AN EXAMINATION OF SOCIOCULTURAL FACTORS INFLUENCING LIFESTYLE, HEALTH AND HEALTH-SEEKING BEHAVIOUR – A CASE STUDY OF MALAYSIAN CHINESE CANCER SURVIVORS

BY

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A thesis submitted in fulfillment of the requirement for the degree of Doctor of Philosophy

Kulliyyah of Islamic Revealed Knowledge and Human Sciences
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JULY 2012

ABSTRACT

This study of Malaysian Chinese cancer survivors aims at analysing the lifestyles, health and health-seeking behaviour of the cancer survivors. The focus of the study is primarily aimed at their early years of life and the ways they lived their lives. This includes their diets, leisure activities, work and social environments, perception of health, and health-seeking behaviours. While looking at these lifestyle components, the analysis of social and cultural factors in influencing their decision making on living and health-seeking behaviours was the focus of the study. 50 cancer survivors with different types of cancer were selected from the group of cancer survivors who frequent the Lembah Kiara Recreational Park in Kuala Lumpur; engaging in 'Guolin Qigong' exercise in the morning. Using qualitative methodology, this study employed participant observation technique as well as face-to-face informal interviews guided by a set of pre-set interview schedule. It is a general truth that the Malaysian Chinese have over the years inherited their forefathers' cultural beliefs and practices especially in their worldview of health and living. This is in turn related to the main finding of this study, which indicates that Chinese cultural beliefs and practices not only have a significant impact on the early lifestyle of the Malaysian Chinese cancer survivors, but also play a vital role in their interpretation and perception of health and illnesses as well as their needs for health care. In this study, the sociocultural values of the Malaysian Chinese community were consistently highlighted in the process of decision-making of the cancer survivors with regard to their lifestyle before cancer diagnosis and their health-seeking behaviours which include medical pluralism and cancer treatment options. Finally, this study holds an important implication in contributing to the literature of medical sociology, in particular, to the epidemiological study of cancer.

خلاصة البحث

تهدف هذه الدراسة إلى تحليل أساليب حياة، وصحة، وسلوك الإرادة الصحية عند المصابين الماليزيين الصينيين بالسرطان والباقين على قيد الحياة. وتركّز هذه الدراسة بشكل مبدئي على السنوات المبكرة من حياتهم المعيشية. ويتضمن ذلك الحمية في الطعام، والنشاطات الترفيهية، والبيئة الاجتماعية والعملية، والتصور الصحي، وسلوك الإرادة الصحية. ومن خلال النظر في عناصر أساليب حياتهم، يهدف هذا البحث إلى تحليل العوامل الاجتماعية والثقافية، التي تؤثر على صناعة القرار في الحياة، والسلوكيات في الإرادة الصحية. واختير 50 من المصابين بأنواع مختلفة من السرطان والباقين على قيد الحياة، من مرتادي المنتزه الترفيهي (ليمباه كيارا) في العاصمة كوالالمبور، لممارسة تمارين (قولينغ كيقوينغ) في الفترة الصباحية. واستخدمت الدراسة المنهجية النوعية، من خلال تطبيق تقنية الملاحظات الميدانية، إضافة إلى المقابلات الشخصية، بتوجيهات من جدول المقابلات المسبق إعداده. ومن الحقائق المسلمة أن الماليزيين الصينيين توارثوا المعتقدات والممارسات الثقافية من أجدادهم، خصوصاً فيما يتعلق بصحتهم وحياتهم العامة. ويأتي ذلك تباعا للنتائج الرئيسية لهذه الدراسة، والتي تشير إلى أن المعتقدات والممارسات الصينية لم يكن لديها تأثير مهم على أسلوب الحياة قديما عند الماليزيين الصينيين المصابين بالسرطان فحسب، بل إنها لعبت دوراً حيوياً في تفسيراتهم وتصوراتهم للصحة والمرض، إضافة إلى احتياجاتهم للرعاية الصحية. وفي هذه الدراسة، تبرز القيم الثقافية والاجتماعية للمجتمع الماليزي الصيني بشكل ثابت في إجراءات صناعة القرار عند الباقين على قيد الحياة من المصابين بالسرطان، وذلك يعود إلى أساليب حياتهم قبل تشخيص مرض السرطان، وسلوك إرادتهم الصحية، والتي تتضمن الازدواجية الطبية، وخيارات معالجة السرطان. وأخيرا، تحمل هذه الدراسة نتائج مهمة قد تسهم في بحوث ودراسات الصحة الاجتماعية، لاسيما في دراسة علم الأوبئة السرطانية.

APPROVAL PAGE

The thesis of Yew Wong Chin Vivien has been approved by the following:

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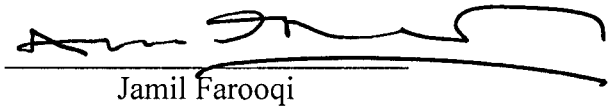

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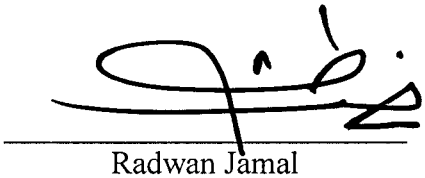

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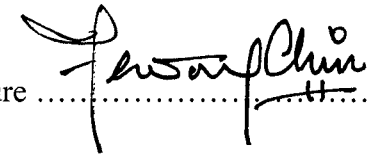
Signature  Date .....

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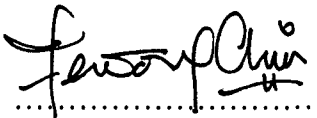

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Signature Date

This thesis is dedicated to my mother Madam Yep Soo Chew, my husband Ng Soon Hoo, and my son Ng Ren Zen.

ACKNOWLEDGEMENTS

First and foremost, a very special thank you to my supervisor, Dr Noor Azlan Mohd Noor, who has supported and guided me throughout my thesis with his patience and knowledge whilst allowing me the room to work in my own way. I attribute the completion of this thesis writing to his encouragement and effort. Without him, this thesis would not have materialised. Next, I would like to express my gratitude to my most respectful advisor, Professor Dr Saiyad Fareed Ahmad for his invaluable advice and comments in the early stages of writing. I would also like to gratefully acknowledge the support of some very special individuals: Dr Pute Rahimah Makol-Abdul and Dr Yew Yeok Kim for their continuous moral support in my entire lengthy Ph.D studies, Dr Jacqueline Liza Fernandez for her prayers and encouragement in my thesis writing, and Miss Davagieammal Govindarajulu for proofreading my thesis proposal. My appreciation also goes to all the informants who have provided their time and valuable information. Finally, I would like to express my heartfelt thanks to my husband and my son for their love, faith, and confidence in me.

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

According to the World Cancer Report 2008 (Boyle and Levin, eds., 2008: 42-43), cancer typically confronts almost every family and hardly any family has not been hit by cancer. This statement then provides support to an estimate made in 2005 that the overall lifetime risk of developing cancer of each individual is expected to rise from more than one in three to one in two by 2015. The alarming data interprets that soon in any part of the world; one of every two persons will be afflicted by cancer (Peedell, 2005). In addition to this, reports from World Health Organisation show that cancer accounts for one out of every eight deaths annually and more people die from cancer every year around the world than AIDS, tuberculosis and malaria. As cancer continues to attack, the impact of the disease on people's lives have become so immense that cancer is seen as a death sentence to anyone who is diagnosed with the disease (Boyle and Levin, eds., 2008).

Further, the World Health Organization ([WHO], 2003a) notes that people who are living in industrialized countries are twice as likely to be diagnosed with cancer as those in developing countries.[1] The global cancer rates disparities between developed and developing countries is mainly due to the Western diet and lifestyle habits, for example, smoking, high fat diets, and high rates of meat consumption adopted in most developed countries. It was reported that as people in developing

[1] Developing countries refers to Latin America and Caribbean, Africa, Asia with the exclusion of Japan, and Oceania with the exclusion of Australia, New Zealand and Hawaii (Paolo Bofetta & D. Maxwell Parkin, "Cancer in developing countries," *Cancer Journal for Clinicians,* vol. 44, no. 2 (1994): 81).

countries continue to adopt unhealthy lifestyles and dietary habits, the rates of colon, breast, prostate, and cervical cancer will also increase (WHO, 2003a). In the low and middle income countries of the developing world, like India and China, the consequences of the growing burden of new cancer cases and deaths are expected to continue to worsen (Boyle and Levin, eds. 2008).

In terms of overall cancer death rates worldwide, the cancer mortality rate in developing countries is almost twice the amount of the death rate in developed countries, and this shows a significant figure of 80 percent of cancer patients dying in poor countries as opposed to 50 percent in developed countries (Boyle and Levin, eds., 2008: 42-43). There are several factors that could have attributed to this scenario, mainly lifestyle habits of tobacco smoking, certain occupational dusts and fumes, limited health knowledge and health screening services, mistrust of the medical community, religious beliefs, and cultural factors (Mills and Porter, 1957; Claeys et al., 2002; Matthews et al., 2002; Boyle and Levin, eds., 2008).

In addition, a steady increase of ageing population worldwide plays a significant role in the sharp increase of cancer death rates globally. In Italy and North America, cancer disproportionately strikes individuals in the age group of 65 years and older. It was revealed that 56 percent of all newly diagnosed cancer patients and 71 percent of cancer deaths are in this age group (Yancik, 2005). Similarly, in Malaysia, the age medians of cancer diagnosis in Malaysian males are 59 years and 53 years for Malaysian females. This indicates a potentiality for increased cancer incidence and mortality in Malaysia as our population grows older, because the proportion of population aged 65 and over is projected to increase to eight percent by 2030 and cancer appears to strike Malaysian individuals in the age group of 53 years and above (Lim and Halimah, eds. 2004: 35).

Next, Doll and Peto (1981) in their review of the causes of cancer deaths in the United States suggested that there is a significant positive association between cancer risk and diet in developed countries, and cancers of the colon, rectum, and breasts are probably related to dietary factors such as high fat and low fibre content. It was stated that the consumption of animal fat, especially fat from red meat, is associated with an elevated risk of colon, rectum, and breast cancers. In fact, some evidence suggested that dietary fat is the most significant risk factor for colorectal cancer whereas dietary fibre serves as a preventive factor (Lipkin et al., 1999). Alternatively, high intake of fruits, vegetables, and reduced meat consumption may decrease the risks of several types of cancer like esophagus and stomach (Aune et al., 2009a; 2009b).

Where diet is part of lifestyle factors, the role of an individual's lifestyle in causing cancer indicates differences in incident and death rates of cancer with regard to race and geographical distribution. For example, Slattery et al., (1999) in their study on colon cancer among the people in northern California, Utah, and Minnesota, suggest that the element of minimum physical activity in the lifestyle components, is an important determinant of colon cancer risk among Americans, besides being obese and eating a diet high in animal products. Similarly, in India, Sukla et al., (2008) in examining gallbladder cancer patients among the North Indian population also found that lifestyle factors play an important role as etiological factors of gallbladder cancer among the people in North India. Two significant lifestyle factors identified in their study that caused gallbladder cancer among North Indians are smoking, and tobacco chewing of pan (lime, areca nut, catechu, betel leaf with tobacco), *khaini* (raw tobacco with lime) or *paanmasala* (processed tobacco, catechu, areca nut and lime). As shown from the findings, though tobacco chewing has an increased risk for cancer, it is a

traditional habit among the female respondents belonging to the lower and middle income classes of the rural areas.

Apart from dietary and lifestyle factors, cultural factors are also categorised as the fundamental causes of cancer. Cultural factors include ethnic and religious beliefs in relation to health and illnesses. Several studies have shown that people from different ethnicities encompass different cultural contexts, and may have different views in looking at health and illnesses. Chinese, for instance, believe that people, who have not taken good care of their health and thus fall ill, are said to be ill-fated. Here, there is a belief in the Chinese community that fate determines health and illnesses. The attitudes of Chinese individuals who subscribe to the concept of 'fate' strongly believe that fate pre-dominates everything in life, including a person's health and illnesses. For some of the Chinese adults with cancer, they simply accept their fate to be afflicted with cancer and believe they can do nothing to prevent it from happening (Chen, 2001: 270). In this respect, some western studies refer those people with ill-health and subscribe to a belief in fate or God's will as having a fatalistic attitude. Also, beliefs such as cancer fatalism in this context might influence people's responses to their diagnosis towards cancer as well as their decision-making in the choice of treatment for the disease (Straughan and Seow, 1998: 85).

In an earlier study by the Cancer Research UK (2007) on more than 4,000 UK adults, 27 percent of the adults across the country commented that getting cancer was beyond their control and it is purely due to fate. The study has also shown that more women than men believe cancer were a matter of destiny than prevention through measures such as quitting smoking or living a healthy lifestyle. Likewise, Taiwanese with terminal cancer participated in a semi-structured interview carried out in a survey in Taiwan that dealt with their experiences of spiritual suffering and the healing

process, claimed that their ill-health was determined by fate which resulted in them suffering from cancer. According to the participants, there was little they could do to prevent the life-threatening illness as cancer is beyond human's control and it was out of their hands (Chio et al., 2007).

Besides dietary, lifestyle, and cultural factors, cancer incidence and mortality rates in both developed and developing societies are also related to the nation's socioeconomic factors. Socioeconomic factors, as part of the social factors according to Kogevinas et al., (1997), include education, income, assets, housing and occupation. For instance, Van Loon et al., (1995) in their study evaluating the differences in lung cancer incidence between socioeconomic groups in the Netherlands, emphasize participants' education level as an indicator of socioeconomic status of the participants. Their findings indicate that there is a negative association between the highest level of education and lung cancer. Participants who achieved higher level of education had a significantly lower incident rate of lung cancer, and vice versa. With regards to that, Behrman and Rosenzweig (2004: 587) in their study on the association between participants' purchasing power and the percentage of low birth weight babies in the United States highlight that most individuals with low education have low income too and thus do not have the means to purchase healthcare for themselves which then lead to higher rates of critical illnesses like cancer.

With regard to Van Loon et al.,'s (1995) findings, Dalton et al., (2006) in their study to investigate the association between Danish women's socioeconomic positions and their risk of being diagnosed with a high-risk breast cancer explain that, participants who had obtained a higher level of education, earn higher disposable income and thus have more resources to healthcare services to address their health needs. Also, as they achieve higher level of education, they tend to have more

knowledge, exposure, and awareness about ill-health, particularly cancer. Therefore, this group of participants with a higher level of education have a lower rate of chronic illnesses such as cancer.

Similarly, the study on breast cancer survival in Sweden (Lagerlund et al., 2005) shared the same findings with Dalton et al.,'s (2006) study that the risk of death for Swedish women with breast cancer was higher among women of low compared to high socioeconomic status. In this Swedish study, the socioeconomic disparities in treatment and survival of breast cancer patients prevail among all other risk factors. The study showed that the higher the occupational status of the Swedish women, the higher income they earn, the better the treatment they obtain, and thus the longer their survival duration.

The association of individuals' socioeconomic status and cancer risk and mortality shows similar trends in both developed as well as developing countries. Generally, cancer studies in developing countries like India (Pakseresht et al., 2009) and China (Cai et al., 2009) suggested that there are significant differences between cancer incidence and mortality in relation to the socioeconomic status of the study participants. For instance, a study by Pakseresht et al., (2009) on the association of various risk factors with breast cancer among 115 women in Delhi reports that the significant difference in breast cancer incidence among women in Delhi is due to the difference in socioeconomic factors such as the women's occupation as housewives and their places of residence whether urban or rural. Women's occupation as a housewife and also staying in rural areas cause them to have limited resources to healthcare services which may influence their health status, and thus exposing them to higher incidence of breast cancer.

In another study, D'Avanzo et al., (1996) on the relationship of occupational and leisure-time physical activity with breast cancer risks in Italy, found that the work activity for housewives when doing housework regularly was considered low and may increase an individual body's fat which then increases the risk of breast cancer.

In China, Cai et al., (2009), in their study to investigate the impact of occupation as one of the determinants in participants' socioeconomic position, on their willingness to attend a colorectal screening program in Hangzhou, argue that blue-collar male informants have poor knowledge of colorectal cancer screening and show poor attendance rate of colorectal cancer screening due to financial issues as compared with white-collar male informants. In the study, the barriers to colorectal cancer screening program causes late diagnosis of colorectal cancer and thus causes male blue-collar informants to have a higher risk of colorectal cancer.

However, Cai et al.,'s (2009) findings contrasted the findings of Hsing et al.,'s (1994) study in Shanghai on the risk of prostate cancer in relation to participants' occupation type in the categories of white- and blue-collar. The findings of Hsing et al., suggest that those in the white-collar categories such as professionals, government officials, clerical workers, and salespersons; involve a low level of physical activity which then lead to obesity, and are later associated with an increased prostate cancer risk. This is further enhanced by the findings of Sharma-Wagner et al., (2000). In their study regarding occupational prostate cancer risk factors in Sweden, higher occupational class Swedish white-collar workers generally have less movement during work and thus causing accumulation of fat that may later contribute to the causes of cancer.

Clearly, the fundamental causes of unhealthy dietary habits and unhealthy lifestyle patterns of individuals as well as their health-seeking behaviours, affect a

broad range of health outcomes such as cardiovascular diseases and cancers. Examining the distributions of these sociocultural influences at various levels across the individual's life duration, exposes significant patterns of cancer-inclined symptoms and may then lead to the outcomes of cancer formation. Thus, transdisciplinary[2] research frameworks (Rosenfield, 1992; Hiatt and Breen, 2008) are significant as they take into account the social and cultural factors as determinants of cancer from the sociology perspective and at the same time, able to discover a more complete understanding of the development of cancer via the interactions between social, cultural, and biological factors in cancer etiology. In this study, the researcher further assessed the influences of sociocultural factors in the lifestyle, health, and health-seeking behaviour of the Chinese cancer patients in Kuala Lumpur, particularly during their life before and after they were diagnosed with cancer as well as during the therapeutic journey of the disease.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Chinese are the second largest ethnic group in Malaysia and they are mostly descendants of Chinese immigrants from the Southern part of China during the 19th century (Soontiens, 2007). The latest statistics show that individuals of the Chinese ethnic group represent 23 percent of the estimated total Malaysian population of 28.9 million (Department of Statistics Malaysia, 2010). In chronic diseases such as cancer,

[2] Hiatt and Breen explain 'transdisciplinary research' as follows: "Transdisciplinarity is a process in team science in which members share conceptual and methodologic frameworks to integrate concepts from their own disciplines with those of other scientists to solve a particular problem at hand; in doing so, they develop new concepts and perspectives that go beyond their own disciplines. It differs from a multidisciplinary approach in which groups of scientists independently or sequentially apply their own disciplinary perspectives to a problem, and from an interdisciplinary approach in which scientists are integrated as a team but still work independently from their own disciplinary perspectives" (Robert A. Hiatt, & Nancy Breen, "The social determinants of cancer. A challenge for transdisciplinary science," *American Journal of Preventive Medicine,* vol. 35, no. 2S (2008): S141).

data from the Malaysia National Cancer Registry (NCR) reports show that Chinese in Malaysia have the highest lifetime risk for cancer (1 in 4), compared with other ethnicities in Malaysia such as Indians (1 in 5) and Malays (1 in 7)(Lim et al., eds. 2003; Lim and Halimah Yahaya, eds. 2004; Lim et al., eds. 2008). The most frequently reported cancer sites in Malaysian Chinese males are lung, nasopharynx, rectum, prostate, and stomach. In the Malaysian Chinese females, breast cancer, as well as cervix uteri, rectum, lung, stomach cancers are the most commonly encountered. Given the factual distribution of cancer in the Chinese community, the researcher gained an insight to explore further into the issue of cancer plaguing the Chinese community in Malaysia, the second largest ethnic group in Malaysia, also commonly referred as the Malaysian Chinese.

In terms of cancer studies on Malaysian Chinese, a review of the literature undertaken so far shows that majority of the studies focus on biomedical perspectives of the disease, identifying some primary risk factors for various types of cancer contracted by Malaysian Chinese. Some of the most accepted risk factors include cigarette smoking for lung cancer (Menon and Saw, 1979; Gopal et al., 1988; Yaacob Ismail et al., 1990); salted fish consumption and prolonged occupational exposure to particles, formaldehyde, and heat for nasopharyngeal cancer (Armstrong et al., 1979; Armstrong et al., 1983; Armstrong et al., 1998; Armstrong et al., 2000b); and nulliparity, family history, oral contraceptives as well as obesity for breast cancer (Norsa'adah et al., 2005).

Taken together, another observation obtained from the above cancer studies of biomedical perspective on Malaysian Chinese is that, the biomedical identification of risk factors, in most cases, may have contributed the risk factors to the type of lifestyle adopted by the Malaysian Chinese. However, most of the study findings do not

elaborate on the sociological perspective of how and why the Chinese type of lifestyle has contributed to the various cancer risk factors among the Chinese community in Malaysia (Menon and Saw, 1979; Yip and Ng, 1996; Hejar et al., 2004; Wong et al., 2008). For example, Hejar et al., (2004: 230) in their study assessing the relation between lifestyle practices and breast cancer risks among Chinese women residing in the Klang Valley of Malaysia suggest that there is a positive association between Chinese women's breast feeding practices and their risk of contracting breast cancer, but half of the participants reported not practicing breast feeding. In this respect, the researchers did not elaborate further on other factors from the sociocultural perspective, such as why breast feeding is not been popular among Chinese women.

As such, for further understanding of the occurrences of cancer in the Chinese community in Malaysia, an additional grasp of cancer contraction from the sociological perspective, besides the normal understanding of cancer from the biomedical perspective, provides a holistic approach to analysing the disease. According to Conrad and Gallagher (eds., 1993: 89 - 91), the sociological explanation in the issue of cancer rests upon the facts that some of the principal risk factors identified by professional health care providers associated with cancer are behavioural factors, that is lifestyle and daily activities such as smoking, alcohol drinking, exercise, and diet. To the researchers, a sociological approach observes that these behavioural factors practiced by the individuals in an ethnic community are deeply influenced by the particular community's cultural values and beliefs. The cultural values and beliefs which include religious values and beliefs, influence directly or indirectly, the individuals' attitudes and values about ways of living such as food and drink preferences, living and working environment, ways of relaxing, and patterns of entertaining. In addition, the ethnic community's cultural values and beliefs also

influence the individuals' behaviour, particularly their health-related behaviour such as health preventive practices, knowledge on etiology of disease, and perception of health and illness.

With regard to the sociological perspective in looking at cancer risks in a Chinese community, Quah (1980) in her survey on the highest cancer risk among Chinese in Singapore as compared to Malays and Indians highlights that the Chinese community (34 percent) exercise less regularly as compared to the Malays (59 percent). In addition, more Chinese (35 percent) were found to be alcohol drinkers as compared to Malay (5 percent). Here, Quah's findings on cancer in relation to the Chinese community and culture in Singapore from the sociology perspective has produced an insight to the causes of cancer focusing on the community's lifestyle, such as lack of physical exercise due to long working hours (Welford, 2008) and regular alcohol drinking habit due to frequent entertaining activities (Xu and Bao, 2000). However, these Chinese cultural factors were only mentioned as the link between factors, but were not given sufficient elaboration of sociological interpretations with regards to the link of factors.

Another significant feature of Chinese cultural setting in a Chinese community is shown by Wu et al., (2006) in their study on knowledge and related beliefs of breast screening services of the Chinese ethnic group residing in the Midwestern United States. Results of their study suggest that Chinese women generally subscribe to their cultural beliefs that if they feel they are in good health, they would ignore breast screening services. There is always a fear in them that if they participate in the screening when they do not feel any discomfort physically, the breast screening results may show a positive sign of breast cancer in them. The ignorant attitude in their health and health-seeking behaviours of these Asian Chinese women has become the

main reason for the breasts being the most frequent cancer site among them, as they generally ignore their mild illness symptoms and thus the cancer is usually at a more advanced stage when diagnosed.

The available literature from the above discussion indicates that sociocultural factors found in a Chinese ethnic group over the past decade have consistently displayed a strong association with the characteristic lifestyle, health, and health-seeking orientation of the Chinese community. In the Chinese community, social, cultural, and religious values are closely intertwined in their Chinese culture, of which these factors immensely influence their ways of life and perceptions towards health and illnesses, such as the management of cancer (Woo, 1997). For instance, Menon and Saw (1979), in an overview of lung cancer cases in the University Hospital of Malaysia between 1967 and 1976 indicate that the excess risk for Chinese population in Malaysia to develop lung cancer was related to several social issues such as the living and working environment of the Chinese community in Malaysia.

In respect to Menon and Saw's (1979) findings, the Chinese community in the 1970s in Malaysia, as Hirschman (1975: 2-3) explains, were mostly labourers working and residing in the urban areas of the country due to British colonialism. Under British rule, which began in the eighteen century, large numbers of Chinese labours were brought in to Peninsular Malaysia for tin mining development in the urban centres and they later remained to settle permanently in the country. As urban centres grew and developed in response to industrialisation process, the urban centres were largely populated by Chinese traders and labourers, mostly associated with manufacturing-sector employment as well as transportation sector. Thus, Chinese ethnic group in Malaysia have been all this while living and working in the city centres since 1970s and thus have constantly expose to the atmospheric pollution in

their living and working environment in the manufacturing and transportation sectors, which plays a significant role in workers developing diseases such as cancer.

Another cancer etiology study regards sociocultural issues in a Chinese community in relation to cancer diagnosis. Wong et al.,'s (2009) quality study to explore knowledge, attitudes, and beliefs of Malaysian women in cervical cancer screening indicates that sociocultural beliefs of the Malaysian women in diseases such as cancer is fatalistic, and beliefs that cancer is incurable regardless of the method of treatment have been shown to prevent and delay the Chinese people from seeking professional healthcare services prior to cancer diagnosis.

Further, in relation to the discussion of cancer diagnosis and method of treatment, culturally-related health practices inherited from their great grandparents from China, particularly with regards to the use of self-medication and home remedies, were among the practices of a minority group of the Chinese people in Malaysia. In a recent survey among Chinese people with lung cancer in Malaysia, Loh et al., (2006) found that 18 percent of their study subjects opted out of cancer-specific conventional therapy such as surgery, chemotherapy or radiotherapy and sought alternative medical practices in improving survival chances. The use of alternative therapies such as Chinese herbal medicines, religious prayers, dietary supplements, qigong, and massage among the Chinese were seen as an act to complement their identified conventional therapy. Most Malaysian cancer studies provide evidence that most cancer patients prefer Western therapies to treat the disease and consume Chinese herbal medicine to reduce the side effects of the western treatment, but do not discuss much the sociocultural factors that lead to the use of the Chinese herbal medicines in providing a holistic approach to healthcare (Loh et al., 2006; Syed Shahzad Hasan et al., 2009). As such, further sociological studies are needed to explore the purpose of