Chapter Three

Roles Traditional Healers Play in Cancer Treatment in Malaysia

Implications for Health Promotion and Education

Introduction

Traditional healers exist in all cultures, and their widespread presence in developing countries is well documented (WHO, 2002). In fact it's been estimated that "*80% of the world's population continues to use their own traditional systems of medicine despite the increasing presence of allopathic medicine*" (Tovey et al., 2007). Western allopathic medicine views disease as chemically and physiologically based, whereas traditional systems attribute illness to social, spiritual and psychological disturbances, and treatment consists of natural and spiritual remedies that restore harmony to the system. A traditional healer is "*a local non-biomedical health practitioner who has inherited, trained in, or created methods that utilize botanical, animal, and mineral products, perhaps symbolic methods and ingredients as well, and is sought out to treat physical, mental and social diseases, and conflicts in his or her community*" (McMillen, 2004). Traditional healers are so embedded in the culture that they are sometimes the first and only source of treatment for ailments ranging from minor infections to bone fractures to chronic diseases, to emotional, spiritual and social distress. Visiting healers is a practice engaged in by people from all socioeconomic and educational strata (Ross, 2008).

Recognition that dual systems of medical care exist throughout the developing world is a first step in tackling some of the pressing health issues in these countries. For example, 80% of deaths related to chronic diseases occur in developing countries (WHO, 2005). We also need a solid understanding of the roles and practices of traditional healers so that health practitioners in both systems

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can better address patient healthcare, especially with regard to life-threatening chronic diseases. However, despite the widespread presence of traditional healers in Malaysia, little is known about the roles they play in the diagnosis and treatment of chronic diseases such as cancer. Knowing what benefits patients derive from these healers would be helpful in informing both educational outreach and policy development.

Malaysia is a country of 26 million people in Southeast Asia. Peninsular Malaysia is bordered on the north by Thailand and on the south by Singapore. The two states of Sabah and Sarawak on the island of Borneo constitute what is known as East Malaysia. It is a multicultural society consisting of approximately 60% Malays, 30% Chinese and 10% Indian.

While it is difficult to get an accurate assessment of the prevalence and morbidity rates of cancer in Malaysia, it is widely considered to be on the rise. The National Cancer Registry (NCR) has been in existence only since 2002 and reports are based on sometimes erratic hospital epidemiology data (Yip, 2008). Breast cancer is particularly virulent as it occurs in younger women in MY, tumor mass at presentation is larger (Parsa et al., 2006), and "*30-40% present with late breast cancer (Stage 3-4) compared to Western countries where more than 80% of women present with early stages*" (Yip, 2008). Because of the late detection and inadequate access to care, survival of women with breast cancer in Asia is lower than in western countries (Yip, 2009; Taib et al., 2011a). These statistics are congruent with other limited-resource countries where breast cancer fatality rates are high "*due to the advanced stage of disease at initial presentation combined with inadequate resources to provide standard cancer therapy*" (Anderson et al., 2006).

Cancer awareness, diagnosis and treatment in MY are hindered by the lack of resources and trained personnel. For example, "*the total number of oncologists in Malaysia is 35, resulting in an "oncologist: population ratio of 1:650,000*" (the UK ratio is 1:250,000) (Yip, 2008). Twelve of the 35 are located in or around the capital city of Kuala Lumpur. Lack of cancer treatment facilities, radiotherapy machines and so on result in restricted access to treatment and if access is facilitated, there is often an extended waiting time for treatment (Yip, 2008; Yip and Samiei, 2012). Mammographic screening is usually opportunistic and early detection programs are often hampered by logistical and financial problems, lack of knowledge about symptom recognition to detect early staged breast cancer (Taib et al., 2011b) as well as socio-cultural barriers, despite improved public educational efforts (Yip and Cazap, 2011). Further, in this majority Muslim country, some believe that cancer is a test of one's faith and can thus be treated through greater spiritual and religious attention and with the help of spiritually-oriented healers. With regard to breast cancer in particular, women in Asian countries are at risk due to issues of modesty, a fatalistic perspective, fear of screening tests, their results, and recommended treatment, "*inability to act without husband's permission, fear of casting stigma on one's daughters, fear of being ostracized, fear of contagion, reticence, language barriers, and preference for traditional healers*" (Parsa et al., 2006; Smith, et al., 2006). Even Hmong immigrants in California "*seek the first course of treatment from traditional healers*" for cervical cancer resulting in late diagnosis and "*mortality rates three and four times higher than Asian/Pacific Islander and non-Hispanic white women, respectively*" (Mill and Rioran, 2004).

Not only are traditional healers often more accessible in health-resource challenged developing countries, they are perceived as meeting social and psychological needs of their patients in addition to addressing physical concerns. "*Traditional healers tend to offer patients and their families a more personal and intimate relationship than most Western-trained doctors and hospital staff can offer. Relatives may be enlisted in healing ceremonies and allegiances reaffirmed in a social catharsis. Sickness is made to signify the presence of underlying social disorder*" (Lau, 1989). Further, "*healers usually take the socio-economic background of individual patients into consideration in their diagnoses. Therefore, the healers deal with not only the patient's illness but also his social reality*". Traditional healers thus play a number of roles in addition to treating the actual physical problem. Ross (2008) reports that healers "*occupy an esteemed position within South African culture as they are consulted for a wide range of physical, social, and emotional problems and are often expected to assume the roles of medicine healer, priest, psychiatrist, advisor, diviner, and herbalist* (Erasmus, 1992)".

Recent research on traditional healers in developing countries has focused on understanding the scope of their practice and how the dual medical systems in these countries can work together to maximize patient healthcare. In Nepal, 70% of the people visit traditional healers before seeking modern medical services, "*as they were easily available, conveniently located, did not request cash for treatment and properly identified the cause of illness—whether an evil spirit was involved or not*" (Shimobiraki and Jimba, 2002). And for well over 20 years, traditional healers have been interacting with the biomedical system in African countries for help in "*addressing the deficits of primary health care*" (McMillen, 2003; Stekelenbury et al., 2005; Nelms and Gorski, 2006). The HIV/AIDS pandemic in Southern Africa has been a major impetus for this growing interaction between healers and biomedical practitioners. The UNAIDS (2000) report on traditional healers and HIV/AIDS prevention in sub-Saharan Africa points out that among other pluses for collaborating with traditional healers, "*traditional healers often outnumber doctors by 100 to 1*," are accessible and inexpensive, "*provide client-centered, personalized health care that is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient*," and "*traditional healers often see their patients in the presence of other family members, which sheds light on the traditional healers' role in promoting social stability and family counseling*".

Despite the prevalence of traditional healers in the developing world, only a few studies could be found that investigated traditional healers and cancer diagnosis and treatment. The most extensive research appears to have been conducted in Pakistan by Tovey and colleagues (Tovey et al., 2005a; 2005b; 2007; Broom and Tovey, 2007). They surveyed 362 cancer patients and interviewed 46 patients as to patients' experiences with both indigenous traditional medicine and Western allopathic medicine. They found that "*only 16% of those surveyed reported not using traditional medicine*" (Tovey et al., 2005a). Further, satisfaction with use of TM was high, with 70.4% using Islamic spiritual healers at some point during their cancer journey. Malik et al. (2000) speculate as to why cancer patients in particular, might seek out traditional healers:

"*Cancer patients are particularly afraid of pain, mutilation, incapacitation, altered body image, altered interpersonal relationships and death. Side-effects associated with*

cancer therapy are also generally severe and believed by many to be worse than the disease itself. Furthermore, use of research protocols in cancer therapy may result in an indifferent and impersonal attitude of the physicians which results in reduced attention given to the patients. Under these circumstances, patients may feel loss of control over their disease, its therapy and life as a whole. This increases the likelihood that cancer patients may more frequently seek alternative methods of therapy".

While the prevalence of traditional healers in Malaysian health care is acknowledged, there is little actual research on the topic. Razali and Najib (2000) found 69% of psychiatric patients had visited traditional healers before seeing psychiatrists. In a later study of psychotic and epileptic patients, Razali and Yassin (2008) found 61.7% of psychotic and 26.7% of epileptic patients had consulted traditional healers and that such "*consultation was uniformly spread across all levels of education and social status*". Deuraseh (2009) surveyed Malay-Moslems in two conservative and heavily Muslim states in Malaysia and found that "in spite of the significant contribution made by modern medicine into many aspects of life of Malay-Muslim society in Malaysia, many Malaysians still use many forms of traditional health care" (p. 450). In particular, 62% of Muslims in these states "believe that diseases may be caused by Jinn [evil spirits] and devil" (p. 454) thus leading them to consult Islamic or Quranic healers. In an earlier study, Heggenhougen (1980b) interviewed 100 patients who had visited the same traditional healer. He found that "the people who consult traditional Malay healers also use cosmopolitan health services. The longer an ailment persists, the higher the probability that people will attribute it to a supernatural cause, and thus make a bomoh the most appropriate healer to consult" (p.43). Further, interviews revealed that the cosmopolitan health system was perceived as neglecting the socio-psychological and spiritual aspects of healing. Patients stated that the bomoh was particularly adept at making people 'feel better'.

As recently as October, 2010, an article in a Malaysian newspaper noted that "*the people in [the state of] Kelantan prefer to go to traditional medicine practitioners or bomoh for cancer treatment than to doctors at government hospitals.*" A Health Ministry official was quoted as saying that because of visiting a bomoh, "*the condition of cancer patients worsened*" (Relying on bomoh for cancer treatment, p. 11). There is little doubt that the majority of Malaysians access traditional healers in dealing with cancer and that this practice appears to be a contributing factor to the cancer burden in Malaysia. A recent study of knowledge of cancer among 25 Malay, Chinese Malay and Indian Malay traditional healers found that these healers knew little about 'the basics of diseases' and were therefore unable to treat patients in an appropriate and professional manner (Al-Naggar, et al., 2012).

Not much is known about Malay Moslem traditional healers compared to those in the Chinese and Indian Malaysian communities. These communities have practices documented through Traditional Chinese Medicine (TCM) or Complementary Alternative Medicine (CAM), or in the case of the Indian community, Ayurvedic medicine. This study focused on Malay traditional healers of which there are several general types including the following: (i) Islamic healers

who draw on Islamic religious beliefs and use verses from the Quran as the major component of their treatment; (ii) traditional healers who know the folklore of disease causation, treatment and prevention and are known by the term 'bomoh'. Bomoh use a variety of handed-down, traditional methods in diagnosing and treating patients including "*herbal remedies, ceremonial rites, incantation, exorcism and sorcery*" (Razali and Najib, 2000); and (iii) "bomoh patah" which loosely translates to bone doctors or bone-setters (Heggenhougen, 1980a). There is some overlap among these types, however. A Quranic healer may also use herbs and other traditional methods, and a traditional bomoh may use some Islamic prayers, and may also treat bone fractures. The majority of traditional healers are men. Ages vary, but most are middle age and older. These three types of healers can be found throughout Malaysia.

Materials and Methods

A qualitative research methodology was deemed most appropriate for identifying the roles healers play in cancer diagnosis and treatment (Patton, 2002; Denzin and Lincoln, 2003; Merriam, 2009).

Sample and data collection

We reasoned that a particularly rich portrait of traditional healer roles could be best obtained by interviewing those most closely involved in this practice–traditional healers themselves, cancer survivors, and medical cancer specialists. For each group we sought a mix of participants from both urban and rural peninsular Malaysia.The number of participants interviewed in each group was determined by saturation—that is, the point at which no new information was forthcoming (Merriam, 2009). The 39 participants consist of 14 traditional healers, 13 patients, and 12 cancer specialists.

Traditional healers

Traditional healers known for treating cancer among other diseases were identified through reputation, word of mouth, and by referrals from cancer patients themselves. Ten of the 14 are men, age ranges from 43 to 80, and years in practice are from 11 years to 48 years. One is a homeopathic healer, three call themselves Quranic or Islamic healers, one is an herbalist, and nine identify as "traditional healers" or "bomoh" using a variety of spiritual/religious methods, herbs, flowers, fruits, and roots.

Most interviews were held in healers' homes where they see patients; three were held in the office of the healer's "day" job, and two were held at the healers' clinics. Interviews lasted from one to three hours and often included tea and other refreshments. Interviews were digitally recorded and transcribed verbatim. Eleven interviews were conducted in Bahasa Malaysia with occasional use of English and three were conducted primarily in English. Bahasa

transcriptions were sent to a professional translation association for translation into English.

Cancer survivors

We sought cancer survivors who had accessed both the Western medical system and traditional healers in the course of their diagnosis and treatment. Referrals were obtained from cancer support groups and from friends and relatives of cancer patients. Of the 13 survivors, 12 are women, age range is 34-75 years, and level of education varied from 6th grade to PhD.

Interviews were conducted at a place of the survivor's choosing and included their homes and cancer support centers, and in one case, a fast food restaurant. Four of the 13 interviews were conducted in English; the interviews in Bahasa Malaysia were translated into English by bilingual graduate students.

Medical doctors

Cancer specialists were identified through patients' recommendations, health clinics, hospitals, and cancer support groups. Of the 12 doctors, five are from the Kuala Lumpur area and seven are from rural areas. Oncologists, radiologists and surgeons comprise the sample. Two of the participants are women (both surgeons). All twelve interviews were held in the hospital or clinic where the doctor has his or her practice. All interviews were conducted in English. Years in practice ranged from 9 to 29 years.

Formal ethical approval for the study was obtained from the university in Malaysia where both researchers were employed. Informed consent was explained to all participants (healers, survivors, and medical doctors) and written consent forms were obtained before conducting the interview. All participants were assured of anonymity. A certificate of appreciation (signed by the researchers) for participation in the study was given to each participant along with cancer education materials from the university's Cancer Education and Resource Center.

Data analysis

Verbatim transcriptions of the interviews formed the data base for analysis. The interview data were analyzed using the constant comparative method of data analysis (Corbin and Strauss, 2007; Merriam, 2009). This method consisted of first open coding each interview transcript for relevant data responsive to the study's research questions. These coded segments were then combined through axial coding into themes/categories that are explanatory of the phenomenon. The same process is undertaken with the transcript of the second interview. Themes/categories from the second transcript are compared with the first transcript and one set of themes/categories is derived from the two interviews. This process continues through subsequent interviews. The final sets of themes/categories are

the findings of the study. These findings are in turn supported by quotes from the participants, each of whom was given a pseudonym.

Results

Analysis of the interview data from traditional healers, cancer survivors and medical doctors resulted in our identifying four roles Malay traditional healers play in cancer treatment: medicinal healer, emotional comforter, spiritual guide, and palliative caregiver.

Medicinal healer

Patients go to traditional healers with the expectation that the healer will treat their physical ailment. Some patients know or suspect they have cancer, and others may have painful physical symptoms causing distress, but have not yet been diagnosed with cancer. These healers use a mix of herbs which include plant roots and spiritual incantations, most often blessing drinking water. Wan, a village bomoh, uses "*white pepper and pure natural honey*" which he called "*the king of medicine*." He also said that for breast cancer it was a 10-day treatment period and that he "*cannot treat if too serious*." Ecah uses a paste made of betel leaf, gambir, lime and "*a little bit of sugar*." She says this paste if used for three days, can cure "*if the lump size is small*." Kamal, an Islamic healer who uses herbs says that for cancer "*we will use a leaf (from a plant) which sticks to a tree, the money plant, or we use the root of white hibiscus plant and mix it with wasp's nest together with shallots. Mix all together and paste on the affected area*." For breast cancer he prepares a drink: "*We use wild kung, we pound and paste button flower leaves and money plant leaves, roots of white hibiscus plant and white turmeric which are boiled for drinking*." Zul who is a bomoh and a bone healer explained how he treats breast cancer:

"*I'll ask her where the pain is. She will show me where it hurts. I'll dip the betel nut leaf in honey. Then I'll recite some (Quranic) verses. I'll transfer the pain. I'll say "you don't stay there, come here." I'll point towards the breast and then touch with my finger. Meaning, the disease don't stay in the person, it should transfer to my finger*".

Abas also 'transfers' the disease saying, "*When patients have cancer, we transfer the disease to the yam plant. We recite and place the yam plant at the breast or at the womb or at anywhere. We instruct the disease into the yam plant*." The patient then plants the yam plant, does not water it and lets it die. This method only works, he claims, if cancer is early stage.

Other healers incorporate specialized practices like Salleh who has been trained in acupuncture. Of a teenager who had cancer, he said, "*I used a combination of treatment. I treat using acupuncture, prayer, verses from the Quran and eating some special herbs for cancer. I also use an egg to pull out the disease*." Aziz removes cancerous tumors through invisible 'surgery' as does Lena who channels a medical doctor. The homeopathic doctor uses micro dilutions of remedies. When cancer patients come to her, "*I will give them remedies to help them overcome the side effects without stopping them to go to chemo. But after they finish their chemo, then I will*

start their specific treatment . . . I will give them the homeopathy remedies to help them with the cancer."

Some patients reported relief from pain after seeing traditional healers. Roziah reported that after drinking water that was blessed by the bomoh, "*I feel the pain go away a little bit. The pain gets less.*" Nowan found that the herbal remedy helped with her breast tumor: "*I see there is a difference. The tumor becomes softer, has shrunk, cold, and this thing, you know, sometimes it's hot, so it becomes a bit cooler. I could sleep comfortably, not like before.*" She went on to say that while the "*the bomoh says that these jeluju seeds can make it (the tumor) disappear,*" she was not convinced and did follow up with standard treatment. Interestingly, Nowan reported that her doctor said the jeluju seed was being scientifically tested and that it held promise for controlling the spread of cancer.

It is no surprise of course that the major role of a healer is to address the physical ailments of cancer patients. As Muslims, the Malay healers rely on faith in Allah, prayers, and their own devotion to assist in their healing. Various herbs, flowers, plant roots and eggs designed to 'extract' the disease from the patient were also used. Most of the healers claimed they can "cure" with these treatments, especially if the disease was in the earlier stages.

Emotional comforter

The literature on traditional medicine points to the holistic nature of this practice. Interwoven with treating physical ailments is attention to the emotional and spiritual dimensions of dealing with cancer. Dr. Mahmud, a clinical oncologist, stated that "*when you treat cancer, you have to treat both sides. You have to treat the physical cancer but you have to treat the emotional, the spiritual side of it to enhance your cancer therapy*" and this he felt could be a role for traditional healers. In this study, survivors and doctors actually spoke more about the emotional and spiritual roles, than about the physical treatment.

Cancer patients experience a wide range of emotions when dealing with cancer. Many feel a diagnosis is equivalent to a death sentence. And in Malaysia as in other developing countries, lack of knowledge about the disease leads to taboos, myths and fears that results in high levels of anxiety. Breast cancer patients in particular experience great anxiety due to cultural taboos and misinformation. Dr. Ismi, a cancer surgeon in the rural northwest said that "*seeing the male doctor is a nightmare because they have to show their breast. . . . Malay is basically Muslim and they are a shy people, they don't like to share their problems with others especially involving private parts.*" Furthermore, as Dr. Salam, a radiologist pointed out, women will do most anything to avoid a mastectomy "*and the bomoh will definitely not remove the breast because they just recite something and hope that the cancer disappears . . . . There's no doubt people will choose that way, rather than surgery.*"

Traditional healers appear to alleviate some of this anxiety. Sami, a university professor and cancer survivor, said one should consult both medical and traditional healers because "*you have to hope.*" Aira recalls the bomoh she consulted told her that her cancer could be cured, and she was "*very relieved at the time*" and

that "*he gave me a positive spirit.*" She went on to recall that "*he said 'don't worry; everything will be cured whether you come to me or the doctor. . . . It can be cured; you are still in a good stage.*'" Roziah went to five different traditional healers while waiting for her mastectomy surgery. She said she was "*hoping for a miracle*," and some "*peace of mind.*" The oldest patient in our study, 75-year-old Ria, had stage 4 uterine cancer in 2001 and in 2005 was diagnosed with stage 1 lung cancer. She regularly sees an Islamic healer whose treatment allows her to "*feel peace, so calm and so relaxed.*" Latif, a renowned Quranic healer who sees upwards of 1200 patients a month, confirmed Ria's view, saying that "*Quranic healing gives them the motivation . . . the courage to fight the cancer.*"

Several doctors mentioned the lack of personal treatment and attention in the medical system that often prompts patients to see traditional healers. A rural hospital administrator pointed out that patients are really scared of the hospital:

"*The hospital is not that friendly, the social part about it. We cut out the patients from the family. You can only come to visit your mother or sister from 1 to 2pm. If you come after 2pm, you will be chased away. If you go to bomoh treatment . . . there's no disruption with family ties. The family members can come, discuss, talk and everybody's involved*".

Dr. Rosli, an oncologist practicing in the south of Malaysia felt that ignorance about cancer and its treatment drives a majority of his patients to traditional healers where the treatment is "*very friendly*" with "*little side effects*" while at the same time "*gives psychological comfort that the patient will be cured.*"

Doctors readily concurred that traditional healers could play a psychological role in cancer treatment. Dr. Rahman said that "*we now realize the prevalence of depression, anxiety and all neurotic problems among the cancer patients surprisingly is very high*" and that "*40 to 50% of patients suffering this kind of neurosis*" need attention. This is a role that traditional healers can play and he doesn't object to them being part of "*our team.*"

Spiritual guide

In addition to attending to the emotional component of dealing with cancer, these Malay traditional healers, especially the Islamic healers, addressed spiritual concerns as well as emotional ones. Latif tells his patients that "*God gave you this illness because God wants you to be closer to Him.*" He goes on to point out that "*if you see the doctor and use Quranic healing that gives a double impact. You heal the person through the modern medicine and tell the patient to recite these verses.*" Abas says that the "*doctor treats this part, while I treat another part. The doctor basically treats the physical part and I treat for the spiritual part. I say the azan [prayer] seven times and I take a deep breath and the patient can feel a little calm after that.*"

Doctors also recognized the spiritual guidance role that traditional healers play. Dr. Manan, a surgeon in rural northwest Malaysia and who revealed to us that his father was a famous bomoh, said that "*Malay is Muslim*" and that traditional healers "*use religious Quran verses and try to relate [disease] to God. They know the disease comes from God. This is more spiritual rather than evidence-based*" and "*Malay people still have that belief.*" Interestingly, not only did two of our medical doctor

participants have a close relative who was a bomoh, ten of the 12 had themselves or had had close family members visit traditional healers. Dr. Mahmud, a prominent oncologist in Kuala Lumpur, said of his family, "*we don't see bomoh, except sometimes when they [family members] get depressed. It's not for medical, but for non-medical, for spiritual guidance . . . . Sometimes, we ask about the holy water. We ask the ustaz [religious teacher who is a spiritual healer] to make some prayers.*" Another doctor said that medicine "*is not purely physical.*" There's a psychological component that "*can be treated by spiritual only. The spiritual part can treat the psychological*" which explained to him why many Malays go to healers.

Not surprisingly, cancer survivors themselves spoke quite strongly about the spiritual comfort obtained from traditional healers many of whom are religious leaders/teachers respected in the community. Roziah said she saw a healer "*for the blessing. He said don't worry. You will be successful and you will be fine again . . . . Thanks to God.*" Ria said that with her Islamic healer's help, "*I pray to God and [ask Him to] save me from the hell fire. This gives me the peace in my feeling.*" Another survivor said that Quranic healers inspire people like her to also seek standard medical treatment: "*You must look for the healing. You must look for the treatment. You must not give up because you have the Most Merciful God that loves you and so if you understand who is God, you will not give up*".

Rashidah, a shop owner, echoes the other survivors in saying that one should see both a medical doctor and an Islamic healer. She believes in "*Islamic medication*," meaning prayers. She thinks "*when you believe and you trust and you ask from God, from Allah, definitely you will get what you want. You have to work for it. So, go to see the doctors and at the same time you get Allah to help you.*"

Clearly, Malay traditional healers have something to offer cancer patients in terms of emotional and spiritual counseling. Unlike the physical healing side of their practice, medical doctors seemed quite receptive to healers treating cancer patients in their role of emotional comforter and spiritual guide.

Palliative caregiver

Both traditional healers and medical doctors recognized the potential of traditional healers as palliative caregivers when there is no other treatment possible. Salleh felt that the best he could offer to cancer patients in stage 3 or 4 was "*good spiritual motivation.*" He says he is sometimes invited to visit patients in the hospital, "*to make doa verses [prayers] for people that don't have any hope. After that, they die.*" Salmah who regularly refers patients to medical specialists, says that "*I tell them when the specialist cannot do anything else to you, you can come to me.*"

While the medical doctors in our study had issues with their cancer patients seeing traditional healers while under their care, they saw some value in traditional healers having a role in palliative care. As Dr. Rahman said, palliative care for cancer patients "*is a huge area we have to explore. I think this traditional healer plays a role in palliative care.*" Another oncologist, Dr. Rasli, says he refers his patients when he has exhausted treatment. "*In other words, in the end stage of the illness we allow the TCM.*" Dr. Muthu concurs, saying "*I recommend patients where I cannot*

provide any treatment like severe pancreatic cancer, and when they [patients] ask us if there is any other hope and I say from our allopathic medicine like chemotherapy, we don't have anything." Breast and endocrine surgeon, Dr. Ismi supports visiting traditional healers "*if the patients refuse surgery [and ask] 'is there any other method because I'm too frail, too old and too scared for the surgery, but I will come to follow up.' If the patients reject everything, [but] come to see me, [then] I recommend.*" Finally, Dr. Ching has no issue with palliative care patients visiting a traditional healer: "*When nothing else can be done, when Western medicine has nothing else to offer at this very late stage, we have no problem with patients seeking a traditional healer.*" She also feels traditional healers are the best ones to deal with the spiritual dimensions of healing in palliative care, calling it "*spiritual therapy.*"

Discussion

From interviews with traditional healers, cancer survivors, and medical specialists, we uncovered four roles traditional healers play in cancer treatment in Malaysia—medicinal healer, emotional comforter, spiritual guide, and palliative caregiver. These roles help explain the powerful draw of traditional healers in Malaysian society. While exact estimates are unavailable, WHO (2002) and a few studies conducted in Malaysia have suggested that some 80% of Malaysians visit traditional healers. With regard to cancer in particular, patients often see healers as a first line of help, thus delaying cancer diagnosis and treatment. The result is late presentation, late stage diagnosis and a higher cancer mortality rate than in Western countries (Yip, 2008; 2009; Yip et al., 2012).

The three roles of medicinal healer, emotional comforter, and spiritual guide are certainly congruent with the literature on traditional medicine. Not only are traditional healers more accessible and more affordable especially in poor, rural areas in developing countries, they are very much embedded in the social, cultural and religious fabric of the country. Although the patients in our study clearly accepted Western medicine in treating their cancer, there was a sense that they hoped a traditional healer could cure them, or at least enable them to avoid surgery and/or chemotherapy. Several did experience some relief from their physical symptoms. While most of the healers claimed their medicine could 'cure' cancer especially if it was early stage, as yet there is no scientific evidence to support their claims. And in a review of the evidence for 24 complementary and alternative treatments for palliative cancer care, the authors conclude that "*for some treatments, the evidence is encouraging but for very few, it is as yet fully convincing*" (Ernst et al., 2007).

It may also be that due to lack of information or misinformation, fear, cultural taboos and so on, cancer patients in particular are drawn to traditional healers. Malaysian women are hesitant to even be screened for cancer. Wong et al. (2008) found Malaysian women reluctant to get a Pap smear because of lack of knowledge about cervical cancer and its screening, embarrassment, fear of pain, a fatalistic attitude, and viewing their own health as secondary to their family obligations. Speaking of breast cancer screening in particular, Parsa et al. (2006)

point out that "*in Asian traditional culture, women's bodily experiences are taboo*," there is much shame and humiliation in exposing their breasts, and women fear the test itself, the results of the screening, and the treatment should they have cancer.

However, focusing on the actual medical treatment role of traditional healers misses what is most compelling about the attraction for Malaysian cancer patients. For that, we need to turn to their roles as emotional comforter and spiritual guide. More than thirty years ago, Heggenhougen (1980a) explained that traditional healers were attractive to Malaysians because the worldview of Malaysians encompasses more than scientifically-based explanations of disease:

"*Most Malaysians are quite cognizant of the germ theory of disease, but understanding 'how' an illness occurs still does not explain to them 'why' this illness should happen to this particular person at this particular time . . . . The question 'why' is often as important, or more so, than the question 'how'. In this light, we may say that Malaysians have dual (or even plural) etiological explanations for the occurrence of any one illness—the cause(s) is (are) seen to be both natural (dealing with the 'how") and supernatural (dealing with the 'why')*" (p. 239).

Worldwide, medical doctors "*tend to tell their patients what has happened, while the healers tell them why. Healers explain ill health in wider, more familiar cultural terms, involving the social, psychological and spiritual aspects of their patients' lives*" (Helman, 2007). Speaking of traditional medicine and cancer treatment in South Africa, Muller and Steyn (1999) confirm that while Western medicine may correctly explain "*the disease processes, . . . the important question 'Why me?' is not answered*" (p. 145). Further, the holistic nature of traditional healing "targets the mind, body, and soul of patients within their family, community and religious contexts" (Ross, 2008). Lau (1989) points out that the actual diagnosis and treatment "*count less than the simple fact that anxiety, fear, and doubt—all of which may contribute to an illness by way of complicating symptoms and reactions—are dispelled. These healers give people hope; they treat the patient as someone who can be cured*" (p.94).

Patients and medical doctors in our study certainly emphasized the emotional and spiritual benefits derived from traditional healers. Patients reported that their faith was affirmed, anxiety was lessened, and psychological distress reduced, even while recognizing that they would still need to be treated by Western doctors for the cancer itself. Tovey et al.'s (2005b) study of traditional medicine and cancer in Pakistan confirms the importance of the emotional and spiritual components of healing. Patients reported high levels of satisfaction with traditional healers despite strong views on the ineffectiveness of these very practices. The authors go on to say that "*it may be that TM (in particular) tends to play a more pivotal role in the patient's emotional and spiritual well-being than potentially curative options*" (p. 247). As in Malaysia, "*in Pakistan, for many patients, health and faith (Islam) are inextricably linked . . . . Being effective at treating one's condition may actually be superseded, in some cases, by a desire for emotional and spiritual well-being*" (p. 247-248).

Finally, the role of palliative caregiver has the strong support of medical doctors who seem to recognize the comfort that traditional healers can provide, not only through alleviating physical pain with their medications, but also through

emotional and spiritual comfort. Conventional medical treatment has little to offer patients in terminal stages of cancer (Pal and Mittal, 2004). Traditional healers, however, may enable patients to feel less despair and restore a sense of control in the final days of their lives (Mohamed et al., 2005).

Further, there is limited palliative care service in Malaysia (Lim, 2008), and insufficient NGOs to assist the government in this issue. For example, there are only 20 members of the Hospice and Palliative Care Society in Malaysia, and most of these services are located in urban areas (Hospice Malaysia, 2011). With limited facilities, patients seek traditional healers who can be accessed easily and who also often spend more time to comfort and give hope to them. Patients see complementary and alternative medicine as more compatible with their values, worldview, and spiritual philosophy or beliefs regarding the nature and meaning of health and illness (Pal, 2002). A healer's support is often critical to patients who have nothing else to count on at this stage of the disease.

Three of the four roles traditional healers play in cancer treatment in Malaysia can be seen as complementary to the allopathic system. Emotional comforter, spiritual guide and palliative caregiver offer support and assistance to cancer patients that do not interfere with medical treatment. In fact, as several of the medical doctors in this study pointed out, emotional and spiritual dimensions of healing may augment the effectiveness of their biomedical treatment. And when little else can be done, traditional healers may bring symptom relief and psychological and spiritual comfort to terminal patients. Only one role, that of medicinal healer is problematic in alleviating the cancer burden in Malaysia. Doctors in our study pointed out the potentially negative interaction effects of traditional medications with their treatments. Further, there is no evidence that traditional medicine can cure cancer, although most of the healers in our study claimed the ability to cure cancer especially if it was early stage.

In health promotion and education, working from the premise that Malaysians will continue to see traditional healers, it seems to us that the cancer burden in Malaysia can be at least partially addressed through educational efforts directed at policy makers, Western doctors, traditional healers and the general public. From a policy perspective, efforts at bringing the two health care systems closer together would seem to be a logical first step. As noted earlier in this article, the World Health Organization (2002) is actively promoting such collaboration, and a number of countries in Asia and Africa have moved in this direction. In Nepal, for example, "*international NGOs and UN organizations have begun to train THs in modern medicin*e" (Shimobiraki and Jimba, 2002). Muller and Steyn's (1999) analysis of possibilities for cooperation in cancer treatment between the two systems in South Africa found that despite cultural differences in their perceptions of disease causation and treatment, "*traditional healers' knowledge of the beliefs, values and psyche of their patients could inform Western medicine if there were effective interaction between the two systems and patients would benefit from applicable referral in the case of serious illness*" (p. 145). A recent report on coordinating care and treatment for cancer patients also underscored the need to "*link community, primary care and hospital-led activities*" (Yip et al., 2012).

It seems to us that what is needed for policy makers is not only information as to the widespread use of traditional healers such as provided by this and other studies, but an action plan to move ahead. Razali (2009) has in fact proposed a three-step process for cooperation between the two systems: First, "*THs would be formally recognized by the government. The second and third steps of cooperation are more challenging. The second step would be to form a body to register bomohs and supervise their activities. The third step would be to organize discussions between traditional and modern practitioners on their respective roles, expertise and limitations. A short introductory course and training in modern medicine may be beneficial to bomohs in order to encourage mutual referral.*" (p. 16).

Our interviews with both traditional healers and medical doctors revealed that most healers, especially Islamic or Quranic healers, and most doctors see points of intersection with the Western medical system. Three of the four roles uncovered in this study (emotional comforter, spiritual guide, and palliative caregiver) can certainly be seen as complementary to biomedical treatment. But how to facilitate this complementary status through education? A starting point would be to identify what Gramsci (1971) called 'organic intellectuals' – those people 'on the ground' who could be called upon to lead and organize first among themselves and then reach out to other constituencies. These leaders would need to come from both the traditional healer community and the medical profession. In many parts of the developing world, for example, traditional healers have organized into informal networks, practitioner organizations and professional associations. "*By creating a professional association, they hope to advance their interests and those of their clients, improve standards, raise their prestige and earning power, gain official support and define an area of health care that only they can provide*" (Helman, 2007).

Health promotion and educational outreach can also be initiated by medical doctors themselves. An intriguing finding in our study was that of the twelve cancer specialists that we interviewed, ten had either themselves or had close family members visit traditional healers. Further, one surgeon told us that his father was a famous bomoh and another said that it was because of his grandfather who was a traditional healer that he went into medicine. All knew that the majority of their patients saw traditional healers and regularly cautioned their patients against taking medications that might interfere with their treatments. Nevertheless, these doctors saw the value in spiritual and emotional support from traditional healers and palliative care support. However, accommodation on a personal level is much less of a problem than changing the organizational culture and thinking of the Western medical system. What it will take will be for well-respected doctors to speak out in support of working with traditional healers to provide emotional, spiritual and palliative support. Given the already stressed medical system in Malaysia, this may be the most challenging suggestion of all. However, it seems to us that with some policy initiatives at the government level and some leadership from traditional healers, there could be enough synergy to engage the medical profession in more formal ways.

Finally, our study suggests that there is a dire need for public education campaigns that position traditional healers as complementary to standard Western

medical treatment. The fact that upwards of 80% of Malays see traditional healers and derive emotional and spiritual comfort from them is testimony to the staying power of this practice. It is clear that if traditional healers are seen as an alternative (rather than complementary) to Western medical treatment, chronic diseases like cancer will continue to devastate countries in the developing world. Health promotion is a task where adult educators, health educators and community development activists can come together through sharing knowledge of program planning, teaching and learning strategies, and research (Daley, 2006). Public education campaigns need to be directed toward validating both traditional and biomedical systems, eradicating the delay and/or interruption in medical treatment, encouraging screening tests, and dispelling myths and fears surrounding various diseases.

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References

Al-Naggar RA, Bobryshev YV, Abdulghani MAM, Rammohan S, Al-Jashamy K (2012). Knowledge and perceptions of cancer and cancer prevention among Malaysian traditional healers: a qualitative study. *Asian Pac J Cancer Prev*, *13*, 3841–50.

Anderson BO, Yip CH, Ramsey, SD, et al (2006). Breast cancer in limited-resource countries: health care systems and public policy. *Breast J*, *12*, 54–69.

Broom A, Torvey P (2007). Inter-professional conflict and strategic alliance between traditional healers and oncologist in Pakistan. *Asian J Social Science*, *35*, 608–25.

Corbin J, Strauss A (2007). Basics of qualitative research: Techniques and procedures for developing grounded theory (3rd ed.), Thousand Oaks, CA: Sage.

Daley BJ (2006). Aligning health promotion and adult education for healthier communities. In S.B. Merriam, B.C. Courtenay, & R. M. Cervero (eds.), Global Issues and Adult Education (pp. 231–242). San Francisco: Jossey-Bass.

Denzin NK, Lincoln YS (2003). Collecting and Interpreting Qualitative Materials. Thousand Oaks, CA: Sage.

Deuraseh N (2009). Using the verses of the Holy Quran as Ruqyah (Incantation: The perception of Malay-Muslim Society in Kelantan and Terengganu on Ruqyah as an alternative way of healing in Malaysia. *Eur J Social Sci*, *9*, 448–56.

Erasmus PC (1992). More about complementary medicine: Traditional healing. *Continuing Medical Education*, *10*, 105–6.

Ernst E, Pittler MH, Wider B, Boddy K (2007). Complementary/alternative medicine for supportive cancer care: development of the evidence-base. *Support Care Cancer*, *15*, 565–8.

Gramsci A (1971). Selections from the Prison Notebooks. (Q. Hoare and G.N. Smith, trans. and eds.), New York: International.

Heggenhougen HK (1980a). Bomohs, doctors and sinsehs—Medical pluralism in Malaysia. *Social Sci & Med*, *148*, 235–44.

Heggenhougen HK (1980b). The utilization of traditional medicine—A Malaysian Example. Social Sciences and Medicine, *148*, 39–44.
Helman CG (2007). Culture, Health and Illness (5th ed.). London: Hodder Arnold.
Hospice/ palliative care societies in Malaysia. Retrieved from Hospice Malaysia website: www.hospismalaysia.org/ (16 Mar 2011).
Kayombo EJ, Uiso FC, Mbwambo ZH, et al (2007). Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania. *J Ethnobiol and Ethnomedicine*, *3*, 6–16.
Lau BWK (1989). Why do patients go to traditional healers? *J Royal Society for the Promotion of Health*, *109*, 92–5.
Malik IA, Khan NA, Khan W (2000). Use of unconventional methods of therapy by cancer patients in Pakistan. *Eur J Epidemiol*, *16*, 155–60.
McMillen H (2004). The adapting healer: pioneering through shifting epidemiological and sociocultural landscapes. *Social Sci & Med*, *59*, 889–902.
Merriam SB (2009). Qualitative research: a guide to design and implementation. San Francisco: Jossey-Bass/Wiley.
Mills E, Sing S, Wilson K, et al (2006). The challenges of involving traditional healers in HIV/AIDS care. *Int J STD & AIDS*, *17*, 360–3.
Mills PK, Riodan, DG (2004). Cervical cancer among Hmong women in California, 1988 to 2000. *Am J Prev Med*, *27*, 132–8.
Mohamed IE, Williams KS, Tamburrino MB, Wyrobeck JM, Carter S (2005). Understanding locally advanced breast cancer: What influences a woman's decision to delay treatment? *Prev Med*, *41*, 399–405.
Nelms LW, Gorski J (2006). The role of the African traditional healer in women's Health. *J Transcultural Nur*, *17*, 184–9.
Omar ZA, Ali MZ, Tamin INS (Eds.) (2006). Malaysian cancer statistics – Data and figures for Peninsular Malaysia, 2006. National Cancer Registry, Ministry of Health, Malaysia.
Pal SK, Mittal B (2004). Fight against cancer in countries with limited resources: The postgenomic era scenario. *Asian Pac J Cancer Prev*, *5*, 328–33.
Parsa P, Andiah M, Rahman A, Zulkefli M (2006). Barriers for breast cancer screening among Asian women: A mini literature review. *Asian Pac J Cancer Prev*, *7*, 509–14.
Patton MQ (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.
Razali SM. (2009). Integrating Malay traditional healers into primary health care services in Malaysia: It is feasible? *Int Med J*, *16*, 13–7.
Razli SM, Najib MAM (2000). Help-seeking pathways among Malay psychiatric patients. *Int J Social Psychiatry*, *46*, 281–9.
Razali SM, Yassin AM (2008). Complementary treatment of psychotic and epileptic patients in Malaysia. *Transcultural Psychiatry*, *45*, 455–69.
Relying on bomoh for cancer treatment. (October 2, 2010). New Straits Times, Kuala Lumpur, Malaysia, p.11.
Ross E (2008). Traditional healing in South Africa: ethical implications for social work. *Social Work in Health Care*, *46*, 15–33.
Shimobiraki C, Jimba M (2002). Traditional vs. Modern medicine: Which healthcare options do the rural Nepalese seek? *Technology and Development*, *15*, 47–55.
Taib NA, Akmal MN, Mohamaed I, Yip CH (2011). Improvement in survival of breast cancer patients—Trends in survival over two time periods in a single institution in an Asian Pacific country, Malaysia. *Asian Pac J Cancer Prev*, *12*, 345–9.

Taib, NA, Yip, CH, Low, WY (2011). Recognising symptoms of breast cancer as a reason for delayed presentation in Asian women – The psycho-socio-cultural model for breast symptom appraisal: Opportunities for intervention. *Asian Pac J Cancer Prev, 12*, 1601–8.

Tovey P, Broom, AF, Chatwin J, Ahmad S, Hafeez M (2005a). Use of traditional, complementary and allopathic medicines in Pakistan by cancer patients. *Rural and Remote Health, 5*, 447–56.

Tovey P, Broom A, Chatwin J, Hafeez M, Ahmad S (2005b). Patient assessment of effectiveness and satisfaction with traditional medicine, globalized complementary and alternative medicines, and allopathic medicines for cancer in Pakistan. *Integrative Cancer Therapies, 4*, 242–8.

Tovey P, Chatwin J, Broom A (2007). Traditional, complementary and alternative medicine and cancer care: An international analysis of grassroots integration. London: Routledge.

UNAIDS, (2000). Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: A literature review. Geneva, Switzerland: UNAIDS.

Wong LP, Wong YL, Low WY, Khoo EM, Shuib R (2008). Cervical cancer screening attitudes and beliefs of Malaysian women who have never had a pap smear: a qualitative study. *Int J Behavioral Med, 15*, 289–92.

World Health Organization (2002). Traditional medicine strategy 2002–2005. Retrieved from WHO website: www.who.int/medicines/publications/traditionalpolicy/en/

World Health Organization (2005). Preventing chronic diseases: A vital investment. Geneva, Switzerland. Retrieved from WHO website: www.who.int/chp/chronic_disease_report/contents/en/

Yip CH (2008). Epidemiology of breast cancer in Malaysia. In Hashim, Z., Sharif, Z., & Muhamad, M. Breast cancer in Malaysia: Issues and educational implications. (1–18). Serd, MY: Institute for Social Science Studies, Universiti Putra Malaysia.

Yip CH (2009). Breast cancer in Asia. *Cancer Epidemiology, 471*, 51–64.

Yip CH, Cazap E, Anderson BO, et al (2011). Breast cancer management in middle resource countries (MRCs): Consensus statement from the Breast Health Global Initiative. *Breast, 20*, 12–9.

Yip CH, Samiei M, Cazap E, et al (2012). Coordinating care and treatment for cancer patients. *Asia Pac J Cancer Prev, 13*, 23–36.

How Context Shapes the Design and Implementation of a Qualitative Study

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While either studying at the graduate level or conducting the research expected in a career, identifying a topic to research is a first and often daunting step in the process. Where do we find topics/issues/problems to be investigated? Then what? How is the issue shaped or the question asked to best guide data collection and analysis? How do we know if the topic is significant enough that the study will make a contribution to one's field? I address these questions as I "walk through" how I conducted the qualitative study of traditional healers in Malaysia with my colleague Mazanah Muhamad.

On a yearlong visiting scholar assignment to a university in Malaysia, I was assigned to a Cancer Research and Education Center. The "work" of the center was to conduct social science (not medical) research on topics of social support and education related to cancer, as well as to hold workshops, organize support groups, and produce educational materials. Since my areas of interest and expertise are adult education and qualitative research methods, for the most part this assignment was a good fit for me. I was also expected to undertake a research project relevant to the center's mission. I knew almost nothing about the cancer burden in Malaysia, however, so the first month or so was spent learning about cancer in Malaysia through reading reports, talking with center staff, and attending workshops put on by the center and a local hospital.

It took a couple of months for me to feel comfortable exploring with my Malaysian colleague possible topics for a research study. But I felt like I was reaching too hard for something/anything to study; I just couldn't get excited about the possibilities I came up with. Then I happened to read a newspaper article about a traditional healer (called a *bomoh*) in a rural village who was treating patients for serious conditions such as cancer. I've always been fascinated by traditional

healers and I recall asking my colleague about this article and about the practice of *bomoh* who treat cancer patients. She explained how embedded traditional healers are in Malay culture, and how their treatment of cancer patients was widespread and controversial, especially with the Western medical system. From that conversation, we designed a study to explore the role of Malay traditional healers in cancer diagnosis and treatment.

Just as in any other study, the context gives rise to the question(s) we might ask. In this example, the context was cancer treatment in Malaysia and in particular the role traditional healers play in that treatment. The next step in designing a study is to determine if research has already been conducted on this topic, and if the question is a significant one that, if answered, has the potential to contribute to practice and/or theory. We found that little research had been conducted on traditional healers in Malaysia, and none was found that addressed their role in cancer treatment. A few articles were found on traditional healers and serious medical conditions including cancer in other cultures (see references for Tovey and colleagues in the article's reference list). We reasoned that since Malays are going to continue seeing traditional healers, it would be helpful to see how healers are treating cancer and possibly how they can be aligned with Western treatments, how policies can be developed at points of intersection between the two systems, and how public education campaigns could position healers as complementary to, rather than substitutes for, standard Western medical treatment.

Once we had a question we felt was significant (the role of traditional healers in cancer diagnosis and treatment), our next task was to design the study. Since we knew so little about the phenomenon, we selected a basic qualitative design as the most appropriate because of its focus on discovery and understanding. And since we wanted to obtain a robust picture of this phenomenon, we reasoned we should not only interview *bomoh*, but also cancer specialists and cancer survivors who had been treated by both traditional healers and medical doctors. Malaysia is a multicultural country with significant populations of Malay, Chinese, and Indian residents, with each group having its own traditional healers. We decided to focus on Malay traditional healers of which there are several types, most commonly *bomoh* who use herbs, and Islamic healers who use the Quran as a major component of their treatment (there is overlap between the two types). We also reasoned that cancer survivors who had been treated for cancer by both traditional healers and medical doctors would be able to inform our study, as would interviewing some cancer specialists.

The context also shaped our data collection in that we traveled to where the healers practiced. This involved visiting some remote villages and their practice site (occasionally a clinic, but more often their homes). This actually proved to be informative to our study in that one of the reasons why people go to healers is that they are in familiar surroundings and family members and friends can accompany the patients to the treatment. Most times, we interviewed the healer as patients sat nearby waiting for their "turn," but on many occasions we observed the healer treating patients. A medical doctor in our study commented on this very factor – that cancer patients lack personal treatment in the hospital

and are isolated from the family support they experience with healers. Another interesting factor concerns context: the cancer survivors we interviewed ranged in education from little formal schooling to advanced degrees and in English fluency from very little to highly fluent. This spread is representative of the fact that according to some estimates upwards of 80% of the world's population visit traditional healers irrespective of income, social class, education, or gender. All interviews were taped, transcribed, and where necessary translated into English.

The rich data we collected from healers, patients, and doctors allowed us to explore the phenomenon from several perspectives including why breast cancer patients visit healers; how healers diagnose and treat cancer, and their willingness to work with the Western medical system; and the roles traditional healers play in cancer treatment (the topic of the attached article). As part of relating the research to the context and hopefully having a positive impact on the cancer burden in Malaysia, aspects of our research have been presented at medical and healthcare conferences and workshops, to the Malaysian Health Department, and in mass media outlets. We feel that our study has made a contribution not only to the literature, but also to the context of cancer treatment in Malaysia.

In summary, context shapes all qualitative research in that we are trying to understand a phenomenon from the participants' perspectives. An interpretive qualitative research design is especially appropriate in an unfamiliar context such as I encountered in Malaysia. In addition to identifying a research problem relevant to the Malay context, conducting research in a foreign country also involves understanding and respecting cultural norms that intersect with sample selection, data collection, and presentation of findings. A local co-researcher/colleague, as I was fortunate to have, can facilitate all phases of the study from framing the problem, to data collection and analysis, to distribution of the findings. However, one does not need to be in a foreign country to be highly sensitive to the context of a study; the purpose of conducting any interpretive qualitative study is to uncover and understand the phenomenon of interest from the participants' perspectives – perspectives that are formed by and embedded in the study's context.