until my children find me a place to stay…Right know they live far away... I don't want to burden them"*
	"No I don't have any... Just go with the flow"

DISCUSSION

Associated Medical Conditions

Previous studies and surveys claimed that there are unusually high proportions of homeless persons characterizing their health status as poor, and physical examinations of subsamples revealed that many have medical problems that limit their activities of daily living and have potentially serious long term health consequences [16]. The study further reveals that high blood pressure, poor vision, peripheral vascular diseases of the feet and legs, and significant skin conditions are prevalent among the homeless in Los Angeles County [16].

Another study done in United States in 2001 [17] [19] found that homeless individuals exhibit high rates of chronic medical health conditions, chronic mental health conditions, and drug and alcohol abuse. Almost three fourths had a mental health condition or drug or alcohol abuse; many reported having more than one condition.

Comparing those study to the findings we had, it was demonstrated that out of 24 respondents, a majority of them have underlying medical illnesses (n = 14). This is a concern as health has always been regarded as a vital aspect of life, especially for securing employment and to maintaining a good family relationship. Conditions like body and limb injuries from accidents are the most common causes of illnesses with over 42.8% of the respondents suffering from these. Amputated limbs, broken bones and wounds significantly reduced their capabilities in handling everyday work. They lost the ability to exercise, to groom and clean and some even had lost their appetites due to their weak limbs and body.

Besides this, 28.6% of the homeless residents presented with a history of diabetes mellitus with or without hypertension. Only one resident suffered from diabetes mellitus type 1 while the rest were of type 2, based on the medical history taken. Previous research suggest that ethnic differences exist in patients with diabetes mellitus [18]. Therefore an investigation on racial distribution was undertaken, which revealed that all of the diabetic patients were of the Malay race. There was no history of diabetes and hypertension in the Chinese and Indian residents. Our finding correlates with that by Chan et al. [19] on type 2 diabetes mellitus with hypertension in Malaysia showing that the Malay ethnic group form the majority of patients (54.6 percent), followed by Chinese (37.7 percent) and Indians (7.4 percent). There are many factors which may contribute to the development of diabetes mellitus and hypertension. We postulated that one of this is a lack of exercise or leading a sedentary lifestyle. A healthy and well balanced diet also prevents one from increasing the risk of diabetes. Other factors such as family history and chronic alcoholism also play a role in contributing to developing diabetes mellitus.

Other medical conditions like migraine, headache, asthma and chronic cough were also present. Although most times these are not serious cases, they do need medical attention. What is of greater concern is the fact that most of the homeless residents usually avoid taking any medication and treatment for their illnesses. This is true for even the diabetic and hypertensive patients, which could lead to serious medical consequences. According to one of the health care workers at the centre, usually it takes several consultations with a doctor and investigations to identify what medical illnesses the residents are suffering from.

It is especially worrying if they have underlying conditions of HIV or tuberculosis which are present but undiagnosed among them. This in turn puts the lives of other residents and workers in the centre at risk. A study done in 2006 [20] found out that the estimated prevalence of homelessness in persons with HIV range from 6% to 27% among a New York State Medicaid population. The author further noted that it is partly due to the overlap between poverty and unstable housing, many individuals with HIV infection experience homelessness.

Factors that Contribute to Homelessness

The second theme introduces the factors that contribute to homelessness, which are family disorganization, job loss and underemployment, having no proper housing and addiction problems. Majority of the residents suffered from family issues; relational brokenness and negligence. This answered the observation we made of why the mean numbers of residents were 53 years old. Most of the residents still have family members left but due to negligence and lack of responsibilities they chose

not to take care of them, thus leaving them to survive on their own. Divorce and child abuse are also contributing factors that lead to homelessness, especially among women and young residents in the centre. Another factor is job loss and underemployment. These are characterized by termination of work, age exceeding over 65 years old, loss of identification card, being a disabled person and a victim of sabotage. Without a stable job and proper income, it is hard for the homeless to start a life. A lack of money will mean a lack of ability to obtain a house, car and even basic necessities such as food, leaving them with no other option than to turn to the streets.

In addition to these factors, losing one's house in a fire or natural disaster such as floods, as some of the residents experienced, will also contribute to their state of homelessness. Being in a state of poverty also heightens one's risk of becoming homeless. With barely enough daily necessities, these people tend to overlook their needs in keeping their house. Lastly, not to forget addiction problems such as gambling addiction and substance misuse like drugs and alcohol that can lead to homelessness. This statement is supported by Alhabshi and Manan's study [6].

Future Perspective of the Residents of Pusat Sehenti Desa Bina Diri

From this study, we found that most of the residents do not have any plans regarding their future. This might be due to the fact that they have lost hope in life or feel ashamed as they view themselves as being at the bottom level of society. Next in terms of future plans is finding a job. This shows the importance of work and occupation to the residents as well as in their efforts to become a productive person [21]. They believe that through this they can change their outcome. With a job, they can finally live in their own house and improve their lives. Some of the residents would like to find their families again. They want to be reunited with their family despite what their family has done to them. For them, their families are the sole support and motivation to go on living. The rest of the residents would like to gain new knowledge or be sent to a shelter.

Suggestion to Prevent the Rise of Homelessness

The following suggestions may be implemented at primary, secondary and tertiary levels of prevention considering the current change in the cost of living, demographic profile of Malaysians with a rise in the aging population. Owing to the fact that our country is still lagging behind in tackling the issue of homelessness, it is appropriate to have country like United States (U.S.) and Canada as an example in the management of homelessness.

In the United States, as part of the state government's mandate on social welfare, city councillors are directed to provide accommodation purely for the homeless. They have taken the initiative to provide housing subsidies as they believed this has the strongest effect on lowering homelessness rates compared to several other interventions tested [22]. The rents and utility bills were provided for free, with the housing the local council providing counselling for the homeless to help them reintegrate back into society.

While some countries are trying to help the poor to come off the streets, in Canada, Vancouver city councillors implemented foldable shelters on benches in the city [6]. They divide the role of assisting homeless individuals into various categories; by government, community and non-profit organisations. In addition, individuals, service providers, faith groups, the non-profit sector and local governments worked to develop a range of services that responded to the immediate needs of people who are homeless, including emergency shelters, drop-in centres, counselling, social supports, and in some cases, health support [23].

In Malaysia, homelessness is still a rising public health issue due to the poor awareness and understanding of what constitute homelessness. The government assisted by the Ministry of Women, Family and Community Development (MWFCD), Department of Social Welfare (DSW) and Desa Bina Diri (DBD) have their own stances in preventing further rise of this group of people. They conducted rescue exercises dubbed 'Operasi Gelandangan' to help get these homeless people off the streets. Welfare officers can, under the Destitute Persons Act 1977, round up a person who has "no visible means of subsistence or place of residence or is unable to give a satisfactory account of himself" and place him in government welfare

institutions that are established for "the care and rehabilitation of destitute persons" [8].

Problems like 'lack of affordable housing' which influence the rise of homeless people can be prevented with providing more affordable housing involving all levels of government and communities across Malaysia. Such a housing strategy must include an expansion of supportive housing for those who struggle with addictions, mental health problems and disabilities – an area where we have developed effective and innovative service solutions. Accommodation and transportation issues, logistic issues, included in-kind emergency assistance such as food and clothing and cash assistance with rent, mortgage, or utility payments to avert eviction are all needed to be considered as this group of people are subject to very low income and these type of housing are mainly situated in urban and suburban area.

Other factors associated with homelessness, like joblessness could be prevented by providing training and teaching homeless adults new skills that suits their individual capability. Grooming class, interview class, or even basic classes like reading, writing, cooking, sewing, planting, all are vital for them to render a job and career. We may suggest a career pathway for them and recruit them into institutions like Department of Skill Development (DSD), where their skills are recognized by industries. Lastly, they have the right to know that there are places that accept them and their future are being acknowledged.

CONCLUSIONS

This study found that factors that is associated with homelessness includes family disorganization, job loss and underemployment, having no home and addiction problems. Most of these factors are associated with their underlying medical conditions like stroke, schizophrenia or multiple personalities, motor vehicle accident, diabetes mellitus with and without hypertension. In regards to their future perspectives and plans, majority of the homeless individuals have no future plans especially among the older age group. However, the younger one thinks more positively of their future and plan on getting a job, leading a stable life, getting married and being happy.

Conflicts of Interest

Authors declare none.

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