THERAPEUTIC PRACTICES IN EVERYDAY LIFE:

ILLNESS AND HEALTH SEEKING IN A RURAL COMMUNITY IN SRI LANKA

BY

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ABSTRACT

Therapeutic practices are enacted by people, around the world, as a means of improving or restoring health. While the ubiquity of therapeutic practices is well documented, there is surprisingly little research into the concrete practicalities of their enactment in everyday life. Further, the contemporary social scientific literature on medication use and care practices is largely concentrated on Western societies and/or the Global North, with a pronounced lack of contemporary studies into small rural communities which straddle the old/new worlds of biomedical and traditional therapeutics.

The present study was designed as a focused/ short-term ethnography on a rural resource-poor community in Sri Lanka. It was shaped around questions on people's understanding(s) of diverse therapeutic practices, their enaction in participant homes, the flow of medications to and from the homes, and therapeutic practices as implicated in the everyday life of the households and the community. I, a Sri Lankan researcher, carried out the fieldwork in one village over a period of nearly three months. The principal method of data generation was household interviews: 20 interviews which included 47 participants (15 men, 25 women and seven children). To gain greater insights into therapeutic practices in the households, photography (of medications) and participant observation (of treatment seeking activities) were used. Additionally, four popular local healers were interviewed in order to better understand the practices involving traditional therapeutics.

Prior to analysis, the household interviews (carried out in Sinhala language) were transcribed and translated to English. Interview data, photographs and fieldnotes were thematically analysed through an iterative analytical process of coding, identifying themes, and drawing out key concepts. The conceptual framework was built primarily on the theoretical work of Veena Das and Annemarie Mol, to explore therapeutic practices as situated and arising within ordinary life.

The findings of the study point to the complexities of a diversified postcolonial therapeutic landscape as played out in resource-poor households. On the whole, household therapeutic practices were identifiable in relation to one or more of the following therapeutic modalities: 'English medicine' (biomedicine), 'Sinhala medicine' (traditional herbal medicine), supernatural therapeutics, and Buddhism-inspired religious healing. As such, therapeutic practices appeared as hybrid practices that seep into and merge different therapeutic modalities; however, the therapeutic potential of these enactions remains situated and relational. Further, medications are entangled in relations of risk, responsibility and trust, as implied through their spatiality in the homes. They are

also variously implicated in time, such as in terms of temporal organisations of treatment and generational transmission of therapeutics.

In addition, it was found that people access a range of healthcare providers, from public hospitals providing fully subsidised healthcare (which, however, often involve other costs) to fee-levying biomedical/traditional practitioners and community pharmacies. Cost-effectiveness of treatment is often prioritised, given the overriding economic concerns of households. Once treatment is received, it is variously adapted, modified or even discontinued within the home. Be it in navigating healthcare settings where they get marginalised as poor and less educated, or in adapting therapeutics to suit their needs and circumstances, what becomes clear is the ingenuity, perseverance and care with which people engage in health seeking and therapeutic practices. I draw on Annemarie Mol and colleagues' notion of 'tinkering' in care practices, and propose a complementary metaphor of 'wrangling' to capture the complexities and contingencies of health seeking in a resource-poor community.

As such, the present study aims to contribute new empirical knowledge on therapeutic realities in a postcolonial/non-Western setting, as well as useful insights to inform public health and policy development in the country. In terms of theoretical contribution, the study seeks to problematise the productivity of Western theoretical notions when adapted to make sense of lived experiences elsewhere. The potential of a situated ethnography in furthering a decolonial research approach towards postcolonial/indigenous/non-Western societies is also examined.

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TABLE OF CONTENTS

Abstract i
Acknowledgements iii
List of Tables and Figures x
Glossary of Terms in Sinhala Language xi
CHAPTER 1: INTRODUCTION 1
Sri Lanka: An overview 1
Healthcare organisation in Sri Lanka 3
Free healthcare policy 3
Public sector 4
Private sector 5
Non-biomedical therapeutics 6
Contemporary therapeutic landscape in Sri Lanka 7
Treatment seeking trends 8
Outline of the thesis 9
CHAPTER 2: LITERATURE REVIEW 11
Therapeutics in everyday life 12
Personal, moral and social dimensions of medication use 13
Implications of therapeutic diversity 15
Therapeutic decisions and treatment seeking 16
Postcolonial and/or non-Western therapeutic landscapes in the Global South 19
Situating therapeutic practices in the household 22
Postcolonial/decolonial concerns and their implications 24
Limitations of (Western) scholarship on non-Western/postcolonial therapeutic landscapes 25
Eurocentrism, cultural difference and the Non-Western 'other' 26
Implications of Western research hegemony and trends of decoloniality 29
Theorising therapeutic practices in everyday life 30
Ordinary life: Living with the fragility and circumstantiality of the 'ordinary' 31
Care practices and 'tinkering' 34
The present study: theoretical implications and delimitations 36
CHAPTER 3: METHODOLOGY 38
Research design 39
Fieldwork setting 39
Fieldwork as ethnography 43
Qualitative interviews in and as ethnography 45

Interview process 48
Recruitment of participants for household interviews 48
Requesting consent for participation 53
Conducting household interviews 54
Photography 56
Managing contingencies: Involvement of non-householders in household interviews 57
Ethical concerns of fieldwork 59
Transcription and translation of interview data 62
Analytic procedure 63
Thematic analysis 63
Coding 64
Themes 65
Reflections and writing up 66
Collaborative process 67
Reflections on researching 'home' 68
CHAPTER 4: HOUSEHOLD THERAPEUTIC PRACTICES: DIVERSITY AND HYBRIDITIES 71
Popular therapeutic modalities 71
English medicine 72
Sinhala medicine 73
Supernatural healing 76
Spiritual and religious healing 79
Hybridising practices, hybrid therapeutic categories 81
Sinhala medicine - religious healing - supernatural healing 82
Sinhala medicine - English medicine 85
Therapeutic hybridity and sense making 86
Practitioners and therapeutic hybridity 87
Discussion 88
CHAPTER 5: THERAPEUTIC PRACTICES: SITUATEDNESS, RELATIONALITY AND FLUIDITY 91
Medications as *beheth* 91
'Being therapeutic' as relational and fluid 92
Prescription and expertise 93
Familiarity and experiential knowledge 99
Contestation by dominant knowledges/practices 102
Malpractices and lack of practitioner integrity 106
Long-term illness and karma 107
Discussion 109

Trust in therapeutic practices 111
Elusiveness of (good) health 112
CHAPTER 6: NAVIGATING THE HEALTHCARE LANDSCAPE 113
Treatment seeking from public hospitals 113
Features of treatment seeking experiences in the public sector 114
Dissatisfaction with patient care 117
Circumventing the system 121
Treatment seeking from private practitioners 123
Kodagoda mahaththaya's private practice 124
Lunuwila nona's private practice 126
Features of treatment seeking from private practitioners 128
Movement between the public and private sectors 130
'Channelling' a specialist 131
Conflicting interests across the public-private divide 132
Treatment seeking at community pharmacies 135
Features of community pharmacy services 136
Risky pharmacy practices 137
Enabling personalised medication practices 137
Discussion 139
Prioritising convenience, flexibility and cost-effectiveness 139
Less emphasis on practitioner-patient relationship 140
Dealing with (ill)health within everyday circumstances 142
CHAPTER 7: SITUATING THERAPEUTIC PRACTICES IN HOUSEHOLD SPACE(S) AND TIME(S) 144
Therapeutic practices and their spatiality 144
Spatiality of shared medications 145
Storing medications: packaging, containers 146
Spatiality of traditional remedies: The kitchen and the home garden 148
Children, medications and risk 150
Medications for long-term use 151
Emplacement of medications, risk and responsibility 154
Therapeutic practices and their temporality 156
Long term medication practices as routines 157
Giving time for the body to heal 158
Waiting prior to seeking professional healthcare 159
Therapeutic practices across time: Linking the past and the present 161
Therapeutic practices linking generations: transmission, continuity and disruption 164

Discussion 167
Risks in therapeutic practices 168
Responsibility 169
CHAPTER 8: PERSONALISING THERAPEUTIC PRACTICES 171
Seeking therapeutics compatible to oneself 171
Notions of therapeutic efficacy 172
Experimenting with herbal alternatives 175
Seeking information on therapeutic alternatives 176
Discontinuation of therapeutics 178
Negative experiences with therapeutics 179
(Prolonged) use of therapeutics conflicting with ordinary life 181
Perceived (non-)need for medications 184
Adapting and calibrating of therapeutic practices 187
Reducing the intake of pharmaceuticals 187
Altering the composition of herbal remedies 188
Idiosyncratic mobilisations of religious/occult beliefs 190
Discussion 192
Issues of dependence and deservingness 194
Local 'good' outcome(s) 195
CHAPTER 9: CONCLUSIONS, IMPLICATIONS AND REFLECTIONS 196
Understanding therapeutic practices in rural Sri Lankan households 196
Therapeutic practices as hybrid, situated, relational and fluid 197
Organising therapeutic practices: Cost-effectiveness, risk and responsibility 198
Delimiters of therapeutic practices: (in)compatibility, perceived (non)need, maintenance of the ordinary 200
Tinkering as metaphor: perseverance, adaptability, making adjustments 201
Knowledges, power and politics in/of diverse therapeutic modalities 204
Implications of Buddhist religiosity in/on the study 206
Healthcare landscape and treatment seeking 208
Therapeutic engagements, delay and 'active waiting' 208
Issues in the provision of healthcare services 210
Epistemic issues affecting treatment seeking experiences 211
Issues identified and some recommendations 213
Therapeutic practices as entwining the personal, the social and the ethical 215
Ordinary ethics in therapeutic practices 217
Looking ahead: Future research directions 219

REFERENCES 223
Appendix 1: Ethics approval received for the study 234
Appendix 2: Information Sheets, Consent Forms, Translator Confidentiality Agreement 236
Information sheet for participant households (English and Sinhala versions) 236
Consent form for household interview participants (English and Sinhala versions) 242
Consent form for children's participation in the study (English and Sinhala versions) 244
Information sheet for local healers participating in the study (English and Sinhala versions) 248
Consent form for local healers participating in the study (English and Sinhala versions) 254
Confidentiality Agreement with the Sinhala – English Translator 256
Appendix 3: Topics for discussion with households 257

LIST OF TABLES AND FIGURES

Table 1 50
Figure 1 146
Figure 2 147
Figure 3 149
Figure 4 151
Figure 5 152

GLOSSARY OF TERMS IN SINHALA LANGUAGE

adura	a practitioner in supernatural healing who performs sorcery and/or exorcism.
adurukam	sorcery/exorcism.
akka	kinship term meaning 'elder sister'. Also used after a person's name. e.g. 'Sujatha akka'.
amma	kinship term meaning 'mother'. Also used to address elderly women, denoting respect for their seniority; or any woman who is pregnant or has children.
as-waha, kata-waha	literally means evil-eye and evil-mouth. The malicious or envious gaze or words of someone considered to be capable of causing harm.
atgunaya	an exceptional capacity to heal, which is attributed by treatment seekers to certain therapeutic practitioners.
ayya	kinship term meaning 'elder brother'. Also used after a person's name. e.g. 'Sumith ayya'.
beheth	medicine, medications, treatment.
bodhi puja	Buddhist religious practice of venerating the sacred Bo tree (*Ficus religiosa*).
budu-guna	the supra-human qualities of the Buddha, as described in Buddhist scriptures and religious verses.
dehi kapuma	supernatural ritual of benediction that involves the cutting of lime-fruit.
deseeya chikitsa	the indigenous therapeutic tradition of Sri Lanka, which dates back to several millennia.
devale	shrine for god(s). Usually there is a priest/ess who appeals to the gods on behalf of the people that seek divine blessings or assistance.
duva	kinship term meaning 'daughter'. Also used after a person's name.
Grama niladhari	*Grama niladhari* (GN) division is a sub-unit of a Divisional Secretariat (DS) division, and the smallest administrative unit that is under the purview of

	the Ministry of Home affairs. The government officer in-charge of a GN division is the *Grama niladhari*.
ingrisi beheth	literally, 'English medicine'. This is the colloquial term for biomedicine in Sri Lanka.
kadum-bidum	traditional orthopaedic treatment.
kalka	a type of herbal medicine, often used as tonics.
kasaya	herbal potion(s), prepared by boiling together diverse ingredients and letting it boil down. Most often prepared at home, following a given recipe.
mahaththaya	'Mr'/ 'sir', or 'husband'. Also used after a person's name, denoting respect for high(er) social status. e.g. 'Kodagoda mahaththaya'.
malli	kinship term meaning 'younger brother'. Also used after a person's name.
mama	kinship term meaning 'uncle'. Also used after a person's name.
mantra	chants used in supernatural rituals.
mathirili	charms; supernatural healing that involves the chanting of *mantra.*
nanda	kinship term meaning 'aunt'. Also used after a person's name.
nangi	kinship term meaning 'younger sister'. Also used after a person's name.
nona	'Madam'. Also used after a person's name, denoting respect for high(er) social status. However, it may also be used as a nickname, e.g., 'Punchi nona'.
paspanguva	five herbs to be boiled together to prepare a herbal potion. A very common remedy for colds. Nowadays these herbs are also available for purchase in ready-to-boil packets.
paththu	herbal plasters, often used in traditional orthopaedic treatment.
pin	merit accumulated through good deeds, as defined in the Buddhist doctrine. It is capable of contributing to one's wellbeing in the present life as well as in subsequent births.
pinas/ pinas roga	a condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma"

	(Obeyesekere, 1976, p. 216). As such, this condition does not easily fit into a biomedical framework. Obeyesekere (1976) finds it a "cultural disease par excellence".
Pirith, pirith ceremony	literal meaning being 'protection', *pirith* refers to the chanting of Buddhist scriptures to ensure protection from evil forces, health and wellbeing. *Pirith* ceremony is an all-night event attended by many devotees where Buddhist monks and/or lay devotees chant *pirith.*
pretha	the spirits of the dead who cannot secure a rebirth yet. Buddhists consider most *pretha*s to be insatiable beings who in their previous birth had craved after material things and continue to do so in their present state of limbo.
putha	kinship term meaning 'son'. Also used after a person's name. As a term of endearment, *putha* ('son') can be used irrespective of the addressee's gender.
santhikarma	rituals of benediction, commonly performed as a part of supernatural healing.
sara	harsh, very strong.
sema	phlegm.
Sinhala beheth	literally, 'Sinhala medicine'. This is the colloquial term for traditional (predominantly herbal) medicine in Sri Lanka.
thanikan dosa	literally translatable as 'misfortune of aloneness' (Obeyesekere, 1969). A heightened state of vulnerability to the influence of (malevolent) supernatural forces.
thaththa	kinship term meaning 'father'. Also used to address older men, denoting respect for their seniority.
thovil	exorcism ceremony.
thun-dos	an imbalance of the three bodily humours, *va* (air), *pit* (bile) and *sem* (phlegm). As per the Ayurvedic theory, ill-health is often caused through imbalance of the bodily humours.

CHAPTER 1: INTRODUCTION

This is a study of household therapeutic practices as enacted in everyday life within a rural community in Sri Lanka. Therapeutic practices, in general, are means of seeking or maintaining good health; and the present study explored those that were carried out by people in their homes, in response to ordinary events of ill-health. People resort to therapeutic practices that are perceived as appropriate in a given situation, which may involve self-administration of medications and/or seeking treatment from healthcare provider(s). Their sense of appropriacy is generally framed within people's health-related beliefs and preferences, which may guide the therapeutic choices and shape the treatment trajectories. Therapeutic practices, therefore, need to be contextualised within the broad trends of healthcare provision that determine the availability and accessibility of services for people, in addition to the array of therapeutic alternatives that make up their therapeutic landscape.

Given the general paucity of sociological research into health-related matters in Sri Lanka, and in the Global South more broadly, the present study offers valuable empirical insights to enrich the academic knowledge base. As a study focusing on the household as a nexus of therapeutic practices, it contributes to the growing body of research that explores health and illness as situated phenomena of ordinary life. In addition to academic significance, the research findings on household therapeutic practices have practical relevance as well, in terms of potentially informing future health policy development in Sri Lanka.

This chapter sets the stage by laying out the context of the study. First, I provide a brief overview of Sri Lanka, the country where the study was carried out. This is followed by a description of the organisation of healthcare in Sri Lanka, particularly the 'free healthcare policy' and the public-private division of healthcare. Next, I map out the contemporary therapeutic landscape of the country, outlining the significance of different therapeutic modalities in terms of their institutional, historical and cultural positionings. I also point to the salient therapeutic trends that have been identified in the country. The chapter concludes by providing an outline of the rest of the thesis.

Sri Lanka: An overview

Situated as a tropical island in the Indian Ocean, Sri Lanka forms part of the South Asian subcontinent. Its multi-ethnic population of over 21 million consists predominantly of Sinhalese (74.9%), Tamils and Moors (Central Bank of Sri Lanka, 2018). Buddhism is the state religion observed by 70.1% of the people, while Hinduism, Islam and Christianity are also practised (Central Bank of Sri

Lanka, 2018). Following its celebrated (and documented) ancient history dating back several millennia, Sri Lanka has undergone nearly 400 years of European colonisation, as well as much political and ethnic turbulence in the recent past. With a 30 year-long state of ethnic strife and terrorism officially ending in 2009, the country remains more or less vulnerable in terms of financial and political stability as well as social cohesion.

While urbanisation has been an ongoing trend in Sri Lanka for decades, only 18.2% of the population was documented as urban dwellers in 2012 (*Annual Health Statistics 2019 Sri Lanka*, 2021). It should also be noted that this urbanity is limited to a few densely populated major cities and developing urban centres. For example, Colombo district, consisting of about 1.2% (800 sq.km) of the country's land area, is the home for nearly 10% of the country's population (i.e., over two million). Beyond such 'urban pockets', the vast majority of the country's population (77.4%) was classified as rural (Department of Census and Statistics Sri Lanka, 2015a). The remaining 4.4% of the population was identified as the estate sector, made up of people living within or in close proximity to commercial plantations (often tea or rubber) in which most of them were employed[1].

Sri Lanka has been classified as a developing country (middle to low income), and the standards of living remain quite low in economic terms. 843,913 of its people (4.1%) have been officially categorised as 'poor' in 2016 (Department of Census and Statistics Sri Lanka, 2017b), while nearly 45% of the population lived on less than five USD per day in 2013 (The World Bank, 2017). However, Sri Lanka ranks relatively high in terms of social development: its human development index was 0.782[2] in 2019, literacy rate 93.1 (in 2016) and life expectancy 75 years (in 2015) (*Annual Health Statistics 2019 Sri Lanka*, 2021; Central Bank of Sri Lanka, 2018). Such progress in social, health and education-related indices are largely attributable to the successive governments' focus on welfare policies, particularly the universal free education and free healthcare policies implemented since the 1950s.

[1] Most of them are descendants of South Indian migrants settled in the country as plantation workers during the British colonisation.

[2] Human Development Index (HDI) is a measure of the development of a country in terms of health, education and income, reported annually by the United Nations Development Programme. In 2020, Norway had the highest HDI in the world, which is 0.957. Sri Lanka, with an HDI of 0.782, was ranked 72nd. (http://hdr.undp.org/en/content/latest-human-development-index-ranking)

Healthcare organisation in Sri Lanka

Sri Lanka's healthcare provision has undergone radical change from its historical past to the present, through the centuries of colonisation and postcolonial governments' health policies. As early as the 4th century BC, Sri Lanka is documented to have had a well-developed healthcare system, including one of the world's first hospitals (Uragoda, 1987). The pre-colonial healthcare system in the country was based on the indigenous *deseeya chikitsa* therapeutics and Ayurvedic, Siddha, Unani and other Asian therapeutic approaches. The Western medical tradition was brought into the country by its various European colonisers between the 16th – 20th centuries; and it was during the British rule (1815 – 1948) that a comprehensive Western medicine-based healthcare system was implemented in place of the traditional system that was in disarray amidst the political chaos of the time (Arseculeratne, 2002; Uragoda, 1987).

Since the colonial government's medical facilities were extended to the local population in 1858, Western medicine had been the state sponsored and mainstream therapeutic modality in Sri Lanka (Kumar, 2019; Uragoda, 1987). Post-coloniality did not impact significantly in this regard as the colonial policy of prioritising Western (bio)medicine was continued after the country became a sovereign state in the late 20th century. Similarly unchanged was the marginalisation of traditional indigenous therapeutics within the biomedicalised healthcare system (Arseculeratne, 2002; Jones & Liyanage, 2018).

Free healthcare policy

Unarguably, the most significant health policy implemented in (postcolonial) Sri Lanka is that of free healthcare provision, which has been effective from 1951. The 'free healthcare policy' covers the entire public sector: "state-financed and administered healthcare facilities that remain free of charge at the point of use, covering about 50% of outpatient services, 90% of inpatient admissions, and nearly all preventive services" (Kumar, 2019, p. 1). The impact and reach of this policy are such that it is commonly credited as the basis for the rather impressive performance of the country's healthcare system.

In effect, Sri Lanka has some of the best health indicators among its regional counterparts and records high performance in nearly all aspects of health service coverage as measured by the World Health Organization, including capacity, low maternal and infant mortality rates, as well as elimination status in several communicable diseases (*2018 Health SDG Profile: Sri Lanka*, 2018; Kumar, 2019). This performance is achieved with remarkably low investment in the healthcare

sector: in 2019, the government's health expenditure was 1.8% of GNP, and its per capita expenditure was 12,037LKR (equivalent to 67USD) (*Annual Health Statistics 2019 Sri Lanka*, 2021). Accordingly, Sri Lanka has been hailed as an example of excellent health service provision at a low cost (Kumar, 2019).

Public sector

The state-funded public sector (predominantly biomedical) healthcare system operates under the purview of the Ministry of Health. It comprises two separate divisions: curative services, delivered through a network of hospitals and other institutions throughout the country, and community services, aimed at preventive health and promotion of maternal and child health. The community services are largely clinic-based, such as immunisations and antenatal care, while public health teams —especially midwives—also visit homes. The curative division is currently comprised of a total of 643 hospitals that offer in-patient care; all of which, as well as numerous primary medical care units, also provide outpatient treatment (*Annual Health Statistics 2019 Sri Lanka*, 2021).

The public sector continues to dominate the healthcare provision in the country. It covers the bulk of in-patient care in the curative sector[3], as well as nearly all of the community health services island-wide (*Annual Health Statistics 2019 Sri Lanka*, 2021). The community services, in particular, have been noted for their exceptional coverage. To illustrate, 99.5% of pregnant women are attended by skilled personnel, and over 90% of children under three years of age have undergone the scheduled immunisation programme (*Annual Health Statistics 2019 Sri Lanka*, 2021; Kumar, 2019).

At the same time, several serious challenges that undermine the effectiveness of public healthcare provision in Sri Lanka have been identified. One is the inadequate state investment in the health sector, which, as mentioned above, is currently at less than 2% of GNP (*Annual Health Statistics 2019 Sri Lanka*, 2021). This has led to many issues including medicine shortages, inadequate staffing, lack of resources, underdeveloped technology and inadequate capacity at hospitals that affect the quality of healthcare offered in the public sector.

Another significant issue is the lack of a proper system of referral from primary care level to secondary and tertiary care. As it is, people may access treatment at any public healthcare institution of their choice. Many prefer the (often better equipped and highly reputed) secondary and tertiary care hospitals located in urban centres over primary care institutions and peripheral

[3] Private sector also provides curative services, though it is most in demand with regard to out-patient care.

hospitals. While this is a pragmatic choice on the part of the people who seek the best available healthcare, this trend has led to a clear asymmetry of resource utilisation in the public sector. The urban and secondary/tertiary level hospitals are always over-crowded and their resources are extended beyond capacity, while many of the rural institutions remain underutilised (S. Perera et al., 2019; Senanayake et al., 2017).

Private sector

Apart from public sector institutions where treatment is fully subsidised at the point of use, there is a thriving private healthcare sector in the country. An offshoot of the 'open economy' policy of 1977, the private sector of the healthcare system consists of institutions and practitioners who offer healthcare services for a fee. Most private healthcare institutions are located in urban areas, the largest number being found in Colombo[4] (*Annual Health Bulletin 2017*, 2017). At present, there is an immense overlap of the public and private sectors in terms of human resources. A vast majority of the professionals in the biomedical private health sector, including 83% of medical officers and 99% of specialists, work as part-time or visiting staff, since many of them are (salaried) employees of the public sector and do private practice only in their spare time (*Annual Health Bulletin 2017*, 2017).

Potentially the most important service provided in the private sector is that of 'channelling'. This is a process of self-referral to a medical specialist of choice through advanced booking. Given the busy-ness and overcrowding in a public hospital, a patient is hardly likely to be examined by a specialist unless they were admitted to the relevant hospital ward; whereas 'channelling' would permit them the opportunity of a private out-patient consultation with the specialist. There are numerous private hospitals and 'channelling centres' throughout the country that are involved in this process. In rural areas, people usually pay a local channelling centre to book an appointment on their behalf at an urban private hospital.

Private sector healthcare services are very much in demand, especially in primary care provision (*Annual Health Bulletin 2017*, 2017). Given the deficiencies in the public sector, the private sector is flourishing as a popular alternative. People who seek a more convenient or higher quality of care than is offered by the fully subsidised public sector services and are prepared to incur out-of-pocket

[4] Colombo is the commercial capital as well as the most densely populated city in the country.

expenditure[5] are increasingly attracted to the private sector (Russell, 2005). Whereas the adoption of advanced technologies and more patient-centred care contribute to high patient satisfaction, it has been suggested that the private sector does not provide higher quality of clinical outcome in comparison to the public sector (Rannan-Eliya, Wijemanne, Liyanage, Dalpatadu, et al., 2015; Rannan-Eliya, Wijemanne, Liyanage, Jayanthan, et al., 2015).

Private sector healthcare services are monitored by the Ministry of Health. The regulatory framework requires that private medical and dental practices be registered under the Private Health Services Regulatory Council of the Ministry of Health, and to follow the relevant guidelines. Similarly, community pharmacies are expected to adhere to guidelines issued by the National Medicines Regulatory Authority. However, their proper enforcement has been questioned, raising concerns regarding the quality of care offered by some providers (Athuraliya et al., 2016; Sakeena et al., 2019).

Non-biomedical therapeutics

Provision, promotion and regulation of traditional, indigenous and non-biomedical medicines come under the purview of Ministry of Health (*Annual Health Bulletin 2017*, 2017). Ayurveda, Unani, Siddha, Homeopathy and Acupuncture are among the non-biomedical therapeutics that are recognised as a part of the country's health system. However, given the state sponsorship and mainstreaming of biomedicine and the general biomedical dominance over the healthcare system, non-biomedical therapeutics have only a marginal presence.

In 2017, for example, biomedical services were made available through an island-wide public sector network of 628 hospitals providing curative services (total bed strength 83,275), 496 primary medical care units, and 341 Medical Officer of Health (MOH) regional offices providing community health services, in addition to nearly 1000 private sector healthcare providers registered[6] with the Ministry of Health (*Annual Health Bulletin 2017*, 2017). In comparison, the public sector non-biomedical healthcare provision consisted of 708 institutions in total, including both hospitals and

[5] Only around 11% of the population is covered by some form of health insurance, as per the National survey on self-reported health 2014 (http://www.statistics.gov.lk/Health/StaticalInformation/NationalSurveyonSelf-reportedHealthinSriLanka2014). Therefore, for a vast majority of illness incidents in the country, any costs of treatment seeking are being borne as out-of-pocket expenditure.

[6] It should be noted that there are also private medical practices that are not registered with the Ministry (and therefore are not being monitored as per the regulatory framework). The Annual health Bulletin 2017 acknowledges the lack of official statistics on the private sector, due to which the actual expansion of private sector would likely be much greater than the official figures suggest.

dispensaries, and a bed strength of 4006 (*Annual Health Bulletin 2017*, 2017). There being no official statistics on non-biomedical healthcare provision in the private sector, it is difficult to determine its expansion and capacity. Previous research, however, points to an array of traditional practitioners, some of them operating within the government regulations while many do not. They often specialise in treatment for one or few illnesses or conditions (e.g. snakebite, fractures, burns), and some (non-registered) practitioners provide services free of charge (De Silva, 2015; Nordstrom, 1988).

The limited availability of non-biomedical treatment in the country, as opposed to the proliferation of the biomedical, is an obvious hindrance to people's accessing them as treatment alternatives to biomedicine. Other challenges for the non-biomedical sector include inadequacy of resources such as funding, trained staff and new technology, as well as a lack of research and innovation that curtail the generation of new knowledges (Arseculeratne, 2002; Jones & Liyanage, 2018). Further, government regulatory frameworks, often guided by a biomedicine-inspired 'scientific' model, tend to selectively support and promote certain branches of traditional therapeutics while neglecting others. When thus shaping traditional therapeutics into institutionally-acceptable versions, some of their socially and culturally significant elements are in danger of being lost forever (De Silva, 2015).

Contemporary therapeutic landscape in Sri Lanka

The institutional prominence of biomedicine as well as the historical and cultural relevance of traditional indigenous medicines have both shaped the contemporary therapeutic landscape. For decades, biomedicine has been reported as the overwhelmingly popular therapeutic modality in the country (Jones & Liyanage, 2018; Liyanage, 2000; Weerasinghe & Fernando, 2011; Wolffers, 1988). The proliferation of biomedical healthcare providers in the country that guarantees convenient access to biomedical treatment, as well as biomedicine's recognition as the mainstream state-sponsored medicine, have contributed to its wide-spread uptake. In comparison to biomedicine, traditional therapeutics are less in demand, though they continue to be closely entwined with people's way of life. To illustrate, it has been observed that the general perceptions of health and illness among Sri Lankans, as well as their notions of treatment efficacy with regard to any therapeutic intervention, are largely situated in lay appropriations of Ayurvedic theory (Nichter & Nordstrom, 1989; Obeyesekere, 1976).

The indigenous therapeutic tradition of Sri Lanka, *deseeya chikitsa*, has historically and ongoingly been heavily influenced by the medical traditions of Ayurveda, Siddha and Unani. Ayurveda and Siddha originated in India, and Unani in ancient Greece, though they have all been practised for millennia in the Indian subcontinent (Jaiswal & Williams, 2017; Sheehan & Hussain, 2002; Weiss,

2009). Through the years, these multiple traditions have more or less merged and developed into a composite traditional medicine in the country, which the Ministry of Health refers to as 'Ayurveda'. This term could be justified in the sense that the Ayurvedic tradition tends to dominate the traditional medical scene in the country. A majority of practitioners (meaning everyone other than the generational practitioners who train through apprenticeship, and the unqualified practitioners or 'quacks') undergo training in state-approved Ayurvedic medical programmes and go on to practice Ayurvedic medicine (Arseculeratne, 2002). However, traditional medicine is popularly known among the people as *Sinhala beheth* (Sinhala medicine), which draws on its core of local indigenous therapeutics[7]. The colloquial term for biomedicine being *ingrisi beheth* (English medicine), the two therapeutic modalities appear to be discursively situated in polar opposition through an evocation of the country's colonial past.

There are other (variously related) local healing traditions that harness the occult, the supernatural and spiritual/religious beliefs. While unrecognised in the national healthcare framework, these continue to hold traction among the population. Methods such as *adurukam* (sorcery/exorcism), *mathirili* (charms) and *thovil* (exorcism ceremony), whereby various supernatural elements are appealed to or propitiated, are indicative of such therapeutics (Kapferer, 1979; Obeyesekere, 1969). Horoscope reading, astrology and divination are also popularly accessed during treatment seeking as means of facilitating the healing process (Amarasingham, 1980; Hettige, 1991).

Treatment seeking trends

The long-standing therapeutic diversity in the country has given rise to certain popular practices of treatment seeking that span multiple therapeutic modalities. In terms of treatment preferences, it has been suggested that people often resort to biomedical treatment for acute conditions and/or in search of a quick relief. On the other hand, they may seek traditional medicine for potentially chronic conditions or where biomedicine does not offer an effective cure. Traditional orthopaedic *kadum-bidum* treatment is found to be particularly sought after for bone fractures, dislocations and sprains. In addition to these, supernatural healing, astrology and religious methods also feature in many people's treatment seeking trajectories. The diverse healing traditions may be accessed either sequentially as therapeutic alternatives, or simultaneously to complement each other, based on the

[7] Sometimes a distinction is made between versions of traditional medicine: *Ayurveda* being medicine administered by a formally (meaning Ayurvedically) trained practitioner, and Sinhala medicine, by a generational/informal practitioner. For example, see Russell (2005).

context of application (Amarasingham, 1980; Broom et al., 2010; Hettige, 1991; Liyanage, 2000; Weerasinghe & Fernando, 2011; Wolffers, 1988).

The urban rural divide was previously reported as important in terms of therapeutic uptake, with biomedical treatment being more in demand in the urban areas while the villagers preferred traditional therapeutics (Wolffers, 1988). This however could be more of a matter of availability and accessibility of therapeutics than preference: for most of biomedical practitioners and hospitals used to be located in urban settings, and traditional therapeutic practitioners, on the other hand, were easily accessible even in more peripheral areas. More recent findings point to a wider availability—and greater uptake—of biomedical services throughout the country spanning both urban and rural locales (Liyanage, 2000; Weerasinghe & Fernando, 2011).

Parallel to the popularity of biomedicine is a high utilisation of home remedies at the outset, as well as a general decline in accessing traditional practitioners. Home remedies, particularly herbal medicines, have always had high traction as a first resort prior to seeking professional therapeutic treatment (Liyanage, 2000; Wolffers, 1988). Conversely, the demand for treatment from traditional practitioners appears to be waning. It is customary that traditional practitioners give a prescription for herbal potions (and other medications), based on which one needs to find the necessary ingredients, prepare the medication(s) at home and use them as prescribed. The arduousness of this process has reportedly deterred many people from traditional medicine (Liyanage, 2000; Weerasinghe & Fernando, 2011). There is also a gradual decline in the generational and apprenticeship-based succession of practitioners in the country, and, with there being fewer new practitioners, it would become more difficult for the people to access traditional medical treatment. In addition, the repertoire of traditional therapeutic knowledges, which used to be passed down from one generation of practitioners to the next, may also dwindle away (Bulathsinghala, 2020). This decline of non-biomedical traditional therapeutics, as well as the escalation of biomedicine's popularity, mirror the developments in other postcolonial therapeutic landscapes around the world, as will be discussed in the next chapter.

Outline of the thesis

Based in the diversified postcolonial therapeutic landscape of Sri Lanka, the present study was aimed at exploring therapeutic practices as situated practices in rural households. The ethnographic fieldwork was carried out in one village community in Galle district, Sri Lanka, where I interviewed people from 20 households on their illness and health concerns and treatment seeking experiences.

Data generated through household interviews, photography and fieldnotes were analysed thematically, and presented in the form of this thesis.

This introductory chapter is followed by the Literature review (chapter 2) and Methodology (chapter 3). The analysis of research findings is presented in the five subsequent chapters. Chapters 4 and 5 attempt to make sense of the household therapeutic practices by exploring their diversity, hybridity, relationality and fluidity. Chapter 6 shifts the focus to the local healthcare landscape, tracing the participants' treatment seeking experiences and the flow of medications into the home. Chapter 7 returns to the home, exploring the situatedness of therapeutic practices in household space(s) and time(s). Chapter 8 continues to delve into the therapeutic practices to explore how they become adapted and modified within the home. Finally, chapter 9 brings together these different strands into a general discussion, through which the contributions of the study and the potential future directions are suggested.

CHAPTER 2: LITERATURE REVIEW

The present study explores how therapeutics are used in the everyday life in a rural community in Sri Lanka, a country in the Global South. As such, it intersects several strands of literature broadly classifiable into the disciplinary boundaries of sociology, anthropology and science and technology studies (STS), and is shaped by theoretical insights on postcoloniality, everyday living, and materialities of care practices. This chapter aims to provide a thematic and cross-disciplinary overview of the literature that forms the basis for the present study and the theoretical literature that it is grounded in.

The first section of the chapter brings together contemporary social research findings on themes relevant to the present study. Firstly, I discuss the use of therapeutics in everyday life along personal, social and moral dimensions. Then I move on to the complexities of therapeutic practices occurring in contexts of therapeutic diversity, and how treatment seeking decisions are made and treatment trajectories organised. Next, I turn to the literature that explores postcolonial/non-Western therapeutic landscapes, with their inherent tensions between traditional medicines and biomedicine, as well as their contemporary developments. This is followed by an exposition on the significance of the household in terms of everyday use of therapeutics, where I collate the available findings and make a case for studying therapeutic practices as situated practices in the home.

The second and the third sections of the chapter take on epistemological and theoretical concerns and sensibilities that shape the present study. The second section primarily involves a discussion of postcolonial/decolonial[8] scholarship in its relevance for the study. I first discuss the limitations of mainstream Western academic projects that have explored non-Western therapeutic landscapes, examining them against postcolonial/decolonial critiques. Then I move on to the Global North-South power relations that manifest in academic knowledge production, within the flows of which I reflexively situate the present study as well as myself as a researcher.

In the third (and final) section, I elaborate the theoretical framework of the study. There, I draw mainly from the scholarship of Veena Das (Das, 2006, 2012, 2015a, 2015b, 2020) and Annemarie Mol (Mol, 2008; Mol et al., 2015) to conceptualise household therapeutic practices as situated care practices in ordinary life. The chapter concludes with my reflections on the theoretical and

[8] It needs to be noted at the outset that "postcolonial" and "decolonial" are, by no means, equivalent nor interchangeable (Bhambra, 2014b). In the context of this thesis, I use "postcolonial/decolonial" as a way of referring to the common trend in these two strands of scholarship of exposing and critiquing oppressive power relations, mounting an "intellectual resistance to [colonialism] associated forms of epistemological dominance" (Bhambra, 2014b, p120).

epistemological implications of this situated, decolonial and ethnographic approach in terms of the present study.

Therapeutics in everyday life

Global literature asserts the significance of medications and other therapeutic interventions as a part of people's ordinary lives in contemporary times. With the international expansion of biomedicine in particular, many conditions that were earlier viewed as natural, normal or had merely been taken for granted (such as menopause, depression, social anxiety) are medically redefined and are deemed to require treatment (Conrad, 2008). Since such treatment often takes the form of pharmacotherapy, pharmaceuticals have become ubiquitous items in everyday life. In addition, pharmaceutical products are gaining wider traction as solutions to personal bodily concerns and as means of improving quality of life (Dew, 2019; Fox & Ward, 2008; Sanabria, 2014). Following the biomedical trend, medications associated with traditional and alternative medicines, such as Ayurveda, are also being manufactured in the form of pharmaceuticals (Pordié & Gaudillière, 2014; Sujatha, 2011). The resulting proliferation of pharmaceuticals is signalled through the phenomenon of 'pharmaceuticalisation' that has been observed in many parts of the world (Abraham, 2010; Dew, 2019; Fox & Ward, 2008; Sujatha, 2011; Williams et al., 2011).

Medication, be it in the form of pill, tablet, ointment, syrup, injection, inhaler, oil, potion, charmed water and so on, is essentially tangible. As van der Geest et al. (1996) suggest, this concrete-ness of medication grants it a unique power. Being a 'thing', it poses a contrast to the intangible- and possibly incomprehensible- nature of the illness or other condition that it seeks to redress. Further, the application of medications requires some action, meaning that they may have to be "swallowed, smeared on the skin, or entered into orifices" (van der Geest et al., 1996, p. 154). In fact, such sensed, perceived and/or embodied action is a part of most therapeutic interventions across diverse therapeutic modalities, even in those where no tangible medication may be involved, such as when chanting religious verses or enacting an exorcism ceremony. Active involvement in the process of healing as demanded by the relevant therapeutic tradition(s) may render the illness experience more concrete and fathomable.

On the whole, medications can be viewed as change agents. From a pharmacological perspective, medications are expected to act in a particular way upon the body and create certain changes, which is the obvious rationale for their use. In this sense, they may be projected as 'magic bullets' or 'cure-alls' (Fox & Ward, 2008; Haafkens, 1997). The overall effects of medications, however, are much broader than signified by their pharmacological properties. As Whyte et al. (2002) put it,

medications have transformative power over bodies; they encompass psychological, cultural and social dimensions in the sense that they "change minds, situations and modes of understanding" (p. 6). These impact both medication users and non-users who associate with them.

Personal, moral and social dimensions of medication use

Once medications are obtained by a person, they tend to be considered personal property (often casually referred to as 'my medication', etc), and their application/ administration may also be 'personalised' accordingly. Such personalisation may often digress from the prescribed application of medications, as reported in the literature. One common reason for such modifications is personal experience. For instance, people may increase or decrease the dosage based on their experience of what works best for them or combine medications to achieve desired results (Dew, 2019; Dew et al., 2014; Fainzang, 2016; Haafkens, 1997; Locker, 1981).

Research into medication practices, predominantly situated in the Global North, bring to light a highly nuanced relationship between people and their medications. This is particularly the case where long-term usage is concerned. Such users often report that their medication makes it possible for them to function normally and carry out a normal life, thus shaping their identity and sense of self. For them, medications may mean the crucial difference between being independent and in control of one's life, or not (Dew, 2019; Haafkens, 1997; Hodgetts et al., 2011). On the other hand, having to depend on medications this way could also evoke a sense of powerlessness and lack of control over one's life (Dew et al., 2015; Haafkens, 1997).

Related to medication usage are the notions of (moral) strength and responsibility, as has been highlighted in Western scholarship focusing on biomedical practices. Medications are most often regulated through medical prescription which delineates their 'proper' use in order to obtain the optimum health-related benefit. Being guided by such a medication regimen and re-arranging one's life so as to adhere to it has been conceptualised as "pharmaceuticalised governance" (Dew, 2019; Dew et al., 2015). Where following the prescription is constructed as the 'right thing to do', careful adherence to medication regimes may be identified as "responsible" behaviour (Gabe et al., 2016), and non-adherence becomes blame-worthy (Murdoch et al., 2013).

Moralising of medication use is further complicated through the notion of 'deservingness'. Unless a medication user is viewed as truly in need of the medicine to manage their everyday life, they would not be deemed a 'deserving' user; and such (non-deserving) use could be criticised as an indulgence (Gabe et al., 2016). Dependence on medication or over-use could be similarly denounced, being referred to as "sinful" (Gabe et al., 2016), a "moral failing" (Dew et al., 2015, p. 275) and a "threat to

one's physical or mental equilibrium"(p. 276). Non-dependence on medication, conversely, is viewed as "noble" and is linked to "moral strength"(Gabe et al., 2016, p. 638) as well as physical strength, stamina and masculinity expressed in terms of "manning up" and "tough[ing] it out" (Dew et al., 2015, p. 275).

Medication use, particularly in terms of following long-term treatment regimes, can be significantly influenced through social relationships, as demonstrated through biomedical as well as social scientific research. For example, recent studies affirm that having positive social relationships and receiving support from family and friends contribute towards continuation of treatment and self-care among adolescents with asthma in the USA (Sloand et al., 2021), older people with HIV and substance abuse problems in Ukraine (Rozanova et al., 2020), and persons undergoing treatment for multi-drug resistant tuberculosis in India (Deshmukh et al., 2018). Social support was also associated with positive attitudes towards treatment seeking for mental illness as reported in a USA based study (Jung et al., 2017). For people living with HIV/AIDS, having close interpersonal relationships (with family, friends, or at least with clinicians) may offer them hope for future and some meaning to life; whereas the absence of such a network creates feelings of alienation and stigma (Rozanova et al., 2015; Wilson, 2007). Information and emotional support exchanged through an online community could also be beneficial as social support in terms of facilitating the treatment trajectory, as shown in the case of an online breast cancer community with transatlantic membership (Rubenstein, 2015).

There is also evidence on how social relationships may be associated with discontinuation of treatment and/or negative health outcomes for medication users. Perceived non-support from family members, especially what is understood as attempts at intentional sabotage of one's self-care regime, may discourage persons from management of type 2 diabetes (including medication) and thus lead to poor maintenance of health (Mayberry & Osborn, 2012). In addition, receiving social support could, at times, negatively impact on medication use as well. Being supported in taking medications may lead some older adults to ignore their medications later on (Warner et al., 2013). Well-meant but 'miscarried help' by family members may also lead to resistance to medications (Mayberry & Osborn, 2012). It is suggested that receiving unsolicited support can be perceived as undermining their independence or interfering with their self-management (Mayberry & Osborn, 2012; Warner et al., 2013).

Having discussed the personal, moral and social aspects of medication use based on the existing literature, I next move on to the phenomenon of therapeutic diversity.

Implications of therapeutic diversity

With biomedicine generally considered the orthodox medicine in many parts of the world today, other therapeutic traditions are classified as complementary and alternative medicine (CAM) or traditional medicines, depending on their specific historical and cultural positioning in the given context (Dew, 2021). Later in the chapter, I turn to studies exploring traditional medicines and their presence in postcolonial landscapes, given their particular significance in relation to the present study. At this point, however, my focus is on how therapeutic diversity manifests within therapeutic practices in different settings.

Where multiple therapeutic traditions are present in a given local geography, they generally continue to profess their own theories or views of aetiology, cure and management of diseases. These often-divergent conceptualisations may variably shape people's sense making of illness experiences and their health seeking trajectories. To draw an example from the therapeutic diversity in Sri Lanka, biomedicine often explains disease aetiology in terms of factors such as germs, tissue damage or inflammation, and various pharmaceuticals are commonly prescribed as treatment; the ayurvedic system proposes an imbalance of bodily humours as the prime cause of disease, and its treatment regime often includes consuming herbal preparations as well as behavioural modifications in terms of food and bathing (Nichter, 1987; Obeyesekere, 1976); while certain indigenous therapeutic traditions attribute ill-health to supernatural or cosmological forces such as demons or planetary alignment and may call for an exorcism or religious rituals to address such conditions (Hettige, 1991).

On the other hand, anthropological literature demonstrates how knowledges and practices associated with diverse therapeutics could evolve in relation to each other and/or develop unique adaptations within a given local setting. To illustrate, studies indicate how the understanding and use of biomedical pharmaceuticals become complicated through local indigenous knowledges and non-biomedical therapeutic practices, a process that has been termed 'indigenisation' (Haak & Hardon, 1988) or 'creolisation' (Naraindas, 2014). In South Asia, people explain the effects of biomedical pharmaceuticals through the ayurvedic notion of heat or *usna* (Nichter, 1980, 1987; Sachs, 1989), due to which many would advocate consuming a 'cooling' substance following the ingestion of pharmaceuticals (Nichter, 1980). Pharmaceuticals may also be used by people for purposes for which they have never been originally intended. A classic example is that of Alophen—a purgative—becoming popular as a contraceptive among the youth in Ghana, while the biomedical community remained unaware of this usage (Whyte et al., 2002). A similar case is that of Misoprostol in Brazil (Zordo, 2016). It was first introduced as treatment for peptic ulcers in the late 1980s, but it was soon appropriated by Brazilian women as an efficacious abortifacient to

circumvent the legal restrictions on abortions. Its popular use in relation to illegal abortions prompted further (biomedical) research, and it was subsequently (re)introduced in Brazilian hospitals, as well as elsewhere, as a drug with revolutionary potential for obstetric treatment (Zordo, 2016).

Apart from local lay adaptations of therapeutics similar to those discussed above, the implications of therapeutic diversity also manifest at the institutional level and practitioner level (Sujatha, 2019; Waxler, 1984). In India, several traditional and indigenous medicines (namely, Ayurveda, Unani, Siddha, Homeopathy, Yoga, Sowa rigpa) have been institutionalised since 2002 as "AYUSH" medicines. This policy has led to the development of 'Integrative medicine', where non-biomedical therapeutic knowledges are being actively manipulated in biotechnological laboratory-based studies (Sujatha, 2019). Further, research around the world points to practitioners who straddle multiple therapeutic systems and the complexities that arise therein (Dew, 2003; Khalikova, 2020). While there may be non-biomedical therapeutic practitioners who succeed in carving out a niche for their conservative practices in a predominantly biomedicalised medical market such as that in India (Albert et al., 2017), it is likely that they would have to contend with the demands of treatment seekers who are biomedically-oriented (Naraindas, 2006). This has led some traditional practitioners to integrate biomedical diagnostic procedures and even biomedical pharmaceuticals into their practice of traditional or indigenous medicines, as reported in Sri Lanka (Waxler-Morrison, 1988; Wolffers, 1989). Such features that manifest in the healthcare landscape, in turn, shape the treatment seeking activities undertaken by people.

Therapeutic decisions and treatment seeking

Before resorting to treatment of any kind, including medications, there is a self-assessment where the person decides whether the illness/ condition requires such an intervention (Jutel, 2011). Many factors come into play, such as the severity of the symptoms as well as its perceived impact on one's life and family. Accordingly, the same condition may be viewed by someone as a threat to health which requires treatment, while another may ignore it and live with whatever its consequences may be (Liyanage, 2000). Once the decision is reached to seek therapeutic treatment, people are confronted with further choices. As Mol (2008) demonstrates in her Netherlands-based study, the treatment seeker is often looked upon as a consumer in the healthcare market who is expected to choose from an array of care-options.

Whereas the therapeutic alternatives available would certainly differ from one context to another, people generally have to choose a therapeutic modality (e.g. biomedicine, homeopathy, herbal

medicine, traditional Chinese medicine) as well as a healthcare provider (e.g. public or private sector) to seek treatment from. In making therapeutics-related choices, studies report that people take into account numerous pragmatic, economic, socio-cultural and personal reasons. Cost and affordability of treatment is a principal concern particularly among low income earners, since expensive or prolonged treatment could easily drain their limited resources (Das, 2015a; Liyanage, 2000). Certain healthcare providers or practitioners may be favoured over others based on the treatment seeker's personal experiences. Culturally-framed notions of efficacious treatment provision may have some traction in this regard. To illustrate, certain (traditional and biomedical) practitioners in Sri Lanka may be considered as having *atgunaya* or an exceptional capacity to heal particular conditions (Nichter & Nordstrom, 1989), and such belief leads to their being popularly sought in relation to their perceived field of expertise.

Where people make sense of illness in relation to one or more therapeutic traditions, treatment seeking practices are organised accordingly. Studies point to certain conditions or symptoms derivative of a local/indigenous (or otherwise non-biomedical) illness idiom that cannot be mapped onto a biomedical framework, and therefore, would inevitably call for appropriate (non-biomedical) interventions. Examples are *lait thied sohpet* among the Khasi in India, which loosely translates to "the navel affecting the nerves, which occurs specifically when a person lifts something heavier than their body weight" (Albert et al., 2017, p. 165); or *pinas roga* in Sri Lanka, a condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976, p. 216). On the other hand, where 'patients' identify their illness and symptoms along a biomedical register, such biomedicalised understandings can hardly be accommodated within a traditional therapeutic paradigm. As Naraindas (2006) demonstrates, a given Ayurvedic practitioner may very well be familiar with "cancer" as a biomedical illness category; yet, when a patient seeks treatment for a tumour that had previously been biomedically diagnosed as cancer, she cannot with a clear conscience identify the condition as "cancer" since Ayurveda does not recognise such an illness category (Naraindas, 2006).

Apart from conditions that require treatment from a specific therapeutic modality or another, most instances of treatment seeking may involve ethnomedical assessments of therapeutic efficacy based on which the treatment choices are made. In South Asia, many studies have noted a general preference of biomedical treatment for acute conditions, though traditional therapeutics may be sought for orthopaedic conditions and certain chronic illnesses (Albert et al., 2017; Haque et al., 2018; Weerasinghe & Fernando, 2011; Wolffers, 1988). For conditions such as asthma or cancer, for which biomedicine has no permanent cure, seeking traditional medical treatment also appears to be a pragmatic alternative (Broom et al., 2010; Wolffers, 1988). There are other popular and/or cultural

notions of therapeutic efficacy which are based on individual (bodily) differences. In the Philippines, for example, medication is expected to be *hiyang* or compatible with one's constitution for it to be effective for a particular person (Whyte et al., 2002). A similar notion is that of *beheth ahanava* in Sri Lanka. Literally translatable as 'medicine answering', it serves as a prerequisite for the efficacy of medicine, gauged in terms of its compatibility to a person's bodily constitution as well as practitioner-patient rapport (Nichter & Nordstrom, 1989).

Literature also affirms that people's treatment seeking trajectories may span multiple therapeutic modalities in their effort to seek a satisfactory solution(s) to their health concerns, and that accessing the different therapeutic alternatives could occur sequentially and/or simultaneously. Uncertainty of therapeutic outcome through orthodox treatment is a common rationale for seeking multiple therapeutics. This is reflected in the global trend of using CAM and/or traditional medicine among people undergoing mainstream biomedical treatment for cancer (Abdalla et al., 2020; Broom et al., 2010; River et al., 2018). Indigenous non-biomedical therapeutics may in fact become an essential feature of treatment seeking where health beliefs are firmly anchored to religiosity and spirituality, as demonstrated in Soweto, South Africa (Bosire et al., 2021). Similarly, cultural conceptualisations of ill-health as having multiple causality may also encourage the use of multiple therapeutics. In Sri Lanka, for example, biomedical/herbal treatment may be sought to manage physiological symptoms of illness, while astrological, religious or supernatural methods may be necessary to find out and eliminate potential cosmological or supernatural causes associated with the same condition (Hettige, 1991).

Research on traversing multiple therapeutics could point to how people make sense of the potentially divergent knowledge paradigms and technologies pertaining to the different modalities that they make use of. In a seminal study, Amarasingham (1980) follows the treatment seeking process of a young woman in Sri Lanka, which involved consulting practitioners ranging from exorcists, astrologers, Buddhist monks and biomedical doctors. At different points in her illness trajectory, the woman was diagnosed with, and treated for, spirit possession, misfortune due to planetary alignments and schizophrenia. Exploring what she finds a "seamless movement" across diverse therapeutics, Amarasingham (1980) highlights how people integrate the contrasting illness and therapeutic narratives into a holistic understanding of physical, mental and social health as situated in a local, indigenous register.

A common alternative to seeking professional therapeutic assistance is to self-medicate, which refers to starting on medications on one's own accord without a prior consultation with a practitioner. Depending on their therapeutic inclinations, people may self-medicate with pharmaceutical products or other (e.g. traditional, herbal) remedies which are store-bought or

prepared at home. Self-medication is often resorted to when the condition is not viewed as severe enough to warrant professional healthcare services and is a popular—and possibly economical—first option before seeking professional assistance (Fainzang, 2016; Whyte et al., 2002; Wolffers, 1988).

Biomedical literature generally portrays self-medication with pharmaceuticals as an act of non-compliance which may have grave consequences on patient health, whereas sociological and anthropological studies may view it as a personal decision, an act of resistance or scepticism of medical authority (Haafkens, 1997; Whyte et al., 2002). In her study on self-medication in France, Fainzang (2016) examines how people rationalise self-medication. For instance, people may opt to self-medicate when they feel a doctor's advice is redundant since they already know which medication they would be prescribed for that particular condition. It may also be that they doubt the competence of the doctor or wish to avoid the embarrassment of a physical examination. In any case, it appears that people rarely self-medicate in a purely arbitrary manner: they tend to follow previous experiences of medical advice, or to inform themselves about new medications (often via the internet, or their social network) before using them (Fainzang, 2016). Or, as shown in research based in Sri Lanka, people may also rely on the recommendations of a community pharmacist in the absence of a medical prescription (Wijesinghe et al., 2012).

Postcolonial and/or non-Western therapeutic landscapes in the Global South

Traditional medicines and biomedicine

Local and/or indigenous therapeutics that have remained in (often non-Western) societies for generations are very often referred to as traditional medicines. Ayurvedic medicine, which originated in India and spread throughout South Asia and beyond, is a case in point. Leslie (1976) identified Ayurveda as a 'great tradition' medicine in South Asia, dating back almost 4000 years, and having a well-established organisational structure, a vast repository of knowledge and a system of rigorous training and generational succession for practitioners. In addition, Ayurveda has always been a multiplicity. It has diverse specialisations such as orthopaedics, snakebite, burns, eye treatment etc, in addition to many affiliated though divergent practices, such as bone-setting and midwifery (Hardiman & Mukharji, 2012; Lambert, 1996; Sadgopal, 2012).

As many countries of the Global South have been former European colonies, historical literature (e.g. Uragoda, 1987 on Sri Lanka) demonstrates how Western medicine was introduced into an already complex therapeutic landscape comprised of traditional medicine(s); and how biomedicine in such settings continues to retain its colonial affiliations. The traditional and local medicines are, conversely, imbued with the indigenous culture and nostalgia of a glorious pre-colonial past. In a

postcolonial political climate, these become potent symbols of nationalism and sovereignty, as observed in South Asia today. The legendary leader of India's freedom struggle, Mahatma Gandhi, was a strong critic of biomedical hegemony and advocated traditional therapeutics (Khan, 2006). The promotion of traditional medicine was a principal propagandistic item of the nationalist movement that secured political power in Sri Lanka in 1956 (Waxler, 1984), whereas the contemporary pro-nationalist governments in India strongly advocate the promotion and 'modernisation' of traditional medicines (Shrivastava et al., 2015).

Scholarship on biomedical dominance explores how biomedicine is constructed as 'modern', scientific and technologically advanced, thus garnering increasing popularity among the public. Further, it is also institutionally organised, often state-sponsored, and its practitioners are well regarded as professionals, adding to its social eminence. In comparison to biomedicine, other contemporary therapeutic systems are multiply disadvantaged: their knowledge claims and means of acquiring knowledge are often not commensurable with the Western scientific framework; their knowledges often remain less updated and might face critique as stagnant; they also often lack state regulation, funding and other organisational resources (Arseculeratne, 2002; Dew, 2021; Jones & Liyanage, 2018).

In their current position as therapeutic alternatives to biomedicine, traditional medicines in former European colonies remain subjected to biomedical dominance. State sponsorship of biomedicine, as well as the social recognition that follows, plays a major role here. To illustrate, biomedicine being the most popular treatment modality in Sri Lanka is in part due to traditional medicines being only a subsidiary and underdeveloped branch within the contemporary biomedicalised health system. High quality biomedical treatment is available throughout the country, while access to traditional therapeutic treatment is extremely limited and its efficacy considered doubtful; biomedical doctors have high social status which is not accorded to traditional medical practitioners (Arseculeratne, 2002; Jones & Liyanage, 2018). Even where the state directly intervenes in promoting traditional medicines, as in India, it may be difficult to compensate for decades of colonial and postcolonial state neglect (Khan, 2006).

Commercial and market interests have been identified as significant drivers of medicalisation in contemporary Western societies (Conrad, 2005). These may also feature in postcolonial non-Western settings, as Shah (2020) demonstrates in Bangladesh. He notes that the pharmaceutical industry directly contributes to the popularising of biomedicine among rural people. There is a proliferation of "village doctors" in rural peripheral areas, who prescribe and/or dispense pharmaceuticals as treatment. Regardless of their dubious qualifications, representatives of pharmaceutical companies associate closely with these practitioners, just as they do with (qualified)

doctors, in order to promote their products. In addition, over-prescription of drugs to treatment seekers appears to be a regular trend in medical consultations, which could at least partially be linked to the incentives that practitioners receive from pharmaceutical companies for increasing their sales (Shah, 2020). While the commercial interest-driven pharmaceutical industry may power the growth of the biomedical sector, the low commercial investment in the case of many traditional medicines may, conversely, be considered as having stunted their development and expansion. One exception in this regard is Ayurvedic medicine in India. There is a growing Ayurvedic pharmaceutical industry in the country (Sujatha, 2019), though it certainly cannot rival its massive counterpart associated with biomedicine.

India is, in fact, a South Asian example for state-mediated interventions at popularising traditional medicines and adapting them to meet contemporary needs. As mentioned previously, a number of traditional medicines in the country were taken under the purview of the newly established Ministry of AYUSH[9] with a mandate to develop and modernise them (Shrivastava et al., 2015). Such efforts at 'modernising' often involves fashioning traditional medicines after a 'scientific' model derived from biomedicine, which requires severing or modifying their 'non-scientific' elements and incorporating others (Dew, 2021). Accordingly, for instance, the state sanctioned Ayurveda can merely be a 'syndicated' version of the traditional medicine (Hardiman & Mukharji, 2012). Ironically, however, the disowned elements of Ayurveda also exist as 'subaltern therapeutics' or clandestine practices beyond the sanctioned national framework (Hardiman & Mukharji, 2012). These attest to the complexity of regulating traditional medicines. In addition, the escalating popularity of biomedicine and the pragmatic efforts of Ayurvedic practitioners to address patients' demands for biomedical treatment (discussed before) have also given rise to diverse—potentially illicit— 'convergences' between biomedicine and traditional medicine which may defy the state and institutional regulations (Nordstrom, 1988; Waxler-Morrison, 1988; Wolffers, 1989).

Access to therapeutics

In his classification of healthcare, Kleinman (1981) identifies medical practitioners' prescription and licensed pharmacies as comprising the professional sector. There is also a folk sector that includes indigenous medical practitioners who have specialised knowledge but no professional training; and an informal or popular sector, i.e. the network of lay persons, such as family and friends (Kleinman, 1981). It has been suggested, however, that the sources of medications in contemporary society are possibly too diverse to be contained within Kleinman's model (Whyte et al., 2002). This is reflected

[9] AYUSH stands for the medicines Ayurveda, Yoga, Unani, Siddha, Homeopathy, and the late addition of Sowa rigpa

in studies that explore the complexities of accessing treatment in diverse geopolitical settings, including those in the Global South.

To illustrate, a recent ethnography into complexities of accessing healthcare is Shah's (2020) study based in rural Bangladesh, which explores biomedical services and healthcare bureaucracy in relation to structural violence and social suffering. It demonstrates how public healthcare provision is shaped by the same "social hierarchy, power relations and social capital" (p. 52) which are observable in the local context. Offering a bribe in order to receive faster/better service or the need to seek a pharmacy where the drugs will not be adulterated are among the regular concerns in the (localised) treatment seeking process. Further, as gender and class-based discrimination is rampant in the healthcare bureaucracies, the existing social inequalities become reinforced and even exacerbated through the healthcare landscape (Shah, 2020).

Underdevelopment of health infrastructure and lack of resources that persist in politically and/or economically unstable regions often hinder the availability and accessibility of therapeutics. Despite a high demand, the public healthcare systems may be ill-equipped to serve the people's needs, which, according to Whyte et al. (2002), has given rise to a thriving trade of biomedical pharmaceuticals that defy any formal categorisation. Some examples, from Asian and African settings, include public hospital employees who trade medications illegally, vendors selling pharmaceuticals at public markets together with other popular commodities, and 'hawkers' and 'injectionists' disseminating medications from urban centres to rural areas (Whyte et al., 2002). Similarly, studies in India and Sri Lanka highlight the widely prevalent but risky pharmacy practice of dispensing restricted or prescription-only drugs over the counter and without a proper prescription (Kamat & Nichter, 1998; Sakeena et al., 2019; Wijesinghe et al., 2012; Zawahir et al., 2019).

In this section, I discussed some concerns pertaining to postcolonial/non-Western therapeutic landscapes in the Global South, shedding light on their therapeutic realities which may often diverge from those captured in studies based in Western contexts. Next, I turn to the (limited) literature on therapeutic practices as situated in households, through which I identify the need for studying the home as a nexus of therapeutic practices and contextualise the present study.

Situating therapeutic practices in the household

Therapeutic practices involve diverse medications and healing methods, various understandings of health and illness, and people who actively manipulate these in certain ways in relation to sick bodies. In addition, the enaction of therapeutic practices in a given situation would always be significantly shaped and impacted by the lived realities of the therapeutic landscape encountered by

the people, and the unfolding circumstances in their ordinary lives. This has been demonstrated through the research findings discussed so far in this chapter in relation to the dynamics of therapeutics use as a process, implications of therapeutic diversity, and with specific reference to postcolonial therapeutic landscapes. However, social scientific literature on medication use has allegedly often overlooked these very "concrete practical contingencies of [people's] lives" (Rosenfeld & Weinberg, 2012, p. 52), resulting in findings that are decontextualised and ahistorical. In order to study therapeutic practices as they are enacted in the everyday life, therefore, it is necessary to approach them as situated in a particular context(s), i.e. as situated practices.

Rosenfeld and Weinberg (2012) suggest the potential of studying medication use as situated domestic practices, highlighting the home as an important backdrop for therapeutic practices. The significance of domestic settings in this regard is clearly demonstrated by the few comprehensive studies that have focused on the household. In a New Zealand based research project into people's medication practices, Dew et al. (2014) identify households as "hybrid centre[s] of medication practice", where people grapple with and come to terms with the various forms of medical knowledges and treatments, as well as choose and modify them as practicable. From the same project, Hodgetts et al. (2011) demonstrate how medications may become seamlessly integrated into a household through shared routines of storage, administration and responsibility. Medications may be stored at specific location(s) acknowledged by the householders. Use of medications may be incorporated into the daily routine of the household. Other householders may become involved in this activity through administering the medication or by facilitating the routine. This ultimately turns into a collective effort and a means of caring for one another, which may reinforce the relationships within the household (Hodgetts et al., 2011).

In addition, people make decisions on whether to seek medical treatment (or not) for a given condition, whether to self-medicate (or not), and which type of medicine would be most suitable. Even with regard to prescribed medications, the way people use them may diverge from the prescription, as they may adapt the frequency or dosage as convenient for them or cease the medication altogether. Such 'personalisation' of medication use often occurs within the household, within the network of its social relationships, and subject to the needs of its members (Dew et al., 2014). In fact, it is in the confines of the household where the medically unacceptable or unorthodox medication practices often stand revealed (Haafkens, 1997; Whyte et al., 2002). As such, these research findings point to the household as a particularly useful vantage point towards exploring medication practices.

Despite the rich research potential of the theme, there currently are few studies that explore therapeutic practices as situated practices in the home. In addition, to my knowledge, there are

hardly any studies that focus on therapeutic practices as situated in households beyond the Global North, and within non-Western and/or postcolonial settings. The everyday lived realities of people in resource-poor communities in the Global South often being worlds apart from those as revealed in studies from the Global North, the limited literature available can only yield a fragmented understanding of the ground realities, materialities and contingencies of therapeutic practices in such settings.

Further, as elaborated previously, postcolonial therapeutic landscapes prominently feature biomedicine and diverse indigenous and/or traditional medicines as therapeutic modalities. Their state of "co-existence" (Leslie, 1976) is one that is complicated with a power imbalance that stems from their divergent histories and oppositional socio-cultural positionings within the postcolonial landscape. These tensions tend to be played out in the different spaces that people access and engage with therapeutic practices, among which the home is, as discussed above, a highly significant space.

Accordingly, the present study was organised around the following research questions:

- How do people understand and relate to various therapeutics in their therapeutic landscape?
- How do medications flow in to, within and beyond the household?
- How are therapeutic practices enacted by people in their homes?
- How are therapeutic practices implicated in people's everyday lives and relationships?

As a project based on rural households in Sri Lanka, the present study contributes towards furthering sociological knowledge on therapeutic practices as situated in households within a postcolonial landscape in the Global South. However, given its very situatedness in a non-Western context, the study is also informed by postcolonial/decolonial scholarship. These theoretical and epistemological insights, which have had a significant impact on the study, are discussed in the following section.

Postcolonial/decolonial concerns and their implications

As a study into a community in the Global South, but which is largely framed within a Western academic research tradition, the present study is situated in the nexus of North–South power relations in the social sciences. In fact, much of the literature on non-Western settings that I engage with are also found in this uneasy space. In this section, I explore the limitations of existing research into non-Western/postcolonial therapeutic landscapes and situate these in relation to

postcolonial/decolonial critiques of Western research traditions. Through this discussion, I point to potential implications for projects that straddle the geopolitical and scholarly boundaries between the Western and the non-Western, such as the present study.

Limitations of (Western) scholarship on non-Western/postcolonial therapeutic landscapes

The point of departure for exploring traditional medicines in postcolonial landscapes (similarly for therapeutics known as 'complementary and alternative medicines' or CAM in the Global North) has often been an assumption of biomedical orthodoxy, resulting in their being constructed in binary opposition as the 'other' to biomedicine (Dew, 2021; Gale, 2014). This has been the default framework in much of the pioneering anthropological[10] work on non-Western settings, the bulk of which, in the late 20th century, was carried out by anthropologists arriving from 'the West'. Such scholarship effectively paved the way for social scientific studies on traditional medicines and brought them into anthropology's research agenda; yet, the Western (biomedical) centric conceptualisation of traditional medicines meant that they were rendered as the 'other' even in their local indigenous settings.

Stemming from biomedical orthodoxy is the assumption of biomedicine as being unitary. As discussed previously, anthropological studies have explored the historical and contemporary processes of fragmentation and multiplying in relation to traditional medicines; whereas biomedicine, in contrast to the traditional medicines, has remained an implicit monolith (Gale, 2014). Some ethnographic studies have, however, challenged this view. Herbst (2017) study in Papua New Guinea, for example, clearly manifests that the biomedicine as practised there is more of a local medicine than the historically imported European version. Having existed within the 'transplanted' community for generations and absorbed the local health traditions, biomedicine itself has become culturally adapted. Studies into 'convergence' (Waxler, 1984) between biomedicine and traditional medicines, otherwise termed as biomedicine's 'creolisation' (Naraindas, 2014) or 'indigenisation' (Haak & Hardon, 1988), also expose the local adaptations of biomedicine in non-Western settings (Waxler-Morrison, 1988; Wolffers, 1989). These findings lend support to the conceptualisation of biomedicine itself as being multiple, or as localised 'biomedicines' (Herbst, 2017).

In terms of studying therapeutic diversity in non-Western settings in particular, 'medical pluralism' is a well-established research programme pioneered by Charles Leslie (1976). His seminal work in

[10] The 'exotic' non-Western settings have traditionally been of interest to anthropologists exploring 'the other'; sociology as a discipline has focused till recent times on the industrialised and 'modern' societies, i.e. 'the Western'. This is discussed later in the chapter.

South Asia explored the tensions and dynamics in settings where biomedicine and indigenous therapeutic systems (such as Ayurveda, Unani and Traditional Chinese Medicine) co-exist, clash and converge. This analysis established the depth of knowledge and institutional complexity of non-Western medical systems to be on par with that of biomedicine, which was till then largely and undisputedly considered their superior (Leslie, 1976).

Currently, however, 'medical pluralism' as a concept is largely disputed. A principal critique against it was that of glossing over the often-asymmetrical power relations embedded in a social setting that is reflected in and reified through the different therapeutic systems and differential access to them (Gale, 2014). For example, as I have explained previously, biomedicine was a colonial legacy and nearly always received state sponsorship as well as the patronage of the elite in postcolonial states, whereas traditional non-biomedical therapeutics have often been degraded and neglected for centuries. Further, not every person in a community has the same access to therapeutics: it is often one's specific socio-economic positioning and social networks—their "web of relations"—that determine the particular therapeutic alternatives that one can access and the resultant trajectory of their treatment seeking (Kołodziejska-Degórska, 2016). Accordingly, the settings in which 'medical pluralism' was initially observed have never actually been a level field. This should lead one to rethink what has been rather optimistically called a plurality of co-existing medical systems.

Another critique of medical pluralism derives from its near-exclusive focus on non-Western and/or postcolonial settings until recent times. Since at least the mid 70's, research on medical pluralism flourished based on anthropological fieldwork in the Global South. However, it took decades longer for social scientists to apply the same paradigm to Western societies and frame the 'co-existence' of biomedicine and CAM as a manifestation of medical pluralism (Baer, 1995). This attests to the tenacity of the assumption of (medical) homogeneity in the West/Global North, as opposed to the heterogeneity and diversity attributed to the rest of the (i.e. non-Western) world. This implicit yet pervasive difference in conceptualising the West and the non-West points to a trend of Eurocentrism in social sciences, as explained next.

Eurocentrism, cultural difference and the Non-Western 'other'

Postcolonial/decolonial scholarship has problematised a strong Eurocentric bias in social sciences. It is noted that *a priori* assumptions in mainstream (Western) research often disadvantage and distort, and thereby misrepresent, the non-Western (Bhambra, 2014b). One example is the category of "Third world woman" in Western feminist writings, as critiqued by Mohanty (1988). She argues that

this category is constructed by homogenising millions of women's situated experiences into an 'average' woman who

> leads an essentially truncated life based on her feminine gender (read: sexually constrained) and being 'third world' (read: ignorant, poor, uneducated, tradition-bound, religious, domesticated, family-oriented, victimised, etc.) (Mohanty, 1988, p. 65).

Similar distortions have been reported by recent feminist and decolonial scholarship that critique the contemporary Western/White discourses on the plight of Muslim women. These women are often represented as oppressed by patriarchal domination and religious subjectivity which has eroded their self-autonomy; whereas the lived realities of those women would be far more complicated and nuanced than captured in the narrow stereotype (Abu-Lughod, 2013; Ahmed, 1992). For example, the veil worn by Muslim women may be conceptualised in Western discourse as a sign of religious and gender-based oppression, while for the women, wearing the veil may even be a means of resistance and activism against White superiority over Muslim culture (Satiti, 2020).

As such, distorted representations of the postcolonial subject from a Western perspective are often used to validate Western-centric projects in non-Western settings. As Mohanty (1988) argues in the case of Western feminist writing, a faulty representation of the non-Western 'other' is the essential foundation for a discursive self-representation of Western women as "educated, modern, as having control over their own bodies and sexualities, and the 'freedom' to make their own decisions" (p. 65). Similarly, in order to ascertain the religio-cultural superiority of those that call for Muslim women's religious emancipation, it is necessary to view the Muslim woman wearing the veil as deprived of self-autonomy and freedom (Ahmed, 1992; Satiti, 2020). Spivak (2003), in her classic paper "Can the subaltern speak?", critiques the construction of the (postcolonial) "brown woman" as voiceless and in need of being saved from her predicament of subalternity and patriarchal oppression, as defined from a Western/White perspective.

Here, it does not mean that the 'postcolonial subject' is not oppressed in their ordinary lives; they may well be, though such experiences can hardly be captured in a Western normative framework that could be meaningless when contextualised into their lived realities. Or, the forms of oppression that they undergo could be quite different from what is perceived as oppression from a Western/White perspective (Abu-Lughod, 2013; Spivak, 2003). Through such misrepresentation and distortion of the 'subject', research studies could risk becoming projects where "white men are saving brown women from brown men" (Spivak, 2003, p. 92), or where the coloniser/oppressor projects themselves as the emancipator of the postcolonial/oppressed (Satiti, 2020). By thus

'speaking for' the postcolonial subjects and 'whitesplaining[11]' their lived experiences, the Western scholarship tends to exert epistemic superiority over local/indigenous knowledges.

Moreover, it appears that much of Western academic engagements in postcolonial settings, as well as their claims to epistemic superiority, is premised on the reification of a cultural difference between the West and the non-West. This resonates with what Mohanty (1988) terms "Third world difference" (p. 80), a condescending view of the underdevelopment, traditionalism and backwardness of non-Western countries as evaluated against the Western norms. In effect, studies into non-European/non-Western contexts are often framed as attempts to uncover and explore their 'otherness': the (social, cultural) dimensions that distinguish them from the 'modern' West, in reference to which the normative frameworks of academic knowledge are synthesised and theorised (Bhambra, 2014a; Connell, 2007; Smith, 1999).

The cultural difference, whereby the 'modern' Western world is discursively differentiated from the non-European/non-Western world as the traditionalist, backward and non-progressive 'other', gives rise to a binary division along geopolitical boundaries (Bhambra, 2007, 2014a). This division has been historically mapped onto the respective fields of sociology and anthropology, both dating back to Europe's colonial empire. Accordingly, sociology has focused on 'modernity' as situated in the Western world, while studying the 'pre-modern' and 'traditionalist' communities became relegated to anthropology as representing the cultural 'other' from a European gaze. Though the scope and outlook of both disciplines have undergone considerable change and their boundaries have blurred through the years, their literature would assert that studying the majority world remains overwhelmingly an anthropological project on cultural difference.

Based on the postcolonial/decolonial scholarship discussed thus far, I would argue that a cultural difference of the non-Western other (as viewed by predominantly Western scholars) in terms of therapeutics use, or more broadly of health/illness, was the aim of much of the overwhelmingly anthropological literature that has focused on the therapeutic realities of postcolonial settings in the Global South. As explained previously, the lens of medical pluralism, which takes heterogeneity and diversity as a point of departure for its analysis, was the principal theoretical framework applied to non-Western therapeutic landscapes since the late 20th century. The facts that medical pluralism was only belatedly noted in comparable Western contexts of therapeutic diversity and that biomedical orthodoxy and unitariness were taken for granted whereas traditional medicines were always

[11] According to dictionary.com, *"whitesplaining* is the act of a white person explaining topics to people of colour, often in an obliviously condescending manner, and especially regarding race- or injustice-related issues". https://www.dictionary.com/e/slang/whitesplain/

approached as heterogenous and fragmented, attest to the representational differences in relation to the Western and the non-Western in the academic literature.

Implications of Western research hegemony and trends of decoloniality

Commenting on the global academic knowledge production enterprise, Connell (2014) observes a trend of "centrality versus dependence" (p. 212). The Global North remains the 'metropole', and it is there that the knowledges are synthesised and theories produced. The 'periphery', meaning the rest of the world, largely serves as a source of data. These data, excavated from the source and often taken to the metropole, will be interpreted using theories that are developed based on the realities in the Global North (Bhambra, 2014a; Connell, 2007). The resulting incommensurability of data and theory would therefore more often than not project distorted images of the social in the Global South, as I have elaborated previously.

However, the global dynamics of knowledge production being such that, contemporary scholars around the world engage with the mainstream Western research tradition(s) and frame their studies accordingly. Beyond the Global North, the intellectual efforts are characterised by "extraversion", an attitude of being orientated to and deferring to the metropole's trends (Hountondji, 1997, in Connell, 2014, p. 211). It follows that many research projects carried out in the Global South appear to be case studies in that they either replicate studies or deploy theories originating in the Global North with an aim to extend them to different (meaning non-Western/postcolonial) contexts (Connell, 2007). Extraversion towards the metropole, as observed in the intellectual work performed outside the metropole, is not solely due to the research leanings of individual scholars. Rather, it points to systemic effects of neo-colonialism and globalisation:

> The intellectual hegemony of the metropole has a broad institutional underpinning, including universities but extending far beyond them into professions, governments, corporations and communities of practice, creating in these institutions a common-sense in which other logics of knowledge seem exotic, objectionable or downright crazy. (Connell, 2014, p. 218)

As a researcher from Sri Lanka, I understand that my research outlook has been one of extraversion as generally observed in the intellectual workers in the periphery. Though I carried out fieldwork within my own 'native' culture and an already-familiar (therefore, not 'exotic') therapeutic landscape, the present study is framed in the Western research tradition and builds on previous literature that is largely Western-centric. Apart from fieldwork, the project was carried out in Western/White academic spaces and influenced by the contemporary research trends there. For

non-Western scholars from the periphery such as myself, such engagement with mainstream research is necessitated through our local institutional affiliations as well as aspirations to reach a global audience (Connell, 2007).

It is, on the other hand, my situatedness within Western academia in a settler colonial state (with access to near-unlimited academic literary resources) that granted me significant exposure to postcolonial/decolonial scholarship. The present study is informed by postcolonial/decolonial dialogues, as I have outlined previously. Such scholarship calls for reflexivity, awareness and radical change on the part of the academic community in transforming the social sciences to become more inclusive, diversity-tolerant and equitable. Through problematising Western research in relation to studying the non-Western/postcolonial, as I have done in this section, my attempt was to develop a reflexive account of my own positionality and research engagements in relation to the local communities, Western academia, as well as the Western research tradition. This marks the initial steps in my personal journey of learning, through which I aspire to embark on more decolonised and 'deimperialised' research in future (Appleton & Bennett, 2021; Smith, 1999).

The theoretical approach in the present study, which is presented in the following section, is responsive to the postcolonial/decolonial sensibilities elaborated above.

Theorising therapeutic practices in everyday life

In the present study, I explore therapeutic practices that involve the use of medications and various healing techniques in households in a rural community in Sri Lanka. As discussed in the first part of the chapter, international social scientific literature often portrays medication use as routinised and taken for granted practices, and medications as ubiquitous materials, within spaces and relations that constitute everyday living (Dew et al., 2014; Dew et al., 2015; Hodgetts et al., 2011). The theoretical framework of the study enables me to capture and explore further these manifestations of ordinariness. Moreover, as the present study explored therapeutic practices located in the household and without specific reference to any illness/condition nor features of illnesses (e.g. chronicity, severity), the theoretical framework was developed accordingly. That is, instead of theorisations on living with severe or chronic illness, I draw from theoretical scholarship that permits approaching therapeutics as a response to ordinary illness events in everyday life.

In this section, I first draw on literature that explores 'the everyday life' as shaped and determined by the circumstantiality of unfolding phenomena/events and how people respond to them. Here I discuss Veena Das's work into the 'textures' of ordinary life (Das, 2006, 2015a, 2020) and the notion of everyday living as an ethical project governed by 'ordinary ethics' (Das, 2012, 2020), grounding

them in Wittgensteinian insights that Das herself builds upon. Against this backdrop, I conceptualise therapeutic practices drawing on Annemarie Mol (2008)'s relational approach to care practices, particularly the notion of 'tinkering' (Mol et al., 2015).

Ordinary life: Living with the fragility and circumstantiality of the 'ordinary'

Ordinary life is as elusive as it is complex, as demonstrated in the scholarship of Veena Das (Das, 2006, 2012, 2015a, 2020), based on extensive fieldwork among low-income neighbourhoods and marginalised communities in India. For her, "… everyday is a site on which the life of the other is engaged, … it is the space not only of habit but of reinhabitation" (Das, 2020, pp. 15-16). The intertwining of the self and the social, as well as the sense of habitual repetition and incessant change, is captured in this succinct description. In order to comprehend the 'ordinary' in its diverse manifestations, Das explains her ethnographic writing as

> … trac[ing] the moods, modalities, and labor that goes into making the everyday inhabitable, to make it count, even as the dangers that stalk the everyday cannot be overcome once and for all. (Das, 2020, p. 5)

An important theme in Das's work, as reflected above, is that of the fragility of everyday life. In the communities that she studied, Das writes of the implications of unfathomable violence such as murder, rape and torture, as well as those of everyday crises such as poverty, discrimination, illness and death (Das, 2006, 2015a, 2020). Given the risk of such pending crisis, maintenance of life as 'ordinary' and 'normal' requires a consistent and ongoing effort. Once ordinary life is marred by disruption, it takes patient and attentive care to make life liveable again, or to restore the 'inhabitability' of life; though the restored normalcy may in fact be a different 'ordinary' than what it used to be. In this light, it becomes necessary to contain, within the self and the social, the potentially disruptive elements (such as violence) which may damage life and its normalcy, or have already done so in the past. This adds to the weighty task of preserving and maintaining the fragile 'ordinary' of everyday life, which, as Das emphasises, is never-ending and laborious work (Das, 2006, 2015a, 2020).

In exploring the ordinary phenomena of life, Das builds on the philosophical oeuvre of Ludwig Wittgenstein.

> The aspects of things that are most important for us are hidden because of their simplicity and familiarity. (One is unable to notice something — because it is always before one's eyes.) The real foundations of his enquiry do not strike a man at all. Unless that fact has at

> some time struck him. — And this means: we fail to be struck by what, once seen, is most striking and most powerful. (Wittgenstein, 2009, §129)

Wittgenstein (2009), pioneering what has come to be known as an ordinary language philosophy, points out the essential imperceptibility of everyday phenomena that pervade life but are hardly noticed. Much of contemporary social scientific scholarship into ordinary life of the everyday owes an intellectual debt to Wittgenstein and, following his exhortations, adopts an empirical and/or praxeological approach to study ordinary phenomena and practices.

Ethnomethodologists, among others, have contributed greatly towards the scholarship on ordinary life. They characterise social life by its constant state of flux, even calling it "a floating crap game" (Liberman, 2016), given that people have to manoeuvre and negotiate within the circumstances that they are entangled in from one moment to another. In doing so, people collectively give rise to social order, an essential orderliness which is manifest in the regularity of everyday mundane activities and interactions (Liberman, 2013; Livingston, 2008; Lynch, 2001; Schatzki, 2001).

> An event drives *itself* with its own momentum, but even the event does not know just where it is heading. It is not that local participants are not intimately involved, but society moves according to its own vectors. … The people who staff each local occasion are embodiedly engaged inside the very displays that instruct them regarding the coherence of those local events, and the parties can only collaborate around the practical objectivities that keep emerging within each occasion, interpreting them, twisting them, and massaging them toward local solutions. And every solution is provisional. The immanence of affairs always presses upon one, and what is most *proximal* is what grabs our attention. (Liberman, 2016, p. 8, original emphases)

Liberman (2016), as quoted above, articulates the continual flux of ordinary phenomena and the uncertainty of their trajectories as essentially shaping what is perceived as everyday life. In this light, how people act in a given (social) context involves impromptu and serendipitous reactions to unfolding circumstances. This calls for ordinary actions and practices of people to be understood as ways of dealing with the on-going circumstantiality of local affairs that they are entangled in (Liberman, 2013, 2016).

Scholarly work on the uncertain trajectories of unfolding phenomena (e.g. in ethnomethodology) and the risks that threaten the ordinary (as discussed previously), also draws attention to everyday mundane actions as creative adaptations in terms of maintaining and preserving ordinary life and/or its orderliness. The ethnomethodological term "artful practices" (Heritage, 1984) implies the elements of creativity and innovativeness displayed by people when dealing with social situations.

Similarly, Veena Das's ethnographic writing sheds light on the ingenuity with which people in resource-poor neighbourhoods manage their everyday circumstances.

Additionally, Veena Das's notion of 'ordinary ethics' (Das, 2012, 2015b, 2020) has relevance for the present study. Through her work on the wide-spread suffering brought about by multiple forms of oppression, such as violence, trauma, illness and poverty, Das foregrounds everyday living as an ethical project (Das, 2012, 2020). It is the simple things—such as people's endurance and will to survive, and the everyday acts of kindness in the community—that enable ordinary life to continue even in dire circumstances. Conversely, people themselves—led by their sense of ethicality and moral principles—may *create* those conditions that endanger life itself and/or corrode social relationships. Das's work covers many such instances: from people disowning family members over matters of family honour, to committing ethnic violence against those who were viewed as not being rightful inhabitants in newly partitioned India and Pakistan in 1947 (Das, 2006, 2020). As she puts it,

> … how can ordinary, everyday acts stand up to the horrors of ethnic, sectarian, sexual violence and at the same time be capable of morphing into these very acts of violence? (Das, 2015b, p. 55)

Ethicality reflected in ordinary living, as Das demonstrates, is multifaceted and fluid. Her notion of 'ordinary ethics' captures not just the ethical, but also what may be understood as unethical, from varying points of view. Her argument is that what constitutes ethical action (or otherwise) is always situational and contingent, and should be explored as such, which renders irrelevant any 'universal' frameworks (Das, 2012). In this light, what Das advocates through 'ordinary ethics' is to explore the particular contexts within which situated actions come to be constructed as ethical/unethical (Das, 2012, 2020). This requires

> a shift in perspective from thinking of ethics as made up of judgments we arrive at when we stand away from our ordinary practices to that of thinking of the ethical as a dimension of everyday life in which we are not aspiring to escape the ordinary but rather to descend into it as a way of becoming moral subjects. (Das, 2012, p. 134)

Scholarship on ordinary ethics, as put forth by Veena Das among others, has been critiqued in terms of its claims of ethicality as intrinsic to and immanent in social actions (Lempert, 2013), as well as for taking for granted a common-sense understanding of ethics by denying it a proper definition (Zigon, 2014). Das (2015b) makes a case for maintaining concepts vague so as to permit them greater fluidity. She points out that notions of morality often defy fixed boundaries, and that, on the other hand, all concepts arguably have some blurring of their boundaries and therefore are "blurred concepts" (Das, 2015b; Wittgenstein, 2009, §71). Her ethnographic writing derives from embodied

social action(s) that occurred in real life contexts and in specific social settings in India, and, given her own positionality as a 'native' to her fieldwork settings, Das could claim epistemic authority to discern the ethical as closely as possible to her participants' perception of it.

To summarise, the theoretical scholarship that I have drawn on leads to an understanding of the ordinary and everyday life as unpredictable, fragile, ongoingly constructed and requiring consistent and creative maintenance work. In an ordinary life that is thus unstable and fluid, the maintenance of health through therapeutic practices would also involve ongoing work. In the following section, I turn to Annemarie Mol's work (Mol, 2008; Mol et al., 2015) upon which I build an understanding of therapeutic practices as care practices.

Care practices and 'tinkering'

Annemarie Mol (2008) introduces the notion of care as the logic (i.e. 'logic of care') underlying good healthcare practices, differentiating it from the contemporary (Western and/or modernist) ideal in healthcare that she terms 'logic of choice'. The latter is market-oriented and constructs the 'patient' as a 'consumer' who can unproblematically make decisions in a given 'situation of choice'. While 'patient choice' is widely applauded, Mol (2008) argues that it may not always be equally relevant in contexts of healthcare: who would 'choose' to be sick in the first place? In addition, informed decision making in terms of one's health itself is challenging. It requires much information and deliberation; and it is complicated by the erratic and unpredictable nature of illness and sick bodies. In this light, Mol (2008) proposes that, what would be more conducive towards improving health is an approach of adaptive and attentive caring (by oneself as well as by healthcare providers).

> In the logic of care, the crucial moral act is not making value judgements, but engaging in practical activities. … It is important to do good, to make life better than it would otherwise have been. But what it is to do good, what leads to a better life, is not given before the act. It has to be established along the way. It may differ between lives, or between moments in a life. (p. 75)

A key element of care is that there is no universal 'good', but multiple and contextually-determined 'goods'. That is, care needs to be attuned to the needs of the person and the requirements of the situation, since what is 'good care' may differ by context. Drawing on her fieldwork with people living with diabetes, Mol (2008) shows how the illness and the sick body can make varying demands, which need to be ongoingly addressed and managed in order to maintain health undisrupted.

Care as grounded in praxis is developed by Mol et al. (2015) through the notion of 'tinkering'. They loosely define good care as "persistent tinkering in a world full of complex ambivalence and shifting tensions" (p. 14). In the same edited volume, Winance (2010) further elaborates:

> To care is to tinker and to doctor. To care is to 'quibble', to handle, to adjust, to experiment, to change tiny details in order to see if it works, … (p. 102)

As Mol (2008) demonstrates, people with diabetes are always active in their self-care: they may check their blood sugar level, limit their consumption of food, be attentive to signs of hypoglycaemia, and adjust their medication intake or the dose of insulin that they inject. Healthcare providers, too, pay attention to the patient's needs and concerns in drawing up a self-management plan for them and helping with any issues that arise. Finding out the contextually-determined 'good' and acting on it would, therefore, often be a matter of experimentation and calibration, or 'tinkering'.

> In care versions of the world, the hope that one might live happily ever after is not endlessly fuelled. You do your best, but you're not going to live 'ever after'. … Along the way there will be unfolding tensions and shifting problems. Care is attentive to such suffering and pain, but it does not dream up a world without lack. (Mol et al., 2015, p. 14)

Regardless of how one may try, given the unpredictability of ill-health and life in general, the potential of failure is always imbued in care practices. Therefore, in a care-based ethic, failure does not entail blame. On the other hand, regardless of outcome, care practices must be continued and improved on, for life itself may depend on 'good care'. Care is an ongoing and never-ending process that continues as long as one is alive, "a sticky combination of adaptability and perseverance" (Mol, 2008, p. 79).

Putting together these theoretical contributions from diverse sources, I approach therapeutic practices as care practices that aim to improve health, or to maintain health, following events of illness. In this regard, health is a context-dependent "good", which is achievable only through "persistent tinkering" (Mol, 2008; Mol et al., 2015). Health itself cannot be taken for granted, similar to other uncertainties that characterise everyday life, and illness could be a potential disruptor of the ordinary (Das, 2015a). As such, therapeutic practices are essentially embedded in the everyday as a means through which people ongoingly try to restore and/or maintain the fragile ordinariness of life. These practices are shaped by and dependent on the contingencies of everyday life, as well as the ethicality of social actions (Das, 2012, 2015b, 2020). Further, given that therapeutic practices are closely intertwined with ordinary life and people's lived realities of the everyday, it follows that the

home would be a significant nexus for such practices. This feeds back into the discussion earlier in the chapter on the relevance of the home to explore therapeutic practices.

The present study: theoretical implications and delimitations

Conceptualising therapeutic practices as arising within and shaped by everyday phenomena and household contingencies, as I have done, permits studying them as situated practices that are local and historical. By generating an ethnographic account of therapeutic practices in participant households in rural Sri Lanka, as will be conveyed through the ensuing chapters, I intend to contribute to the global social scientific literature on themes such as the use of medications, traditional medicines (and CAM), therapeutic diversity, treatment seeking and people's sense making of illness/health. Further, these new insights could usefully enrich the social scientific literature on matters of health seeking as pertains to contemporary therapeutic landscapes in the Global South, which, as I have explained previously, remain less explored.

In addition, my theoretical framework also signals my commitment to developing a decolonial approach towards research, though situated within a Western research tradition. In the present study, through detailed ethnographic writing that is attentive to specificities and complexities of the local setting, I aim to present therapeutic practices as enmeshed in the materialities of ordinary life in the rural Sri Lankan households that I studied. Through this approach, I have attempted what Appleton and Bennett (2021) call "a tightrope walk":

> To see the space outside the confines of a colonial gaze, but not through the jingoistic nationalistic and/or nativist mobilisations, requires ethnographic attention to detail and complexity around regional patterns, alongside the theoretical nimbleness of a cultural studies project. (Appleton & Bennett, 2021, p. xxii)

In the present study, I draw from the theoretical scholarship of Veena Das (Das, 2006, 2012, 2015a, 2020), whose work in India highlights epistemological issues similar to those I have come across in the present study based in Sri Lanka. Das (2006) writes of the limits of the existing theoretical repertoire to capture the nuances of lived experiences (of pain, trauma and suffering) of her interlocutors who represent poor, marginalised and/or socially underprivileged communities in the Global South. Relying on established theoretical concepts and language from mainstream (Western) research tradition may risk the distortion or silencing of already marginalised voices, as I have discussed previously. Faced with this issue, Das had chosen to "beg, borrow, steal and invent" (Cavell, 1996, in Das, 2020, p. 308) language in order to ensure her research participants' experiences are presented as accurately as possible. I am guided by her to draw on language and

concepts as required and to put them to work in ways that would best do justice by the participants' voices as well as to render intelligible to a global audience the lived realities of the people who shared their experiences with me.

Accordingly, the conceptualisation of therapeutic practices in everyday life that I constructed above would serve as a point of departure for the present study; however, it will not be considered a concrete theorisation. On the contrary, the meaning(s) of therapeutic practices may mutate and progress through the ensuing chapters of the thesis up to (and including) the final reflections.

In the following chapter, I describe how this theoretical approach was put to work in the present study, through ethnographic fieldwork and the processes of data generation, translation and analysis.

CHAPTER 3: METHODOLOGY

The present study is based on fieldwork carried out from January to March 2019 at the Pitawella[12] village, in Galle district, Sri Lanka. Ethical clearance for the project was granted by the Human Ethics Committee of Victoria University of Wellington, New Zealand (Ref.0000026273) and by the Ethics Review Committee for Social Sciences and Humanities, Faculty of Arts, University of Colombo, Sri Lanka (Ref. ERCSSH/18/16).

To give a brief overview of the fieldwork, the principal means of data generation for the study was household interviews conducted at 20 homes. This involved the participation of 47 householders including men, women and children (details of participants are shown in Table 1 on page 50). Interviews were supplemented by photographing the medications that people used and the general emplacement of medications in household spaces. Four traditional healers in the village were also interviewed in order to better understand the local therapeutic landscape. In addition to the generation of interview and photographic data, the fieldwork enabled an intensive engagement with the community as well as occasional participation in their routine health seeking activities, as characteristic of a short-term or focused ethnography (Knoblauch, 2005; Pink & Morgan, 2013; Wall, 2014). The interviews were carried out in Sinhala language, and the transcripts (in Sinhala) were subsequently translated to English. These data, together with photographs and my field notes, were thematically analysed using the software NVIVO 12. An initial deductive framework of themes was derived from the literature, which was ongoingly modified and refined with the emergent themes identified from the data during the analytical procedure.

In this chapter, I elaborate the research process and the methodology of the present study. First, I present the research design and the fieldwork setting, followed by an overview of the fieldwork engagement and interviews as ethnography. Next, I detail the research process in terms of how the participants were recruited, consent was received, and interviews and photography were carried out. This is followed by the ethical concerns arising through the fieldwork. Then I describe the transcription and translation process, followed by the analytical procedure based on thematic analysis. The chapter concludes with my reflections on researching 'home' as a researcher from the Global South, where I explore my own positionality in terms of how it has shaped the present study.

[12] Name changed

Research design

The research design for the present study was inspired by a New Zealand based study exploring household medication practices (Dew et al., 2014; Dew et al., 2015; Hodgetts et al., 2011). In that project, householders from 55 homes around the country were interviewed regarding their medication use in everyday life. The participants were requested to photograph medications present in their homes, and to maintain diaries on their medication use. Both photos and diaries were used as means of elicitation during the household interviews. The participants were also requested to draw a map of their home, indicating the emplacement of medications (Dew et al., 2014).

Though deriving inspiration from the above project, the present study was adapted as a focused ethnography (Knoblauch, 2005) of household therapeutic uses in one village community. Given the therapeutic diversity that was present in the field setting, an ethnography would permit in-depth engagement through which rich and locally situated data could be generated. Further, data generation methods were adopted based on their practicability in the field setting. For instance, maintaining a diary and map drawing were methods used to great effect in the original study (Dew et al., 2014), though they were left out of the present study design. Diary writing presupposes participant literacy, and map drawing requires a specific acquired ability to depict three-dimensional space on paper; neither of which could be taken for granted among the rural community that I worked with.

Accordingly, the principal data generation method in the present study was household interviews. In the light of the complexity of multiple therapeutic practices that was expected to be captured within the study, it was decided that interviewing 14 – 20 households with varying demographic and medication use profiles would generate adequate data for an in-depth analysis, while also being a feasible plan. Interviews were supplemented by photographing, where consent was given, the medications used by householders and their general emplacement in the home. In addition, ethnographic engagement with the community in the present study also allowed field notes on observations and participant observation of health seeking activities to complement the data.

Fieldwork setting

The study was based in Pitawella, a village community in Galle district, Sri Lanka.

Galle city, located on the southwestern coast, is the capital of the Southern province of the country. Beyond the city limits, the greater part of the Galle district – including 85.7% of its population - is categorised as rural (Department of Census and Statistics Sri Lanka, 2017a). Similar to most rural regions

in the country, the principal economic activities in Galle district are those related to agriculture, forestry and fishing, which provide employment for 34.6% of the district's population (Department of Census and Statistics Sri Lanka, 2017a). Tea cultivation is particularly notable among them, with Galle ranking second out of 14 districts and accounting for 13.5% of tea produced in the country (Ministry of Plantation Industries Sri Lanka, 2013). Cultivation of paddy, rubber and coconut are some of the other important agricultural activities in the district (Department of Census and Statistics Sri Lanka, 2002).

In 2016, the poverty headcount index in Galle was 2.9%: which includes 5,699 households (Department of Census and Statistics Sri Lanka, 2018). Yet the full extent of poverty is not captured by these data alone. For instance, 33,014 houses in the district (12.17%) were either semi-permanent or improvised (i.e. constructed of mud, metal sheets, planks or cadjan[13]), reflecting the occupants' inability to afford a permanent construction made of brick or concrete (Department of Census and Statistics Sri Lanka, 2015b). In addition, 68,922 of the households have participated in the government benefits programme ('Samurdhi') for the lowest income earning families in the country in 2016 (Department of Census and Statistics Sri Lanka, 2017a).

Where healthcare is concerned, there are 25 state hospitals in Galle district that provide biomedical treatment, as well as 11 Ayurvedic medical facilities, where treatment is fully subsidised (Department of Census and Statistics Sri Lanka, 2017a). This is in addition to many private sector (fee-levying) hospitals and medical practices scattered throughout the district.

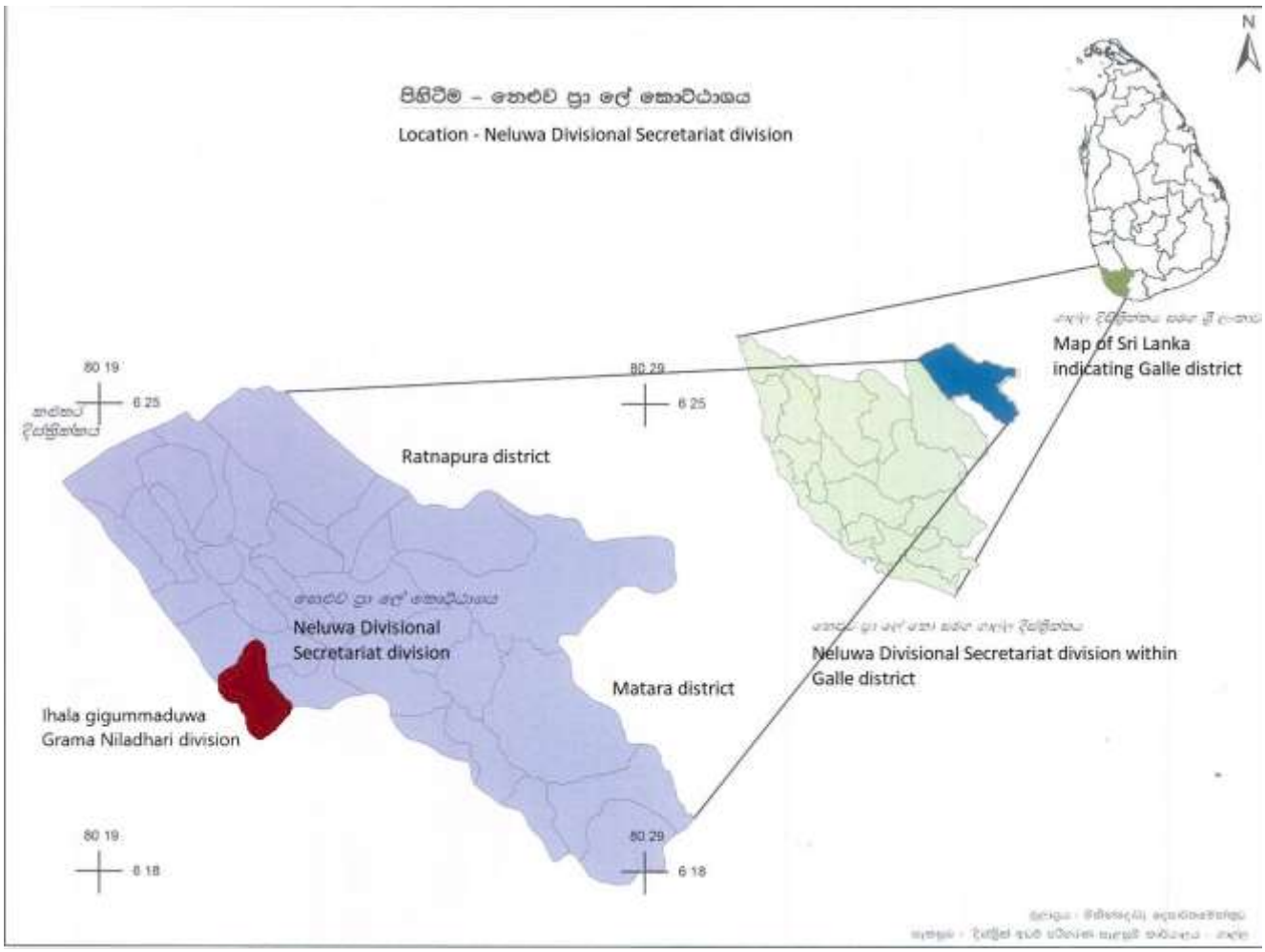
Pitawella village is found in the Ihala gigummaduwa *Grama Niladhari* (GN) division[14] in the Neluwa Divisional Secretariat (DS) division (Figure 1). Located nearly 60 km inland from the low-lying coast of Galle district, within the drainage basin of *Gin* river (*Gin ganga*), and at an elevation of around 100 metres, Pitawella has an average annual rainfall of over 4000mm and a relatively temperate (though tropical) climate (Neluwa Divisional Secretariat, 2019). The Sinharaja tropical rainforest reserve and world heritage site is found 13km from Pitawella. The particular topoclimate of the region is considered ideal for tea cultivation. In fact, the tea produced there is arguably one of the best among the varieties of "Ceylon Tea", surpassed only by those grown in the central hills of the country (Sri Lanka Tea Board).

[13] Coconut palm leaves interwoven to be used as thatching for houses.

[14] *Grama niladhari* (GN) division is a sub-unit of a Divisional Secretariat (DS) division, and the smallest administrative unit that is under the purview of the Ministry of Home affairs. The government officer in-charge of a GN division is the *Grama niladhari*.

Figure 1

Location of Neluwa DS division and Ihala gigummaduwa GN division



Source: Survey Department of Sri Lanka (Captions in English added)

The GN division of Ihala gigummaduwa reported a population of 1783 in 2020, of which 94% were Buddhists of Sinhalese ethnicity (Neluwa Divisional Secretariat, n.d.) According to its officer in-charge, the *Grama niladhari*, this GN division included 492 households. Further, out of the 1206[15] persons aged 18 years or above, 810 (67%) were involved in tea cultivation, while many supplemented their income through small-scale cultivation of black pepper, cinnamon, passion fruit and coconut. In any case, as I was informed by the *Grama niladhari*, the average monthly income per head was around 12000 Rupees (i.e. less than 100 NZD), and 68 households (around 14%) were

[15] There was a discrepancy between the figures quoted by the *Grama niladhari* and those on the Neluwa DS website. Here, I have indicated the former.

recipients of the government benefit scheme 'Samurdhi'. Besides the wide-spread economic precarity, the GN division faced frequent incidence of earth-slips during heavy rainfall, potentially aggravated by activities such as clearing hilly land for plantation purposes. Also rampant were infrastructural issues such as poor-quality roads and non-availability of public transport. In terms of health concerns of the population, the *Grama niladhari* was particularly critical of the government officers in-charge of public health in the region for their lack of care and attention in performing their services (personal communication with the *Grama niladhari,* 04.02.2019).

When choosing a fieldwork setting for the present study, my reasoning was guided by methodological as well as practical considerations. The research project's aim was to explore therapeutic practices within a therapeutically diverse landscape, where both biomedicine and indigenous and traditional therapeutics were widely used by the people. The most appropriate setting to study such therapeutic dynamics would be a rural region, as evident from my own 'insider' knowledge as well as previous literature on therapeutic uptake in Sri Lanka (Jones & Liyanage, 2018; Liyanage, 2000; Weerasinghe & Fernando, 2011; Wolffers, 1988). Further, in order to capture diversified and indigenous therapeutic practices within the ethnography, I narrowed down my search to the Southern region of the country, specifically to Galle and Matara districts, which are well-known for the popular uptake of ritualistic healing practices and the availability of skilled practitioners of supernatural arts (Kapferer, 1979; Obeyesekere, 1969). Having zoomed in thus far, my final consideration was one of practicability: given the time constraints of doctoral study as well as my family commitments, it was important to ensure that I could enter the field setting with some ease in order to successfully complete the fieldwork as planned.[16] Having some relatives living in Ihala Gigummaduwa GN division, which is essentially a rural region in Galle district, I looked for a potential field site in its surrounds. Accordingly, I selected Pitawella village, situated within the same GN division though in a more secluded setting further away from the main roads. It was less than one kilometre off Maduwa village[17] where my relatives lived, and they assisted me in negotiating entry to the field as well as by hosting me and my family[18] through the fieldwork phase.

[16] In this regard, my initial plan, as I outlined in the ethics application, was to seek the support of a university colleague from Sri Lanka. Since this did not work out, I had to adopt the plan which is described in this chapter.

[17] Name changed

[18] My husband and five-year-old son

Fieldwork as ethnography

Ethnography, its etymological meaning being "writing about people" (Hammersley, 2007), has been a prominent research method in the social sciences. While ethnographic practices being diverse and fragmented across disciplines and research areas challenge any unified definition, they would generally involve immersion in a field setting over a period of time during which the researcher attempts to grasp the social realities as lived and experienced by the people within that setting (Atkinson et al., 2001). As Ingold (2008) puts it, "the objective of ethnography is to describe the lives of people other than ourselves, with an accuracy and sensitivity honed by detailed observation and prolonged first-hand experience" (p. 69).

Though traditional ethnography may entail periods of fieldwork spanning over several months or years, given the practical constraints on extended research projects (such as time limitations and budgetary allocations), there is an increasing trend towards performing ethnographies that involve relatively shorter periods of time spent in the field. Such projects have been critiqued for the researcher's not being immersed in the field over a long period, as "quick and dirty" versions of ethnography (Pink & Morgan, 2013, p. 353). However, it could be argued that their (relatively) brief fieldwork is not inherently a flaw; but, on the contrary, that such engagement may be called for by the particular topic(s) being investigated. As Knoblauch (2005) explains, sociological ethnographies or "focused ethnographies" tend to be of shorter duration than the anthropological, since they are usually oriented towards a particular phenomenon or matter of interest within a field setting. In terms of public health research, ethnographies are often performed as short-term and "intensive excursions into [people's] lives" as opposed to extended immersion in a community (Pink & Morgan, 2013, p. 352).

The principal critique of short-term ethnography is that it yields only a superficial analysis, with the researcher not having engaged in extensive fieldwork and therefore possessing inadequate understanding of the field setting. In its defence, Knoblauch (2005) argues that focused ethnography is "experientially intensive" (p. 9) though time-limited. It is "data intensive" (p. 9) in that it employs multiple methods and technical devices (audio/video recorders, cameras) to complement the ethnographer's observations and fieldnotes as well as to facilitate a rigorous analysis (Knoblauch, 2005). Moreover, the call for extensive fieldwork dates back to a time when anthropology was largely limited to (Western) ethnographers studying 'exotic' settings vastly removed from their own (Hockey, 2002). In a case where the ethnographer is researching 'home' and already has close affinity to the community and their ways of life (as in the present study, as detailed later in the

chapter), an extended immersion in the field may not essentially be required for the purpose of producing an in-depth and sensitive analysis.

In this light, the fieldwork for the present study can be termed as a focused or short-term ethnography carried out for a period of approximately three months, with the specific focus of exploring household therapeutic practices in a rural community. I, as a Sri Lankan myself, share a common native culture and language with the participants and am positioned to understand their practices from a near-insider perspective; which I believe is a distinct advantage for an ethnographer. (The ambiguities of being an insider/outsider in the field and beyond is explored later in the chapter).

Ethnographic engagement with the community was rendered possible through my living in Maduwa, about one kilometre from Pitawella, throughout the fieldwork phase. It granted me easy access to the participants' homes to carry out the household interviews at any time of day that was convenient for them. Some of the people from Pitawella were already acquainted with my host family, which facilitated my negotiating entry to the fieldwork site. In addition, I crossed paths regularly with my research participants going about their everyday lives, for instance, at the Champa[19] dairy at Maduwa junction, the Saturday market in Neluwa town, and in the bus to Neluwa. Or they would call out to me from a roadside ledge, where they would be plucking tea, as I walked along the gravel road on my way to or from a participant household.

On several occasions during fieldwork, I was also able to participant-observe the health seeking activities undertaken by the community. Once I accompanied my host on a visit to the *Nona* (woman practitioner) who runs a popular private medical practice in Lunuwila, a small town close by. Another time, Sumudu[20], one of the research participants, invited me to go with her to the village *devale* (shrine) to seek treatment for her son. I also visited the G—traditional practitioner's shop[21] and the E—(biomedical) community pharmacy, both in Neluwa, as a customer myself. In addition, whenever I was in Neluwa, I could observe the crowds gathered to seek treatment at the private medical practice of Dr Kodagoda[22], who is arguably the most sought-after medical practitioner among the Pitawella community.

[19] Name changed

[20] Name changed

[21] Having volunteered to source some ingredients for a *kasaya* (herbal potion) for my hostess.

[22] Name changed

Qualitative interviews in and as ethnography

Given the aim of exploring everyday therapeutic practices in households, the principal means of data generation was qualitative interviews conducted at 20 homes with the participation of all consenting members of each household. During the interview sessions, photographs were taken (by me or by a householder) showing the medications they used and the general emplacement of medications within the home. Four traditional healers in the village were also interviewed - three of whom participated in household interviews as well- in order to better understand the local therapeutic landscape. The interviews, conducted in Sinhala, were audio recorded with participants' consent, and later transcribed (in Sinhala) and translated to English.

While interviewing is a popular qualitative research method, Heyl (2001) cautions against conflating ethnographic interviewing with qualitative interviews in general. For her, ethnographic interviewing warrants a significant time commitment of the researcher towards the participants in terms of both the duration of contact and its frequency, and a research relationship that empowers the participants within the interview and enables them to shape the research study itself:

> … respectful, on-going relationships with their interviewees, including enough rapport for there to be genuine exchange of views and enough time and openness in the interviews for the interviewees to explore purposefully with the researcher the meanings they place on events in their worlds (Heyl, 2001, p. 369)

Spradley (2016), in his seminal text on ethnographic interviewing, describes how the ethnographer's outlook towards interviewing should be made explicit to the participants. Given the ethnographer's purpose of exploring the social realities of the participant/s, the research relationship appears to be construed as one between a master and disciple:

> I want to understand the world from your point of view. I want to know what you know in the way you know it. … Will you become my teacher and help me understand? (Spradley, 2016, p. 34)

In the present study, developing a rapport-based empowering relationship with the participants was a challenge due to their being an underprivileged community in terms of economic precarity, low literacy and low socio-economic status. At the outset, many people were reluctant to consent for participation on learning that the present study was university-affiliated research, their concern being that they were not educated and therefore would not know how to respond adequately. Evoking Spradley's (2016) views on the research relationship, I explained to the participants – and reiterated whenever necessary- that I was there to learn from them about their lives, and that they

were the experts who would be doing me a favour if they chose to share with me their lived experiences. The notion of doing a favour was intended, by me, to convey to the participants that, within the context of their potential participation in the study, they were in the empowered position of making a choice (at least within the scope allowed by social norms that shaped our social interactions, given the different social positionings of me as researcher and them). While my attempt was acknowledged by them, their understanding of a favour was often framed within the Buddhist teachings[23] on helping others as a meritorious act (*pin*). "As long as we can be of help to someone", said many of them who consented, "It's *pin* to help others".

There is an increasing body of literature that explores the potential of qualitative interviewing itself as ethnography. The proponents of this view, many of them anthropologists, critique the popular conflation of ethnography with participant observation, which they allege has led to the devaluing of interview-based studies within the field of anthropology (Hockey & Forsey, 2012). Interviewing becomes particularly important in relation to 'home-based research', where one stays 'home' and studies one's own people as opposed to researching unfamiliar settings that involve travelling and living abroad. While participant observation may have its merits in the latter case, Hockey (2002) argues that interviewing would be preferable in the former, since interviews would closely approximate the fragmented and temporally-bound nature of everyday social interactions in contemporary techno-mediated societies. Further, certain phenomena of interest, such as those that involve people's choices and decision making (Forsey, 2010; Hockey & Forsey, 2012), could be most effectively captured through interviewing participants.

Interviews are undeniably an important data generation method in/as ethnography. Forsey (2010) finds that ethnographers most often use "participant talk" heard during fieldwork as data, as opposed to data from participant observation, due to which he suggests that "participant listening" – including interviewing – should gain primacy in ethnography. However, interviews are not necessarily limited to participant listening, as Hockey (2002) illustrates through her interviews with aged persons living alone. She reports of messy unmaintained living spaces and the pungent scent of urine and disinfectant that constituted a sensory backdrop to the interview setting within participants' homes. Her interviewees 'conjured up' their past and interactions with their dead loved ones, sometimes acting out certain scenarios using her as a prop, thus constructing a situated and embodied narrative which transcended the boundaries of space, time and even life (Hockey, 2002).

[23] All the participants in the present study self-identified as Buddhists.

In the present study, the interviews were embedded into and shaped by the everyday life within participants' homes.

> Kasun[24]'s house is tiny, constructed of wood planks. Inside, polythene sheets nailed to the walls make a bright purple wallpaper. We sit on old peeling plastic chairs in the hall. The door to the garden is open, letting in the cool night breeze (and mosquitoes). There's a large table with TV and books. A tiny alcove in the wall has a Buddha statue, some flowers and a lighted lamp. A scent of burning incense. Kasun is dressed casually in sarong; chews betel and goes out occasionally to spit. Seated next to me is his wife, mixing rice and curry on a plate and feeding the toddler (about 3 years?). He keeps eyeing the voice recorder while walking back and forth between me and his mother. The son (12 years) is keenly involved in our chat. I ask his help to photograph the medications and he is delighted: takes all the photos himself using my device. (Fieldnotes, 26.02.2019)

Almost all the interviews were done in the evening or at night, since this was the time that most householders said they would be at home and available to talk. This, however, meant that they would have just returned home from work or from after-school tuition classes. When I visited a house as agreed upon previously, the adults were most often in the process of preparing dinner and going about their household chores, and children played or did their school homework. Consequently, the interviews were shaped around the contours of everyday life happening within the household. While the interviews went on, meals were cooked, children fed, and babies rocked to sleep. Interviews took place in the kitchen, in the living/dining space or the verandah of the house. Some interviews were paused for a young mother to breastfeed her infant, to allow the householders to watch a favourite TV show, or when a neighbour dropped by for a chat.

In addition, the interviews were firmly situated within the local customs of a social visit. I was treated with much hospitality and respect as befits a guest to their homes, which almost always included being offered a cup of tea as refreshment. The interviews proceeded more or less as a conversation, in a relaxed and casual manner. The token of appreciation that I offered to participant households—some household consumables—was packed into a bag as a gift, to fit with the local customs of gift-giving during a social visit. Following the interviews, a few of the research participants paid me the customary return visit at my lodgings, bringing their garden-produced fruits and vegetables as gifts.

[24] Name changed

Interview process

Recruitment of participants for household interviews

As a means of securing community support for the study, I had planned to seek the assistance and endorsement of the *Grama niladhari* officer overseeing Pitawella village as well as the chief incumbent monk of the village Buddhist temple (as mentioned in my ethics application). However, there was no incumbent monk at the temple at the time that I commenced fieldwork. Therefore, on reaching the fieldwork site, one of the first appointments I had was with the *Grama niladhari* officer for the GN division of Ihala gigummaduva, which includes the Pitawella village. The *Grama niladhari*—or Gunasekara mahaththaya[25] as he is generally known—was in-charge of two GN divisions. It turned out that he was not as closely acquainted with the people in Pitawella as I had expected; therefore, his assistance towards the study was limited to providing the necessary background information.

In terms of recruiting participants for the study, I received the support and endorsement of an informal community leader, Gunapala mama[26]. As the main patron of the village temple and the founding chairperson of several village collectives, he is a prominent person in the community and is well-regarded by many. Gunapala mama arranged for me to talk to the people at a meeting of the 'village development cooperative society' that he convened. Almost every household in Pitawella was a member of that association, which allowed me the opportunity to reach out to a wide audience.

Following my exposition at the meeting, eight people expressed interest in taking part in the study. I paid each of them a casual visit at their homes, during which I could meet the rest of the householders and explain the study in more detail. Where the householders were interested to participate in the study, I asked them for a day and time when all of them were at home and available to be interviewed. Post-interview, I requested each household to recommend others who might be interested in taking part in the study. Through this snow-ball method, I was able to find potential participants with due attention to households of different compositions and medication usage profiles, for example, households that included elderly persons, children, infants, long-term medication users, chronically ill persons and so on. In addition, participants spoke to me about their acquaintances' intriguing histories of illness and/or medication usage, such as chronic illness that

[25] *Mahaththaya* is a term denoting respect, its meaning translatable as 'sir' or 'Mr'. Gunasekara (pseudonym) is his name.

[26] *Mama* is a kinship term meaning 'uncle' though applicable to any adult male considerably older to oneself. Gunapala (pseudonym) is his name.

remained medically undiagnosed or miraculous recovery through traditional therapeutics. I contacted some of those persons who were living in the village itself and recruited them (and their households) as participants, with a view to diversify the experiences of illness and therapeutic practices captured within the study. (Please see Table 1 on page 50 for details on the participating households.)

Following up on the interviewees' recommendations was a very effective means of recruiting potential participants. Mutual contacts often offered to inform potential new participants of the study on my behalf, which I did not often encourage, since I preferred to speak to every potential participant myself to ensure that they received all relevant information before they decided to consent or not. However, word-of-mouth was always ahead of me: it was most often the case that the potential participants that I contacted through the snowball method were informed in advance of my project and the research interviews. On the one hand, it was convenient for me that such potential participants seemed quite prepared to consent for participation, presumably due to a favourable impression of research participation as conveyed to them by their informers. On the other hand, whatever the previous interviewees had told them of household interviews and the study as a whole, and *their* own resultant fragmentary understanding of what might be expected from them as interviewees, could certainly have shaped the illness and health narratives that they co-constructed during subsequent interviews with me.

Whenever I communicated with the people in Pitawella, for the purposes of my study and beyond it, the language I used was the simple colloquial version of Sinhala. In Sri Lanka, fluency in English language and code-switching between first language (Sinhala or Tamil) and English is considered a status marker of the middle class and the elites (Gunasekera & Rajapakse, 2005). Such language practices, for instance, would stand one out in a rural community. Therefore, I was particularly attentive towards adapting my language usage to approximate that of my participants. This included addressing them by appropriate kinship terms (such as *akka*, *ayya*, *nanda*, *mama*[27] and so on), as is the local custom.

[27] These kinship terms are translatable, respectively, as older sister, older brother, aunt, uncle.

Table 1

Demographic, health and medication details of the households participating in the study

Household	Pseudonyms	Age	Gender	Some health and medication characteristics in the household
1 - Three generations living together (including an infant)	Mahasen mama* Mahasen nanda Nuwani Ruwani	76 59 29 28	Male Female Female Female	Chronic illness and long-term medication use; Discontinuing long-term treatment; Experience of exorcism
2 – Family with school-aged children	Nagoda akka	47	Female	Chronic illness and long-term medication use; Comorbid chronic illness; Using multiple therapeutics; Discontinuing treatment
3 – Family with a school-aged child	Sumith ayya Surangi akka	54 48	Male Female	Chronic illness and long-term medication use; Comorbid chronic illness; Selectively discontinuing medications; Following traditional *kadum-bidum* (orthopaedic) treatment
4 – Elderly couple, grown-up children living nearby	Gunapala mama Gunapala nanda	72 66	Male Female	Experience of *kadum-bidum* treatment; Recurrent illness episodes
5 – Family with a toddler	Kalana Thilani	36 29	Male Female	Therapeutic practices involving, and on behalf of, young children
7 – Elderly couple, grown-up children living elsewhere	Matara mama Matara nanda	80 68	Male Female	Chronic illness and long-term medication use; Comorbid chronic illness; Experience of exorcism
8 – Three generations living together	Punchi nona Punchi nona's mother Punchi nona's son	24 69 7	Female Female Male	Therapeutic practices involving, and on behalf of, young children
9 – Three generations living together	Ishani Ishani's mother Ishani's son	25 63 7	Female Female Male	Chronic illness and long-term medication use; Therapeutic practices involving, and on behalf of, young children

10 – Elderly couple, grown-up children living elsewhere	Dolahe-gedara mama Dolahe-gedara nanda	81 77	Male Female	Chronic illness and long-term medication use; Comorbid chronic illness
11 – Three generations living together	Sunimal mama Sunimal nanda Sumudu (daughter-in-law) Sumudu's son	58 61 27 9	Male Female Female Male	Recurrent illness and medication use; Using multiple therapeutics; Therapeutic practices involving, and on behalf of, young children
12 – Family with grown-up children living with parents	Herath akka	47	Female	Recurrent illness and long-term medication use; Using multiple therapeutics
13 – Family with school-aged children	Timira Manori akka Manori akka's daughter Manori akka's son	35 39 15 8	Male Female Female Male	Therapeutic practices involving, and on behalf of, young children
14 – A couple with grown-up children living elsewhere	Sujatha akka	48	Female	Discontinuing treatment; Experience of exorcism
15 – Family with a school-aged child	Kalu mahaththaya* Kalu nona	59 56	Male Female	Therapeutic practices involving, and on behalf of, young children
16 – Family with school-aged children	Menik ayya* Menik akka Menik akka's daughter	45 40 18	Male Female Female	Therapeutic practices involving, and on behalf of, young children; Recurrent illness and medication use
17 – Elderly couple, grown-up children living nearby	Patty mama Patty nanda	63 59	Male Female	Chronic undiagnosed illness; Using multiple therapeutics; Experience of exorcism
18 –A couple with grown-up children living elsewhere	Rathu ayya Nita akka	58 52	Male Female	Discontinuing treatment
19 – Family with a school-aged child	Roshan Sarika	34 32	Male Female	Chronic illness and long-term medication use

20 – Elderly couple, grown-up children living elsewhere	Jaya mama Jaya nanda	79 65	Male Female	Resisting treatment; Divergent therapeutic preferences among householders
21 – Family with school-aged children and a toddler	Kasun Kamala Kamala's son	37 31 13	Male Female Male	Therapeutic practices involving, and on behalf of, young children

*This householder was also interviewed as a local healer

Note: Household No. 6 involved in the present study did not participate in a household interview, therefore it is not included in the above table. Its resident Mudalali (pseudonym) was interviewed as a local healer.

Requesting consent for participation

The consent process preceded each household interview. I first explained the study in detail to the householders, based on the information sheet in Sinhala. Secondly, I read out the consent form in Sinhala, explaining the contents further in simplified language. When children were among the prospective participants from a household, I also read out and explained the consent form for children's participation in Sinhala. (All information sheets and consent forms used in the study are included in Appendix 2). Thirdly, I checked whether they had understood and whether they needed further clarification on any point(s). Once the householders said they understood and were satisfied with the explanation, I requested their permission to switch on the voice recorder to record their verbal consent to participate in the study. Then I read out the consent form, explaining where necessary, and asked them to state whether they were willing to take part in the study. In households with children, the same procedure was followed again using the consent form for children's participation. A copy of the information sheet and the consent form(s) were also provided for them to keep. Once the participants' verbal consent was recorded, the recorder was switched off (until it was switched on again, with participants' consent, at the beginning of the research interview). The recording of verbal consent was later uploaded to the University server.

The standard process of consenting to participate in a research study involves potential research participants reading and signing a consent form to express their willingness to participate in the study. However, as the present study involves an underprivileged community, there was a possibility that the potential participants include less educated or illiterate people. For them, the requirement of a signature could be a daunting or even a humiliating task, which could dissuade their participation in the study itself. Therefore, it was decided at the outset to request verbal consent from the participants and to have it audio recorded.

An interesting observation was that though information sheets and consent forms were handed over to each of the households that I interviewed, it was only in two households that the participants took time to read through the documents before signalling their readiness to declare consent for participation. All others expressed consent solely based on my verbal explanation of the study. Therefore, it is highly likely that the standard practice of obtaining participants' written consent based on their reading and understanding the relevant documents would have failed in this context; so that the decision to request verbal consent from participants (as opposed to requiring a signature) appears to be justified.

Conducting household interviews

The interviews followed a set of pre-determined themes around the households' ordinary use of therapeutics, covering therapeutic preferences and decision making, management of medications in the home, and their flow to and from the home. (The full list of themes is included in Appendix 3.) These themes were used as a guide to shape the contours of the interview, whereas the structure of the interview was kept as flexible, spontaneous and situationally responsive as possible. My aim was to allow the conversation to flow freely with minimal interruption on my part as a researcher, so as to capture the participants' co-construction of the narratives of illness and health. Maintaining a casual informal style similar to everyday conversation was useful to establish good rapport with the participants and to put them at ease.

The presence of a voice recorder was the main anomaly in what was structured as more or less an informal conversation during a social visit. Prior to every interview, I checked whether the participants consented to my using the voice recorder, and I informed them before switching it on. None of the participants opposed their interviews being recorded. Several of them were slightly nervous at the beginning of the interview, voicing concerns that they might utter something irrelevant which would get recorded. This was clearly underpinned by a feeling that their casual everyday utterances would not be 'good enough' to be transformed into a (relatively) permanent record which they felt to be of a formal nature. On such occasions, I explained the purpose of recording the interviews[28] to alleviate their concerns of being 'caught on record', but also offered them the option of being interviewed without the recorder. Appearing to be satisfied with my explanation, all of them expressed willingness for their interviews to be recorded. In any case, almost all the participants seemed to forget the presence of the recorder once they warmed up to the conversation. The children in the households, on the other hand, continued to be very curious about the recorder, which allowed me an opportunity to connect with them and engage some of them in the interviews as well.

The dialogic nature of the interviews meant that I had to engage in some self-disclosure at times. As Hampshire et al. (2014) write, it was important as a means of catalysing shared experiences and views. For instance, I drew on my experiences of mothering or of seeking treatment from local healthcare providers when similar experiences or views were expressed by a participant, so that our shared experiences would both strengthen the rapport and further the interview process. In addition, as a Sri Lankan woman myself, I felt that I was often accepted by women interlocuters as a fellow 'sufferer': someone who they felt to have a similar gendered existence and therefore understood their gendered

[28] The main reasons were that I could focus on the interview without having to note everything down, and to ensure that nothing important gets left out when analysing the interview data later on.

experiences within the household and the community. As one woman-participant, Matara nanda, put it, "it takes a woman to understand the *duka*[29] of another woman" (fieldnotes, 27.01.2019). Consider the following excerpt, where Jaya nanda expands on an everyday ordeal she underwent due to an injury to her ankle:

> The next day, I couldn't get up, couldn't even go to the toilet. I was crying, I couldn't help crying. Then *mama*[30] helped me to the toilet. I don't feel comfortable with that. I think I did that only twice or so. I just stopped eating. I ate very little, because otherwise I'd need to go to the toilet. … Even if I go, I couldn't squat [on the toilet pan]. Holding my leg [extended] like this... It was such *duka*[31]. Sometimes, I'd just stop it halfway and wash myself and come back. You are a woman, too, *duva*[32]. You understand how it is.

Her physical pain is complicated by her gendered and embodied experiences of embarrassment and helplessness. Yet she chose to disclose them to me—a complete stranger to her, but a woman, who she expected would be capable of understanding her suffering and empathising with her. Though not always expressed outright thus, a number of insightful conversations I had with women participants were likely rooted in our shared (or thus assumed) gendered experiences, which transformed the research interview into a space of mutual solidarity.

During fieldwork, I also observed a certain unwillingness on the part of men to join a discussion on their household's healthcare practices, as opposed to women's apparent enthusiasm. Even where the former did participate, other than in a few homes, it was usually the women participants who dominated the discussion.

> During interviews, I end up talking to women mostly. Even when men are present at the time previously agreed on for the interview, most of them would be at a loss about what to talk and/or may try to avoid the conversation. Like, when mid-interview Thilani told her husband to talk to me while she went off to breastfeed the child, he was quite miserable at being put in a spot and complained, "What can I say?" (Fieldwork reflections, 28.01.2019)

One potential reason for men's reluctance to participate could be the implicit understanding manifested in many households that therapeutic practices, or matters of health and caring in general, were a

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[29] Suffering, pain. In Buddhism, living is conceptualised in terms of (diverse) suffering. In this quote, the reference is to the gendered life experiences of a woman.

[30] Reference to her husband

[31] Suffering. Here, it could refer to physiological pain, feelings of helplessness and embarrassment, or all of them.

[32] Daughter. This term can be used to call any woman/girl considerably younger to oneself.

woman's domain. This was maintained even in homes where in-depth discussions revealed considerable evidence of men's undertaking healthcare-related practices. As "the doing of health is a form of doing gender" (Saltonstall, 1993, p. 12), the householders' emphasis on women's performance of healthcare work, as well as downplaying that of men, may potentially serve to project, to me, that their healthcare work aligned with the gendered norms that were upheld in the community.

Photography

A secondary means of data generation for the present study was through photography. Visual data was generated by photographing the medications that the participants brought to show me at the interview, as well as the general emplacement of medications within the homes. Most photographs were taken during the interview as and when the relevant medications and their emplacements were being discussed, and a few were taken post-interview. Photography for data generation was carried out only where participants' consent was explicitly and unambiguously expressed (as described under the ethical aspects of fieldwork), due to which limited visual data is available in the present study.

Photography that generates visual data for research purposes can be performed by the researcher or the participants. Participatory photography, i.e. photography done by participants, may generate visual data that offer valuable insights into the participants' lives; and as a method, it may be a means of empowering them within the research process (Byrne et al., 2016). In the present study, a lack of photographic know-how was a real possibility among the research participants from the resource-poor rural community being studied. Therefore, I offered each household the alternative of either taking the photographs themselves or of directing me as to what should be photographed and how. In some households, older children volunteered; in others, it was I who took the photos. Being thus focused on the practicalities of generating photographs, the research design of the present study does not maintain a uniform participatory approach towards photography.

Overall, photography may have methodological and/or analytic relevance in a study. Photo elicitation technique sees photographs being used to prompt and further the discussion during interviews. In Dew et al. (2014), for example, photographs taken by participants between a first and second interview were used as prompts during their household interviews into medication practices. In the present study, photography was carried out during the interviews or afterwards; and the visual data thus generated was used in the data analysis with the textual data, as elaborated later in the chapter. As Byrne (2020) demonstrates in her doctoral thesis into (participatory) photography as a methodology, in-depth analysis of visual data may highlight the nuanced and complex nature of materially mediated relations in/with

space and place. In the present study, the limited availability of visual data did not permit such in-depth analysis, though it was used to supplement the textual data in the data analysis.

Managing contingencies: Involvement of non-householders in household interviews

Unexpected participation of non-householders in an interview was a challenge that I faced quite often. Neighbours coming for a chat—and prolonging the visit over tea—was a frequent occurrence during interviews, at which point I would switch off the voice recorder and indicate to the participants that the interview was paused. This was done in recognition of my ethical obligations as a researcher to maintain confidentiality of the interview. However, the householders were often perplexed as to why I had paused the conversation. In some cases, the householders requested me to carry on the interview in the presence of the visitor(s) stating that they were close friends or neighbours. On consulting my fieldwork supervisor from Sri Lanka, I was advised to carry on with the interviews in the presence of the visitor(s), provided that my intended interviewees wished to do so (Dr D. Abeysinghe, personal communication, 30.01.2019). This was the pragmatic option given the time constraints of the study as well as the local norms, though it meant a slight deviation from the established research ethics.

> As soon as I recommenced the interview with [Sunimal mama, his wife/*nanda*, and their daughter-in-law Sumudu], Thushara (a neighbor) came in. I informed the interviewees and switched off the recorder. *Nanda* suggested that I let Thushara join in the chat, Sunimal mama and Sumudu agreed. But I did not do so and observed their ongoing interaction. In the meantime, Sunimal mama explained to Thushara what we had been talking about so far. Nanda asked him about his medicine for gastritis and he joined in the conversation. Sunimal mama made cups of tea and served us. Thushara remained, drinking tea leisurely like the others, very much a part of the conversation. Sumudu asked me again to restart the interview. It was late evening already. Then I checked with everyone present, gave a quick briefing to Thushara about my study, and switched the recorder on again. (Fieldnotes, 31.01.2019)

On such occasions, it was clear that the householders did not mind their visitors (such as neighbours, friends) being there while personal information involving illness and medications was being discussed. In fact, most visitors were already aware of such concerns of the household. Incidents like the above point out the possible incongruence of Western conceptualisations of ethicality (in this instance, those of privacy and confidentiality) to field sites elsewhere. This resonates with Das's (2012) call to approach "the ethical as a dimension of everyday life in which we are not aspiring to escape the ordinary but rather to descend into it as a way of becoming moral subjects"(p. 134). If the ethical is thus embedded in the fabric of everyday life, it is no wonder that the attempt to apply a 'universal' model of ethics would

have limited success in a given field setting. In such a case, the researcher would require a good understanding of the local "ordinary ethics" (Das, 2012) as well as a willingness to adapt in order to make it work. (The ethical concerns of fieldwork are taken up in detail later in the chapter.)

Once the ethical dilemma was negotiated, the presence of visitors during household interviews could in fact be beneficial to the research. My experiences of this were two-fold. On the one hand there were visitors, often extended family, who volunteered to support the interviewing process by taking care of other household matters, thereby leaving the householders free to be interviewed.

> During the interview [with Roshan and his wife Sarika], Patty nanda (Roshan's mother) walked in, carrying a torch (it was dark outside) and some parcels. She had brought cooked dinner for Roshan's family. That was Patty nanda's way of helping me, by releasing Sarika from cooking dinner so that she'd have time to talk to me. I'm very touched. Patty nanda pressed a small parcel into my hands as well: it was some cooked *Polos*[33], for me to take home for dinner. (Fieldnotes, 21.02.2019)

In such cases, the visitors' presence was of short duration and/or they remained in the background without joining in the conversation. Their impact, therefore, was *felt* as a contextual factor rather than rendered visible through the interview itself. In one instance I felt the presence of the mother-in-law (to take care of the baby) might have put a young woman ill at ease during the interview, therefore I conducted a follow-up interview with the latter, alone. The following excerpt is taken from my post-interview fieldnotes:

> I didn't learn too many new things today [at the follow-up interview]. But Thilani was clearly more relaxed and talkative. Last time, Gunapala nanda was also there to mind the baby, which might have affected Thilani. Today I made it a point to mention that I didn't bring the voice recorder. We shared some of our experiences of mothering as well. All of these could have helped put her more at ease today. (Fieldnotes, 06.02.2019)

Such presence of visitors in the fringes of the interview can be contrasted with cases where they engaged actively in the interview, making an important contribution and shaping its direction. Involvement of neighbours and/or friends often put the interviewees more at ease than they would otherwise be when talking to a researcher, allowing the conversation to flow naturally as in the course of any everyday interaction among them. In one case, the intended interview participants were a household made up of a young couple, their child and the wife's elderly mother (who was undergoing treatment for oral cancer);

[33] Young Jak fruit cooked in spices. A popular delicacy that is rare in the city, which also requires a lot of skill and time to prepare.

though the actual participants were the wife (Ishani), her child, her mother and two neighbourhood women. Below is an excerpt from the interview (translated to English).

Researcher: How do you apply this [medicine]?

Ishani: [The ulcer] is in her mouth. The cancer is also in her mouth.

Ishani's mother: [I] have to take some [medicine] onto a spoon or something and apply [inside the mouth]. Then the burning sensation gets less.

Neighbour 1: [she's] been treated with 'current'[34]

Ishani's mother: [I've] been treated with 'current'

Neighbour 1: When they do that, in the mouth, ulcers occur

Ishani's mother: …ulcers occur

Neighbour 1: And the cream is to apply on those [ulcers]

Neighbour 2: How many years has it been now?

Ishani: About three years

Ishani's mother: …three years

Here, it is clear that the neighbours are quite familiar with the illness trajectory and the treatment process being discussed, and they make an attempt to bring it to light on behalf of the only outsider, i.e. myself. What is reflected in such exchanges is the deep mutual understanding and solidarity among these women, and the neighbourhood at large, in terms of sharing their struggles of everyday life. Das (2015a) speaks of similar evidence of solidarity where people covertly help their neighbours facing financial crisis in order to save the latter from social humiliation. During my fieldwork, though the presence of unexpected visitors disrupted my original research intention of interviewing a household, I was granted insight into the remarkable communal networks in which everyday health concerns were shared and managed.

Ethical concerns of fieldwork

In view of the ethnographic ideals of sensitivity to and nuanced understanding of the point-of-view of another, it is essential that the researcher attempt to maintain a respectful and empowering relationship

[34] This was the word they used to indicate the treatment. It probably refers to radiation therapy.

with the participants. Kvale (1996) presents two metaphors of a research interviewer: one as a miner who extracts buried treasure, and the other as a traveller who returns from a journey with stories to tell (Heyl, 2001). Research projects in the Global South, often carried out by Western researchers, have historically been of the extractive kind and underlined with a strong colonial bias. It is in relation to similar intrusions upon Māori in New Zealand that Smith (1999) writes,

> The word … '*research'* is probably one of the dirtiest *words* in the indigenous world's vocabulary. When mentioned in many indigenous contexts, it stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful. (p. 1).

While my project was based in my own country, it was with a socially underprivileged community where my presence as a university-educated middle-class person might be experienced as oppressive. Further, I approached them as a researcher affiliated with a foreign university, equipped with a research framework developed within White academic spaces. As I came to know in the early days of fieldwork, one participant had commented on my research as being a covert attempt by the *Suddah* ('White man') to 'steal' traditional indigenous knowledges. This was strongly reminiscent of the (well-founded) negative attitude towards research among Māori as recounted by Smith (1999). While I believe such conceptions of the study were dissipated once the community came to know what my intentions were, they alerted me to the potential harm that I (however inadvertently) may inflict on the community.

The contemporary critiques of the research interview identifies it as an inherently imbalanced power relationship. Kvale (2006), for instance, is highly critical of the "warm and caring dialogical conceptions" of interviewing that gloss over the ethical conflicts, participant manipulation and overall power differential that constitute the interview process. As he argues, interviewing involves a one-way dialogue where the interviewer sets the agenda and asks the questions while the interviewee is expected to respond; it is aimed at serving the researcher's purpose of gathering data, with little or no benefit (in fact, occasionally even causing harm) to the interviewee; and the researcher retains epistemic superiority in terms of interpreting the interviewee's talk (Kvale, 2006). In their position of power within the interview, the researcher could, in fact, become a 'big bad wolf' whose "big eyes and ears sensitively grasp for potential consumption what the multiple interview voices tell them" (Kvale, 2006, p. 498). While I maintained the stance of the ethnographic interviewer (Spradley, 2016) throughout my interactions with the participants, I was and am aware of the power asymmetry that constitutes the interview process that I cannot dismantle entirely, augmented as it was within the incommensurability of social positionings between myself and the participants. However, this awareness informed my efforts to minimise the potential negative impact on the participants through interviewing.

A key aspect of participant empowerment was enabling them to make a free, uncoerced choice on whether to participate in the study and to what extent. It is with this purpose that the information sheet and consent forms (Appendix 2) were prepared for the present study. As described earlier in the consent seeking process, I emphasised to potential participants that they were free to decide whether to participate in the study or not, and that deciding not to participate would not have any negative impact on their lives. While I was planning to offer a gratuity to the participants as a token of appreciation, this was purposefully not mentioned to them at the outset, since I wished them to decide freely without their decision being influenced by a potential gift. Further, I explained to them that their consent does not have to be absolute: that they could withdraw their previously granted consent if they wish to change their decision at some point. (However, none of them withdrew consent this way.)

Similarly, the participants were informed that they have control over what information they shared with me and how, and their decisions in this regard were fully respected. For example, where visual data was concerned, the participants were given the choice of taking the photos themselves or of guiding me on where/what to be photographed. Participants from all households handed over their medications to be photographed during the interviews; but it was only in three of the households that the normal emplacement of medications within the home was photographed. While none of the other households *refused* to provide visual data for the study, there was some reluctance on their part to engage with photography as opposed to their willingness for a 'chat'. This could be due to numerous reasons, ranging from an unfamiliarity with photography as a casual everyday activity, to an unwillingness to permit me—an outsider—into the private spaces of their home. In any case, I respected their unwillingness to share information and did not press them on the matter. As a result, there is little visual data on the emplacement of medications within the homes. However, interview data more or less compensated for the lack of the visual, as emplacement of medications was discussed in detail during the interviews. The participants willingly described where and how they stored their medications in the home and why they followed such emplacement practices.

As discussed earlier in terms of the issue of unexpected visitors during household interviews, there were occasions where I had to navigate the incommensurability of (Western) research ethics against the "ordinary ethics" (Das, 2012) embedded in the locality. For example, the former requires that confidentiality must be maintained with regard to sensitive personal information divulged by participants during interviews, such as that regarding their health; however, I noted that such information was openly discussed among themselves by the members of the close-knit community that I was working in. Many of them had no qualms about discussing with me their own illnesses and health seeking efforts as well as their neighbours' and friends', so much so that such information appeared to be in general circulation within the community. This greatly facilitated the process of participant recruitment, since every

household that I interviewed was able to suggest to me more potential interviewees who had interesting illness histories and/or treatment seeking trajectories. On the other hand, there were several occasions where participants informed me of certain illness-related information of their neighbours, which the latter—who were previously interviewed—had not disclosed to me. This raised an ethical quandary regarding whether, and in what manner, I could ethically use such information in the study. My conclusion was to use such unsolicited second-hand information, if it were to be used at all, only in relation to its context of utterance and without association to the person to whom it referred.

Transcription and translation of interview data

Since the interviews for the present study were carried out in Sinhala language, it was necessary to translate the interview data to English in order to make them amenable for collaborative analysis at the university in New Zealand. All the interviews were audio recorded (with participant consent). I transcribed the recordings, and the transcripts were then translated to English. A professional Sinhala-English translator from Sri Lanka was contacted for this purpose, who, on an agreement of confidentiality (included in Appendix 2), translated seven transcripts; and I[35] translated the rest of the transcripts. Each translation was checked against the relevant interview transcript to ensure their consistency of meaning, before being used for data analysis.

Temple and Young (2004) critique the notion of translation as merely a practical concern in a research project, where a translation is considered more or less equivalent to the original so that both the translator and the act of translation would "disappear" from the final report of the study. On the contrary, translation/interpretation of interview data from one language to another gives rise to methodological and epistemological concerns in any cross-language research study. Where the researcher does not speak the language of the research participants, the degree of mutual intelligibility within a research interaction largely depends on the language interpreter whose own social positionality and subjectivities would "filter" the original meaning to some extent (MacKenzie, 2016). This was, however, not the case in the present study, as I share a common first language (Sinhala) with the research participants and the interviews were conducted in this language. Therefore, any potential cross-language concerns of the present study occur post-interview, during the translation of interview transcripts to English.

The professional translator and I both possessed the linguistic and translation competence to perform an effective translation from Sinhala to English, and I closely verified that the translated texts were "faithful

[35] I am a native speaker of Sinhala as well as a sworn translator (Sinhala-English) in Sri Lanka.

to the sources" (de la Vega, 2019, p. 1634). There were several persistent semantic issues which we discussed and resolved. One such issue involved the Sinhala word *beheth,* which, depending on context, may invoke different meanings associated with medicine and treatment (as I elaborate in chapter 5). This word occurred frequently in every interview as participants spoke of their medications and health seeking practices; and given the focus of the present study, it was crucial that the word was translated to convey the most appropriate meaning in each instance of its occurrence.

In any case, a translation can never be a neutral process of transferring meaning from one language to another (de la Vega, 2019; MacKenzie, 2016; Temple & Young, 2004). Being capable of speaking a certain language, or being from a certain ethnicity, does not necessarily involve sharing similar worldviews, as Temple (2006) explains in terms of bilingual researchers and their tenuous ties to language communities. Being cognisant of the non-neutrality of translators and its impact on translation work alerted me to the socially privileged position that English-educated Sri Lankan translators (including me) occupy in comparison to the research participants whose marginalised voices were being translated from Sinhala to English. With de la Vega (2019), I consider it an ethical obligation to be critically and reflectively analytic of the translation as well as of oneself as a translator.

The English translations of interview transcripts were uploaded to the University server to ensure their safe storage. The same procedure was followed previously for the audio recordings of interviews, interview transcripts, fieldnotes and the photographs.

Analytic procedure

Thematic analysis

The method of analysis followed in the present study was thematic analysis. Though a popular and widely used method in qualitative research, it was not theoretically demarcated until recently and there are several variants of thematic analysis that range from positivist to interpretivist stances (Gavin, 2008; Joffe, 2012; Terry et al., 2017). The diversity and flexibility of thematic analysis permits its use in research studies that are variously framed and derive from different theoretical approaches. Recent writings also emphasise the significance of the researcher and their positionality in terms of the analytical outcome, thus embracing reflexivity as an essential feature of the analysis (Terry & Hayfield, 2020).

There is general consensus among theorists that thematic analysis focuses on identifying important themes in the research data (Joffe, 2012; Riger & Sigurvinsdottir, 2016)[36]. When considered as a process, as outlined in its diversified scholarship, thematic analysis commences with becoming familiar with the data. This is followed by creating codes (labels) and coding the data, grouping the codes under suitable themes, editing and reviewing the themes, and finally, writing up. It is understood that this is an iterative process that calls for close and sustained engagement with the data (Riger & Sigurvinsdottir, 2016; Terry & Hayfield, 2020), within the theoretical approach(es) that have framed the study. In this section, I detail the analytical procedure of the present study as it was carried out within a framework of thematic analysis.

The English translations of interview transcripts, the photographs showing medications and their emplacement within homes, and the fieldnotes (which I originally wrote in English) were used in the data analysis for the present study. These were uploaded as data files to NVIVO for thematic analysis. The translated interview transcripts and photographs were tagged with the number assigned to the household where they were generated. Fieldnotes were clearly labelled so as to be distinguishable from the other textual data.

In the present study, the bulk of the data was generated through household interviews (the transcripts of which were then translated). Having carried out the interviews, transcribed them in Sinhala and then translated most of them into English, I was quite familiar with the interview data by the time I started the analysis. Reading through the translated interview data again was useful for me to get a clear overview of the content, following which I started coding the data on NVIVO using nodes.

Coding

The coding process in the present study was both inductive (data-driven) and deductive (theory-driven) (Terry & Hayfield, 2020). Prior to data analysis, I developed an initial set of potential codes based on the literature. While reading through the data, I reflected on this deductive set of codes. When coding the data into nodes on NVIVO, I expanded on the deductively generated codes. In addition to these, new codes were inductively generated as was necessary, based on the data.

Coding was overall an intensive as well as time consuming process, since it involved going back and forth within a single text as well as returning to previously coded texts to check for appropriacy and accuracy of coding. This involved introducing new codes, modifying and refining existing codes, and removing

[36] However, in the analytic procedure for the present study, I also considered what appeared to be 'deviant cases', as I elaborate later.

redundant codes by merging the content of similar codes into one. Iterativeness of coding was essential to ensure consistency and coherence, given the large amount of textual data that I analysed in the present study.

Coding fieldnotes was a similar process to that of translated interview data. Most of the fieldnotes were coded under the same nodes already used with the translated interview data, with only a few new codes being introduced.

After coding the textual data, I coded the visual data, i.e. the photographs. Sometimes the whole photograph was relevant for a particular node, while for others only a part of the photograph was; and accordingly, the whole photograph or its relevant part was coded (Byrne, 2020). Visual data was limited in the present study to 14 photographs. Coding these did not require any new nodes to be generated; they were coded within the existing ones.

Themes

Thematic analysis primarily involves the identification of important themes (Joffe, 2012; Riger & Sigurvinsdottir, 2016). Having coded a large portion of the data, I started organising the seemingly related nodes under tentative themes. This classification of nodes was only temporary; it was ongoingly changed during the analysis as more data was coded, new nodes were introduced, and existing nodes were refined. I was, however, mindful of the risks of constructing themes too early in the process, which could lead one to miss important data and end up with a superficial analysis (Terry & Hayfield, 2020). In any case, the preliminary organisation of nodes at that stage was very useful for me to grasp the potential themes and to relate the codes to the themes included in the deductive framework that I had drawn up previously.

The organising of nodes into themes means, in other words, tracking similarities across the data and grouping together of related cases. However, while organising the nodes, I also made note of "deviant cases" (Silverman, 2014) that contradicted the general trends in the data. For example, whereas most households preferred private sector providers for their primary healthcare needs, there was one household that regularly sought treatment at the public hospital out-patient department. Though I did identify seeking private practitioners as a common theme across a majority of cases, the one deviant case was also important in order to understand the variability and nuances in treatment seeking practices. Therefore, taking deviant cases into account has added to the depth of the analysis.

The themes that I identified guided my reflections on the data and led me to explore various pathways towards making sense of the data. For instance, observing the significance of materiality of medicines

within households, I explored the potential of medications as vibrant matter in their capacity to act and bring about change (Bennett, 2010); while the mundane practical reasoning that seemed to constitute everyday medication practices pointed me towards exploring an endogenous ordering (Heritage, 1984) of organised and recurrent human activities (Schatzki et al., 2001).

Reflections and writing up

Coding and classification of themes was highly immersive and so engrossing a task that I found myself reflecting on the data continually through the day. Such reflections and flashbacks, often while engaged in other non-research related activities, illuminated certain aspects and connections of the data that I had not remarked upon so far. The following is an entry from the reflexive diary that I maintained to document my thought process during the data analysis period:

> Been marking essays [of Sociology undergraduates in the NZ university]. The essay task requires students to reflect on their own/ their household's use of medications. Something that really struck me is the (relatively?) wide uptake of treatment for mental health. There are many [students] who wrote of taking treatment for some psychological condition, such as depression, anxiety. And how common anti-depressants are! This is a sharp contrast to what I saw/heard at the houses of my research participants. There, I never saw any psychiatric medications. They never even spoke of going for such treatment, apart from interview 014 that mentioned one hypnosis session at the public hospital, where the 'patient' was redirected to traditional methods. Even in that one interview, the stigma of being mentally ill was clearly articulated. The absence [of seeking treatment] however, does not mean the community was free of mental health issues: they were just not biomedically framed nor diagnosed. Spirit possessions, on the other hand, were freely spoken about. I even stumbled across one suicidal death and one attempted suicide among the 20 households that I interviewed. (Reflexive diary, 11.10.2019)

Reflecting on the on-going coding and classification, as well as the literature that I had reviewed, I started to follow up and write on prominent themes that threaded through the data. Accordingly, I did descriptive and analytic writing on a number of themes including the practice of discontinuing medications, gendering of health work within the household, and emplacement of medications. The on-going nature of the coding and analysis meant that the themes remained protean, somewhat elusive, and possibly in need of refinement. On the other hand, early write-ups on selected themes facilitated in-depth reflection of and engagement with small chunks of data, rendering the potentially daunting task of data analysis a more manageable one. Identifying potential themes early was also important given the richness and the vast amount of data that I was handling, which might otherwise have obfuscated the

significance of certain relevant themes. In addition, writing up involved positioning the data-driven themes of the present study in relation to previous research findings, ensuring an on-going dialogue with the literature.

Having thus written up on a number of potential themes, I then attempted to organise them. The first attempt was guided by the research questions of the study, where I simply classified each write-up under the research question in relation to which the relevant data was generated. It soon became clear that this was not the best way forward: there was a lot of overlap as the themes that I had identified and written-up on often merged multiple research questions. As such, a more appropriate choice in organising the content was to follow the important themes rather than the research questions. This theme-based organisation was reviewed and refined through the period of writing up, leading to the organisation of the thesis chapters. The thesis, accordingly, comprises five analytical chapters, an overview of which is provided at the end of this chapter.

Collaborative process

While I performed the coding, classifying and analysis of data for the present study, the process was greatly enhanced by discussions with and feedback from my supervisors and academic peers. Using English-translated data in the analysis was primarily aimed at facilitating communication within the academic context that I was carrying out my doctoral studies. I regularly met with my New Zealand-based supervisors every two to three weeks to discuss the on-going process of data analysis and to resolve any emergent issues, in addition to email communications in the interim. My fieldwork supervisor in Sri Lanka also communicated with me via email. Presenting my research as a work-in-progress at several academic forums was an opportunity for further engagement with the academic community. The constructive feedback I gained through such academic collaborations was instrumental towards clarifying my own understanding of the data and improving the on-going analysis.

My research design included collaboration session(s) with the research participants where I intended to share with them the progress of data analysis and to invite their feedback and suggestions towards developing it further. On-going collaboration with research participants can ensure that their voices are captured effectively and represented as authentically as possible. Beyond such methodological concerns, a collaborative approach also has important ethical implications in terms of empowering participants by balancing out the power gradient inherent in any research context (Chase, 2017). When working with marginalised or underprivileged communities in particular, on-going and engaged collaboration with the participants could attune the research to become more relevant and potentially useful towards the actual needs of the community (Nagar, 2002). However, my plans were affected by the international

travel restrictions imposed to control COVID-19, which led to cancellation of my scheduled travel to Sri Lanka in April 2020. Using technology-mediated communication methods to organise virtual meetings with the participants is not feasible due to the lack of technological resources and know-how in the community. Therefore, the collaborative sessions with the research participants were postponed until such time as when I could travel there to meet them face-to-face.

Reflections on researching 'home'

As a Sri Lankan researcher at a university overseas, my fieldwork for the present study involved travelling 'home'. This would, in the conventional sense, identify me as a 'native' researcher. Yet as Narayan (2013) argues, labelling a researcher 'native' is inherently problematic, due to "the shifting identifications amid a field of interpenetrating communities and power relations" (p. 23). Given my background as a woman from a middle-class family in urban Sri Lanka, English-educated and currently studying at a foreign university, I was often neither native nor non-native within the close-knit rural community in which I did my fieldwork. The fluidity of my 'native' status meant that I constantly had to navigate the ambivalent position of insider/outsider during fieldwork interactions.

As a 'native' Sri Lankan researcher, I shared with my participants a common native culture and Sinhala as our first language, which immensely facilitated my interactions with them. Drawing from my 'insider' knowledge of rural customs, I attempted to blend in with the community and to project myself—and my research—as friendly and non-threatening as possible. The research participants often identified me as a native and an 'insider', addressing me as *duva*, *nangi* or *akka*[37]. I was invited into their homes, offered cups of tea over lengthy discussions, and even hugged warmly by some elderly women who claimed I was "like [their] own daughter". Similarly, Sheoran (2012) writes of having to navigate the conflicting role(s) of woman/ girl/ daughter/ sister that she was cast in by her research participants who identified her as an 'insider'.

On the other hand, a researcher's insider/outsider status in relation to their research participants may change from one moment to another (Sheoran, 2012). Observing the dynamics of his and his research participants' Filipino identities, Labrador (2015) comments on the interactional nature of identity as constructed in relation to multiple gradients. Similarly, I was cast as an 'outsider' by some participants who continued to address me as *Nona* (Madam). This formal appellation signalled the power distance they perceived between me and them, possibly in terms of social status and education. There certainly were participants who were self-conscious of their lack of formal education and inability to understand

[37] Kinship terms meaning 'daughter', 'younger sister', 'older sister'.

or communicate in English. In a community where successful completion of school education is not yet the norm but an exception, a woman-researcher coming from a foreign university would certainly stand out.

Differences in our knowledges, both real and assumed, particularly marked me as an outsider. Since I was researching medications (and despite my having clarified my academic background), people often assumed me to be a doctor-in-training or at least to have some biomedical knowledge[38]. I was requested to help in navigating medical matters of everyday life, such as making sense of the readings of a new digital thermometer (Fieldnotes, 06.01.2019) or for advice on putting on weight (Fieldnotes, 31.01.2019). In parallel, research participants would often attribute to me an ignorance of rural life. They tended to kindly—sometimes condescendingly—inquire whether I was familiar with some herb or a folk practice that they happened to mention; or they would straightaway explain it in detail assuming my ignorance. This, however, had its benefits, as pointed out by Hampshire et al. (2014): as an outsider to the community, any ignorance on my part was excused and even expected by the participants, and it often led to detailed explanations on matters which would generally not come up in a discussion among 'insiders'.

Moreover, as Sheoran (2012) notes, a researcher's presence in the field is always limited and bounded, since they have to leave the field and return to spaces outside of the research participants' lives. Yet the conundrum of the 'native' researcher is not limited to the bounded sites of fieldwork. As any 'native' researcher who leaves the fieldwork site located 'at home' and returns to her 'home university' abroad, I returned to New Zealand to continue working on the thesis. Western academia poses a further dilemma to the researcher from the Global South, as I have discussed in chapter 2. As a doctoral researcher with close links to the academic community, I would be an insider; yet my lived and embodied experience as a Sri Lankan within the (mostly White) international academia would always set me apart as an outsider, in which position I felt a deeper affinity towards my fieldwork site 'at home'. Such sensibilities have guided my reflexivity and self-critique as a researcher and pointed me towards postcolonial/decolonial scholarship (as discussed in chapter 2). The following is an excerpt from my reflexive diary:

> [Richa Nagar argues that] while sophisticated analyses are being done on the data, the actual needs of the people could be completely ignored. This is something I should come to terms myself. Am I being too distracted by the fashionable research trends in the Global North, so that I

[38] Similar misunderstanding of researcher credentials has been reported by others undertaking studies on illness and health, e.g. Locker (1981).

> am straying far from the actual data? Am I paying enough attention to the voices of the people who were generous enough to share their stories with me? (Reflexive diary, 01.08.2019)

This complexity could perhaps be better understood through the concept of "*mestiza* consciousness" as theorised by Gloria Anzaldúa (1987). *Mestiza* is a hybrid of multiple identities and multiple allegiances which involves "continually walking out of one culture and into another, …. [and exists] in all cultures at the same time" (Anzaldúa, 1987, p. 99). It is, therefore, a borderland status wedged between multiple identities, which is fluid and constantly evolving. I would suggest that a similar hybrid existence is led by the non-White researcher who has ties to the academia of the Global North as well as to the field sites of the Global South, while being neither an insider nor an outsider in either space.

In the chapters that follow, I present the findings of the study. They are organised into five chapters around the following themes: making sense of therapeutic practices as enacted in households (chapters 4, 5), navigating the therapeutic landscape and treatment seeking (chapter 6), medications as situated in household space(s) and time(s) (chapter 7), and personalising of therapeutic practices (chapter 8).

CHAPTER 4: HOUSEHOLD THERAPEUTIC PRACTICES: DIVERSITY AND HYBRIDITIES

This chapter begins an exploration of therapeutic practices and their meaning(s) as enacted in the households in Pitawella, which continues into the following chapter.

In this chapter, I first present an overview of the popular therapeutic modalities accessed by the householders. These are, namely, biomedicine which they referred to as "*ingrisi beheth*" ('English medicine'), traditional herbal therapy ("*sinhala beheth*", translatable as 'Sinhala medicine'), religious healing, and supernatural healing. These modalities are identified based on existing literature, and their usage and significance are discussed with regard to household interviews. In the subsequent section, I contest the conceptualisation of therapeutic modalities as clear-cut categories. By illustrating household therapeutic practices as permeating and merging across multiple modalities, I construct them as hybridising practices. Drawing together various insights on what is understood as ill-health in the households, as well as the diversity in the therapeutic landscape, I suggest that therapeutic hybridity to be an essential feature that marks householders' efforts towards restoring health.

Popular therapeutic modalities

The therapeutic practices that were identified through fieldwork could be aligned with one or more of four therapeutic modalities identified in previous research in Sri Lanka: biomedicine (*ingrisi beheth* or English medicine), traditional herbal medicine (*sinhala beheth* or Sinhala medicine), traditional supernatural healing, and religious/spiritual methods. During household interviews, the participants produced various pharmaceuticals including pills, syrup and ointment as English medicine available at home. Ritualistic ceremonies and chanting of *mantra* were described as part of supernatural healing, and Buddhism-inspired practices were noted as religious methods. The widest range of objects and practices involved herbal medicine: from *kasaya* herbal potions to *paththu* herbal plasters, from home-brewed infusions to commercially manufactured herbal products, and from simple home remedies to elaborate cures performed by professional practitioners.

Labelling a given therapeutic practice as associated with any one therapeutic modality, however, would be an oversimplification. Therapeutic practices emerged as complex entanglements of medications, knowledges, beliefs, care practices and bodies within households, which defied clear-cut categorisation (Dew et al., 2014). The resultant blurring of boundaries between different therapeutic categories will be discussed later in the chapter. Prior to that, however, I wish to present the therapeutic modalities based

on their differential conceptualisations in households, even at the risk of constructing them as more-or-less distinct categories.

English medicine

Western biomedical pharmacotherapy or English medicine was undoubtedly the most widely accessed therapeutic modality in the participating households. Seventeen out of the 20 households mentioned regularly seeking biomedical treatment, and it was the first choice whenever children's illnesses were concerned.

The popularity of biomedicine seemed to derive from a general understanding of its capacity to provide fast relief for everyday ailments. A quick cure from ill-health was vital for the participating households, since most of the adults earned a daily income from labour-intensive work and therefore wished to continue their work without any illness-induced interruption. A child's illness may wreak even worse havoc in a household, causing anxiety as well as disruption to work through increased care responsibilities. Quoted below is Sunimal mama, who had tried Sinhala medicine for his recurrent skin condition before discovering English medicine to yield a more satisfactory solution:

> I took [Sinhala medicine] for one or two months. I was told to continue it for longer. It didn't work. I mean, it didn't work instantly. On the other hand, [English medicine] clears up [this condition] in three days. [Sinhala medicine] would take about one year, because it would stir up and unsettle everything [inside the body] before curing the condition. … The thing is, that treatment won't give instant relief. It takes time. We can't afford to follow treatment for one year or two. If we get ill today, we'd want to be well by tomorrow.

The perceived potency of biomedical pharmaceuticals, which leads to quick relief from illness symptoms, is closely associated to a popular narrative of *sara* (harshness) of English medicine. In other words, it is strong and potent medicine, as understood from its capacity to give fast relief; therefore, it is considered likely to have strong/harsh effects on the body. What biomedicine may identify as side-effects of pharmacotherapy (e.g. nausea, heartburn) were made sense of, by the research participants, as manifestations of the *sara* of the medicine. Accordingly, dizziness, gastric pain and dryness in throat, among others, were commonly attributed to the *sara* of English medicine.

This notion of *sara* is underpinned by a popular understanding of 'hot' and 'cold' effects derived from Ayurvedic theory. As Nichter (1987) elaborates, this lay framework is based on the Ayurvedic notion that different substances produce heating or cooling (or neutral) effects in the human body. In addition, people may have a bodily propensity to heat (*ushna anga*) or cold (*sema anga*), which renders them

more susceptible to ill-health through exposure to those elements (Nichter, 1987). The *sara* (harsh) effects of pharmaceuticals on the body approximate those of *ushna* (heating) substances, and the notion of constitutional vulnerability would explain why the medicine's *sara* effects manifest only on some bodies. In view of the potential of English medicine to 'heat' the body, consuming 'cooling' substances immediately following the medicine intake is expected to offset the heating effects (Nichter, 1987). Similarly, several interlocuters in the present study spoke of drinking king coconut water, a well-known 'cooling' substance, after ingesting pills.

Sinhala medicine

Sinhala medicine was clearly not as popularly sought by the households participating in the present study: only two out of the 20 households reported seeking herbal medicine regularly from a traditional practitioner. On the other hand, the participants used home-brewed herbal remedies based on popular Sinhala medical recipes for a variety of minor conditions. It was notable that nearly all householders, whether they acknowledged using Sinhala medicine or not, were quite knowledgeable about its effects and treatment processes; and that these knowledges were largely shared across the households. It further appeared that Sinhala medicine was being constructed during household interviews as the polar opposite to English medicine, as I illustrate below.

Soothing and natural

As discussed previously, English medicine was perceived as *sara* or harsh on the body; whereas Sinhala medicine was appreciated for being mild and soothing. Patty nanda, quoted below, admitted that her illnesses were rarely cured by *kasaya* herbal potions, yet she continued to prefer Sinhala medicine due to its nurturing effects on the body.

> *Kasaya* does not cause discomfort to the body. When you take English medicine, you feel dehydrated, like your skin goes dry. That doesn't happen with *kasaya*: they are good to the body. They are like good food.

Such experiential differences in treatments were often associated with the contrasting discourses on naturalness of Sinhala medicine and 'artificiality' of English medicine. As Dolahe-gedara mama put it, "There's nothing bad in [Sinhala medicine]: it's all herbs". The belief of Sinhala medicine being natural-therefore-benevolent is strengthened by the domestic preparation of herbal potions, during which process one gets acquainted with all the ingredients that go into it. Interestingly however, the same belief of naturalness was extended unquestioningly to store-bought herbal medicines that were commercially manufactured, even where the medicine's labelling did not detail its ingredients. Similar

discourses of naturalness are reportedly attributed to traditional medicines around the world (Dew, 2021; Sher et al., 2016).

Slow but permanent cure

Sinhala medicine is known for its gradual action over a long period of time, through which a permanent/long lasting cure can be achieved.

> What English medicine does is, keeping an illness under control. It is very rarely that a doctor completely cures an illness. The medicine hides the illness, keeps it under control. [So] the illness will resurface later. Let's say asthma. The pills will keep the condition under control. … When the condition returns, you take the pills again, and it will again be controlled. But Sinhala medicine can cure asthma completely. … In Sinhala medicine, the treatment prescription [for asthma] includes some one hundred *kasaya* (herbal potions) to be administered, one per day, and without fail. … It will cure asthma and get rid of *sema* (phlegm) completely. … What happens [through the treatment] is, the body becomes habituated to the 'cold'[39] element.

In explaining the potential of Sinhala medicine to offer a permanent cure, the local healer Kalu mahaththaya (quoted above) presents it in terms of a gradual habituation of the human body to illness-inducing elements, as opposed to symptomatic treatment that he attributes to English medicine. Developing asthma is associated with an excess of 'cold' element in the body, of the surrounding environment and of ingested substances (Nichter, 1987; Obeyesekere, 1976), which, therefore, calls for the body to be 'acclimatised' to the 'cold' element. This way, with Sinhala medicine, one's entire body will undergo gradual change through a period of time, after which it will not be affected by the same illness triggers in future; whereas English medical treatment needs to be administered whenever an illness occurs.

This comparison of the functionality of Sinhala and English medicines explained by Kalu mahaththaya was echoed by most of the research participants and appears to inform the community's general understanding of the differential efficacy of the two therapeutic modalities. For example, quoted below is Mahasen nanda, whose views on the different therapeutic modalities closely reflect those of Kalu mahaththaya the healer, though expressed in more general terms:

> Sinhala medicine will eliminate the phlegm in the body, [but] it happens slowly. English medicine will give a quick relief. When you take English medicine, just one dose can relieve any phlegm condition or any cold. Sinhala medicine isn't like that. You'll have to follow the medication for

[39] In the traditional medical paradigm of 'hot' and 'cold', asthma and other phlegm-related conditions are understood as 'cold' conditions (Nichter, 1987).

> days to get better. Because [Sinhala medicine] makes the phlegm pass out of the body. Then only will you be cured.

Complex and demanding

Research participants also contrasted the process of preparing/administering Sinhala medicine with that of English medicine. As Matara nanda put it,

> With English medicine, it's a matter of bringing the pill and swallowing it. But Sinhala medicine isn't like that.

Following Sinhala medicine is known to involve a complicated process of medicine preparation and life-style modification. Preparing the medicine begins with finding the ingredients by searching in the neighbourhood for the necessary plants to get their specified parts and buying some ingredients from a traditional medicinal pharmacy. These then need to be boiled in a pot as a *kasaya* herbal potion according to the given instructions. Sinhala medicine also involves strict proscriptions in terms of food and use of water. To illustrate, quoted below is Sujatha akka's comparison of her experiences of following de-worming treatment and purgatives prescribed under English and Sinhala medicines respectively[40]:

> When we take the deworm-medicine pill, it purges the stomach, and meanwhile we can go on working [as usual]. But when we take a purgative [*kasaya* potion], we can't. We must use hot water for a body-wash. Mustn't eat rice with curry: only rice with *thambum hodi*[41]. … Now if a child is given a purgative, and if he is being breast-fed by his mother, she too must avoid cool water. If the person who took the purgative comes into contact with cool water in some way, the purgative won't be effective.

Given their work and living circumstances, many of the study participants declared that they cannot adhere to the dietary and behavioural recommendations prescribed in traditional medicine, nor spend time and effort in sourcing and preparing the herbal medications at home. Such difficulties appeared to render traditional herbal medicine a less viable alternative for the participants, as opposed to the convenience offered by English medicine; which is supported by the findings from previous research in

[40] In this quote, Sujatha akka expresses the understanding that *kasaya* purgatives and deworm medicine are more or less equivalent. However, Kalu mahaththaya the traditional healer explained to me that this was in fact a popular misconception. According to him, purging the stomach (in Sinhala medicine) is a means of getting rid of any accumulated toxins and cleansing the body in preparation to receive a course of medicine. This has nothing to do with deworming; as there are other medications for that purpose. Biomedicine, in any case, does not advocate purging as does Sinhala medicine.

[41] an infusion of spices

the country (Jones & Liyanage, 2018; Liyanage, 2000; Weerasinghe & Fernando, 2011).

Supernatural healing

Household interviews in the Pitawella village indicated supernatural healing to be a popular therapeutic modality accessed by many of the participants. They often differentiated between the different forms of supernatural healing, such as *mathirili* (charms), *adurukam* (exorcism, sorcery) and *santhikarma* (rituals of benediction).

Mathirili or charms were often performed as treatment for (relatively) minor illnesses experienced in everyday life, such as indigestion, stomach-ache, vomiting, headache, and fever. The healer will chant *mantra* over some herbal infusion, water or oil, whereby it is imbued with the healing power of the *mantra*, becoming a powerful cure.

> For indigestion or something. When it doesn't respond to medications. Then [we'd] go to Kalu mahaththaya's place. [We take] a king-coconut or [an infusion of] cumin or coriander. He'd charm it for us. … That works. Now, for [the boy], I got a bottle of *pas-thel*[42]. He gets a headache in the morning. It's called *iruvaradaya* (migraine). [I'm] taking him [to Kalu mahaththaya's house] on Sunday. … Have to be there around five o'clock [in the morning].

In the excerpt above, Kasun mentions the charming of king coconut, cumin or coriander as remedy for indigestion, and of charming oil for a headache. *Mathirili* (of king coconut) was also reported to relieve menstrual pain. Treatment for *ulukku* (sprains) involved *mathirili* as well. Mahasen mama, a local healer[43] who specialised in tending to *ulukku* (sprains), used *mantra* as a part of the treatment. As he explained to me, the procedure involved chanting *mantra* while applying oil on the affected part of the body, followed by a vigorous pull – enacted exactly right – that would fix the sprain.

In all iterations of *mathirili* in household interviews, the *mantra* was only one part of the treatment. It would be chanted over some substance that was consumed or applied on the body (e.g. infusion, potion, oil), which was in itself a traditional remedy for the condition in question. Any treatment procedures involved, such as the pulling of *ulukku*, had to be performed properly, as the *mantra* could not make up

[42] A mix of five oils

[43] Mahasen mama's *ulukku* treatment was popularly sought by the households participating in the study. As he explained to me, he had learnt the healing techniques from his great-grand father and memorised a few *mantra* "from a *mantra* book". He did not have any formal qualifications to perform as a traditional practitioner. Instead, he functioned as a local healer, treating only those neighbours and friends who sought him out "based on trust".

for faulty technique. This way, the *mantra* itself often appeared to serve as a catalyst or an additive to the desired therapeutic effects of traditional remedies.

Santhikarma (rituals of benediction) are performed to bestow divine blessings on a sick person and to remove any potential malefic influences that may impede their illness being cured. These rituals, therefore, are most often subordinate to therapeutic practices related to biomedicine or herbal medicine and are aimed to complement or facilitate their efficacy. In the following interview excerpt, Nita akka recounted the particulars of *dehi kapuma*, a ritual of benediction that involves the cutting of lime-fruit, performed on her husband by the traditional healer Kalu mahaththaya.

> Now, I felt that [the wound on his leg] wasn't getting healed. Then we talked about what to do. I went to Kalu mahaththaya and asked, "Kalu mahaththaya, what should we do?" He told me to bring [my husband] along, to do a *dehi kapuma*[44]. We did that. Then [his] leg got better. … You need to do *dehi kapuma* (ritual) to get rid of *as-waha kata-waha*[45]. [If] there is any *as-waha kata-waha*, the wound wouldn't be cured. … The wound would get a bit better but then go bad again. [This was going on] for some time. [He'd] be yelling in pain at night. Then when [I] told Kalu mahaththaya… *Aney*[46], as soon as Kalu mahaththaya did *dehi kapuma* (ritual), *deiyange pihiten*[47], the wound healed and [he] could even walk.

In this case, the ritual was performed to avert *as-waha kata-waha*. Literally meaning evil-eye and evil-mouth, these imply the malefic potential of the envy and enmity of others close to oneself, such as neighbours, relatives and acquaintances. Similar rituals were reported in other households for potential malefic influences of astrological, cosmic or supernatural origins, such as those attributed to planetary alignment, bad *karma* or malevolent spirits.

Mathirili and *santhikarma,* this way, often appeared as complementary to the therapeutic practices associated with biomedicine and herbal medicine. However, *adurukam,* also a type of supernatural healing, would differ in this regard. *Adurukam* literally refers to the (therapeutic) practices performed by *adura,* a person adept in supernatural healing that involves sorcery and/or exorcism. Some interview participants also used *adurukam* as an umbrella term for all supernatural healing ceremonies, including

[44] Lime cutting ritual

[45] 'Evil-eye and evil-mouth'. The malicious or envious gaze or words of someone is considered to be capable of causing harm.

[46] Interjection indicating pity, compassion

[47] With the gods' blessings

those for curing illness caused by spirits or demons as well as those for benediction (*santhikarma*). In any case, as Mahasen nanda clarifies, *adurukam* is a distinctive category of treatment:

> There are certain illnesses that can be cured by *adurukam*. If someone got a sudden fright, or a *thanikan dosa*, then it must be cured by *adurukam*. Other treatment won't work.

The traditional theories of illness causation among Sinhalese Buddhists in Sri Lanka include the potential malefic influence (*dosa*) of demons (*yaksa*) and spirits/ghosts (*pretha*) (Kapferer, 1979; Obeyesekere, 1969). As per the cosmic hierarchy in Buddhism that is widely accepted by lay Sinhalese Buddhists, human beings are considered superior to demons and spirits of the dead. However, a person could be rendered vulnerable to the latter's influence due to *thanikan dosa*, literally translatable as 'misfortune of aloneness', which Obeyesekere (1969) analyses in terms of physical and/or psychological aloneness. Accordingly, being suddenly shocked or frightened by a demon or an evil spirit during such a moment of vulnerability may cause *yaksa dosa* or *pretha dosa*, which may call for *adurukam* as treatment. In addition, *adurukam* may also be required to 'cut' (i.e. remove) malefic charms performed by one's enemies, as in the case of Matara mama's illness outlined below.

As it was revealed in the household interview, Matara mama had awakened one morning, nearly 15 years ago, unable to utter a single coherent word. His mouth had "gone to the side". This being during a period of political unrest in the region, all public hospitals were closed, and most private healthcare providers were unavailable. In their desperation to make sense of this sudden illness and to find a cure, the family had sought a well-known *adura* (sorcerer/exorcist), who told them that Matara mama was the victim of a *kodivina* (malefic charm). Such a charm would only be performed by someone who wished him to be grievously harmed; and this fitted in perfectly with the fact that Matara mama was the only eye witness in an ongoing court case involving a murder and had already received threats from the defendant's family who lived in the same village. As his wife Matara nanda explained,

> That *adura* told us that [a *kodivina*] had been done. So, we said, "we'll pay you as much as you want, please cut [the *kodivina*] so that it gets reversed". [Reversed] on those who did it [to us]. So [the *adura*] came and did the *thovil*. He put protections in place beforehand. … He did protections and charmed lime-fruit. He made a *pahan pela*[48] with an image of the god placed inside. Then he'd appeal to the god and enter a trance. In his trance, he'd 'see'. [An assistant was] there to cut [the *kodivina*].

Once the *kodivina* was cut, Matara mama was cured and was able to speak normally. Further, just as the *adura* had foretold, the effects of the malefic charm had reversed on to its supposed-perpetrators: one

[48] A small covered altar made of woven young coconut leaves (*gok kola*)

of them had died ("fell dead all at once" as Matara mama enthusiastically explained) and the others had had to leave the village in disgrace (over some other dispute).

Spiritual and religious healing

All the participants of the present study self-identified as Buddhists, and religious practices associated with or inspired by Buddhism were often mentioned as therapeutic practices aimed at seeking an improved state of health. (It should be noted that here I describe only the orthodox Buddhist religious practices enacted for therapeutic purposes. There were also highly personalised and idiosyncratic practices inspired by Buddhist notions, which will be taken up in chapter 8.)

Bodhi puja

The religious practice that was the most commonly followed with a therapeutic purpose was that of *bodhi puja*, or the veneration of the Bo tree (*Ficus religiosa*). As the tree that sheltered the Buddha while he meditated with the aim of achieving a state of enlightenment, the Bo tree is one of the sacred relics of Theravada Buddhist tradition and is essentially present in every Buddhist temple in Sri Lanka. People walk around the tree with a pot of water (or milk, as the ritual may demand it) which is then poured on the roots of the tree, in addition to which they chant specific *gatha* or verses in praise of the Bo tree.

Bodhi puja goes beyond the theme of appreciation that guides the veneration of the Bo tree as a sacred relic. Carried out over a number of consecutive days, it aims to evoke the sacred power (*anuhas*) of the Bo tree to dispel any potential maleficence over one's life and/or to restore normalcy. The faith in its *anuhas* and the ritualistic nature of the practice may also calm people's heightened anxiety in the face of the unknown. For Sarika, quoted below, performing a *bodhi puja* was a part of her preparation for a thyroid-gland surgery:

> Before I went for the surgery, we did a *bodhi puja* and made a *bhara*[49] that [we'd] do a[nother] *bodhi puja* and make a donation towards the construction of the Buddha shrine [at the temple]. We do *bodhi puja* like that. We believe in *budu-guna*[50].

In the present study, householders reported performing *bodhi puja* in events of severe or prolonged illness (while following biomedical or traditional medical treatment), or where they felt misfortune was brought on by cosmic forces such as bad karma or malefic planetary alignments that may cause/prolong ill-health as well as disrupt ordinary life. To illustrate, Kasun's family performed *bodhi puja* to alleviate

[49] A promise made to gods (or in this case, to Buddha and/or the bo tree) when evoking their blessings

[50] Literally, the supra-human qualities of Buddha.

the potential maleficence predicted in his daughter's horoscope, as did Patty mama's family in the event of his chronic (and undiagnosed) illness.

It was also significant that *bodhi puja* was as often performed by others – friends, extended family or neighbours – on behalf of the affected person, as by the person themselves. In addition, *bodhi puja* manifested as a group effort, with the participation of many well-wishers and the proceedings being led by one or more Buddhist monks. Several *bodhi puja* being performed by multiple others on behalf of one sick person was also mentioned during household interviews.

Buddhist rituals

The research participants often acknowledged their faith in Buddhism and gaining peace of mind through engagement in Buddhist religious practices. Patty nanda and Patty mama, in particular, also reported the therapeutic effects of regular Buddhist rituals of veneration in terms of providing relief from long-term illness conditions that could not be cured through any other means.

When Patty nanda was a young woman living with her parents, and for some time after her marriage, she (and her three sisters) had been suffering from a *disti*[51]. The family had followed the popular cure for spirit possession, which was exorcism through *thovil* rituals; but to no avail.

Patty nanda: I started chanting *pirith*[52] and got my mind to calm down. I started to live by Lord Buddha's teachings. Now I feel fine! Those days, I didn't attend any *thovil* ceremonies [in the neighbourhood] or go to a temple. Couldn't go to a temple to venerate Lord Buddha. [If I did so,] the *disti*[53] would come over me.

Patty mama: [She] couldn't go to a *pirith* ceremony[54], couldn't listen to *bera* (drums) being played. Couldn't go anywhere where there was *mantra* being chanted. [If she did,] she'd start shaking uncontrollably[55]. So many *thovil*[56] were done, great big *thovil*. But nothing worked. Then [she] started regular practices of venerating Lord Buddha and so on. Then gradually, the *disti* wore off.

[51] *Disti* literally means 'gaze'. It refers to the malefic influence of a demon or spirit that has its gaze fixed on a human victim.

[52] Buddhist verses and scriptures

[53] Spirit possessing her

[54] chanting of Buddhist scriptures to ensure protection from evil forces, health and wellbeing. *Pirith* ceremony is an all-night event attended by many devotees, where Buddhist monks and/or lay devotees chant *pirith.*

[55] This is an approximate translation of the word *dagalanava*. It is used to describe spirit possession.

[56] Exorcism ceremony

Patty nanda: I cured [the illness] by myself. Without doing any *thovil*!

For Patty nanda, her eventual cure from *disti* was both a personal triumph as well as evidence of the curative potential of the everyday religious rituals of chanting *pirith* and Buddha veneration. *Disti* or spirit possession, in her case, had manifested as involuntary bodily spasms triggered by sounds of *pirith* and drums being played. Having overcome the *disti* through Buddhist rituals, she would go on to encourage her husband to follow similar practices to seek relief from his chronic bodily pain that remained biomedically undiagnosed at the time of the interview.

Patty mama: But now, I do feel [the pain] to be less. [Now] I worship Lord Buddha daily.

Patty nanda: [He] worships Lord Buddha. And meditates.

Patty mama: Perhaps they do [have an effect]

Patty nanda: Now [he] is a good *upasaka*[57]. [Now] he doesn't smoke even a cigarette.

As they explained, Patty mama followed the rituals of venerating Buddha at home every day, meditated, and observed *sil*[58] at the village temple every month. Lay Buddhists being expected to avoid any form of intoxicants in everyday life[59], his quitting smoking should also be viewed as a part of a religious transformation where his life and habits were undergoing radical change. These rituals and practices are advocated in Buddhism as a means of improving one's quality of life and leading to the lofty aim of ultimately ending one's *samsara* (cycle of rebirth). However, what had principally motivated Patty mama was their therapeutic potential in providing him relief from his chronic bodily pain.

Thus far I have discussed the four modalities, derived from existing literature, that household therapeutic practices can principally be identified with. However, as I mentioned earlier, therapeutic modalities were not clear-cut categories; which I discuss in the following section.

Hybridising practices, hybrid therapeutic categories

Household therapeutic practices could well be linked to four therapeutic modalities discussed above, namely, English medicine, Sinhala medicine, supernatural healing and religious/spiritual healing. On the

[57] A devout lay disciple of the Buddha.

[58] Observing *sil* – *ata-sil* (eight precepts) to be exact – involves practising ascetism for a day. One has to remove oneself from the comforts and indulgences of lay everyday life and focus on religious rituals and meditation.

[59] The *pan-sil* (five precepts) to be observed in everyday life by lay Buddhists includes the avoidance of any intoxicants.

other hand, it was not always possible nor realistic to categorise therapeutic practices in this manner, for they often transcended modality boundaries.

In the light of such complexity, Hettige (1991) employs a two-fold classification of therapeutics as 'natural' and 'supernatural'. Biomedicine and Ayurvedic (herbal) medicine being empirically-based, he identifies these as 'natural'; whereas the religious methods and what I have discussed earlier as supernatural methods would constitute his category of 'supernatural'. While this may arguably be more practical a classification than a narrow modality-based one (such as what I have followed in the previous section), it still fails to capture the diverse entanglements that complicate therapeutic practices: for even the 'natural' and 'supernatural' categories merge in practice. For example, as Hettige (1991) himself writes, traditional herbal practitioners in rural regions resort to magical and other supernatural methods that defy the empirical basis of Ayurveda.

More recent studies elsewhere have productively adapted the Latourian notion of 'hybrids' to explore the complexities of therapeutics use in everyday life (Dew, 2016; Dew et al., 2014). In their study on household medication use in New Zealand, Dew et al. (2014) report people as negotiating diverse health-related knowledges and practices in the home and manipulating these in pragmatic ways to achieve a solution that works for them. In view of such "mixing up and reassembling" work, households are theorised as "hybrid centres" (Dew et al., 2014, p. 28). These adaptive processes 'hybridise' divergent therapeutic knowledges and practices creating hybrid therapeutic categories; as opposed to 'purifying' attempts that seek to maintain distinctive categories (Dew, 2016).

In the present study, therapeutic practices often spread across multiple therapeutic modalities, amalgamating different—even seemingly incompatible—elements, and giving rise to hybrids. In this section I follow therapeutic practices as they link and cut across multiple modalities, shedding light on the hybridities that arise in practice.

Sinhala medicine - religious healing - supernatural healing

Household interviews pointed to a significant overlap among the therapeutics that I presented under the three categories of religious/spiritual, supernatural and Sinhala medicines. These are therapeutic modalities that are deep-rooted in the local culture and history (as opposed to the relatively shorter history of biomedicine in the country) and are consequently looked upon as local and indigenous healing traditions.

Consider the following example of a supernatural ritual performed on Nagama akka:

> Cutting *thun-dos*[60] means, it was a *dehi kapuma*[61]. Kalu mahaththaya did it, [he] cut *thun-dos* through *budu-guna*[62].

As Nagama akka explains above, the *dehi kepuma* performed on her was a ritual of benediction to eliminate *thun-dos* from her body. Though a supernatural ritual, it is underpinned by an Ayurvedic conceptualisation of ill-health as found in Sinhala medicine: *thun-dos* being derivative of the Ayurvedic theory of bodily humours, *va* (air), *pit* (bile) and *sem* (phlegm). It follows that an excess of any one or more humours would cause a humoral imbalance, *dos*, in the body and lead to ill-health (Obeyesekere, 1976). The ritual that was performed to eliminate *thun-dos* involved chanting religious verses in praise of Buddha's supra-human qualities. It is common for *santhikarma* (supernatural rituals of benediction) to make use of Buddhist *gatha* (verses) and rituals to confer blessings of gods and of the Buddha upon the sick person. The *dehi kepuma* being conduc*ted* by Kalu mahaththaya, a derobed Buddhist monk whose former religious associations continue to command reverence in the community, adds to the religious dimension of this iteration of the supernatural ritual.

A recurrent practice reported in households was giving alms with a therapeutic purpose, which can be identified as a religious-supernatural therapeutic hybrid. Research participants spoke of several instances where almsgiving was organised post-*thovil* (exorcism ceremony).

> When [the girl] became possessed [during the *thovil*], the *disti*[63] said, "Do an almsgiving for me and I'll leave". It's because of that that we organised the almsgiving, so [the spirit] could accept the offering and leave. But if the offering is polluted or there's something lacking, then it won't leave [her].

According to Sujatha akka (quoted above), the main purpose of giving alms was to placate a malevolent spirit. She described how they offered various appetising food items as part of the alms, as an inducement for the spirit to leave the body of the girl. Further, the offering must be prepared in adherence to stringent guidelines so as to be acceptable to the spirit.

Giving alms, or *dana*, on the other hand, also has enormous significance from a Buddhist perspective. It is expected to cultivate the virtue of giving up worldly attachments *en route* to the ultimate Buddhist goal of *nirvana*; and is also a means of accumulating *pin* (merits) that would contribute towards one's future wellbeing. Since only human beings are considered capable of performing meritorious deeds, it is up to

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[60] An imbalance of the three bodily humours which causes ill-health, as described in Ayurvedic theory.

[61] Cutting lime-fruit

[62] Supra-human qualities of the Buddha

[63] Spirit possessing the girl

them to accumulate and offer *pin* to supernatural beings such as gods and spirits, who also need *pin* for their wellbeing and rely on humans for it. This, incidentally, places humans in a position of privilege in relation to supernatural beings; and conversely, at the risk of being harassed by the latter who desire *pin*.

While Sujatha akka's interpretation of almsgiving in an exorcism-related context was devoid of explicit religious affiliation, others who spoke of similar events often veered towards a Buddhism-oriented approach. Consider Sumith ayya's explanation of how almsgiving fits in with exorcism:

> … there are those loved ones who are dead-and-gone and who expect to receive *pin* [from us]. They may come and possess you. *Thovil* ceremonies are performed to get rid of such possessions. According to Buddhism, you have to offer them *pin* to make them leave the possessed body. There are those who can't get a rebirth. They are called *pretha*. They are stuck in that [*pretha*] form, so they need *pin* to move on [into a new birth]. So, you have to give alms [to monks], do a *pirith*[64] ceremony, give alms to the needy people, do something like that and offer *pin* for that [dead] person. Only then will that spirit [leave the possessed body and] be reborn in a good birth.

According to Sumith ayya, the *pretha*[65] who possess a human body are spirits in a state of limbo due to not having enough *pin* to be reborn again. Almsgiving, in this light, is performed as a meritorious deed to accumulate *pin* and offer it to the spirit. Once adequate *pin* is received, the spirit can move on to a new birth and potentially a better state of existence; and the person who had been possessed by the spirit will also be cured.

Other instances of popular hybrid practices include *mathirili* and *bodhi puja*, discussed in the previous section under supernatural and religious modalities respectively. *Mathirili* involves chanting a *mantra* over some substance, often a traditional remedy (herbal infusion or oil), which is then consumed or applied on the body. *Bodhi puja* centres on veneration of the sacred Bo tree. However, this Buddhist religious practice is deployed to counter potential malefic influences of supernatural or cosmic origin that impact on one's life and health, such as those related to planetary alignment and karma.

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[64] *Pirith* refers to the chanting of Buddhist scriptures to ensure protection from evil forces, health and wellbeing. *Pirith* ceremony is an all-night event attended by many devotees, where Buddhist monks and/or lay devotees chant *pirith.*

[65] The dead who cannot secure a rebirth yet

Sinhala medicine - English medicine

In the previous section, I elaborated on the differences between English medicine and Sinhala medicine as discussed in household interviews. The emphasis on difference was such that they were often constructed by householders as polar opposites: artificial vs natural, harsh vs mild on the body, quick action vs time-consuming, and so on. While this remains the case, there were also strong linkages between English and Sinhala medicines as construed in households, illustrative of leaky boundaries of therapeutic categories giving rise to hybrid practices.

> My lips cracked due to the medications. [The doctor] told me to eat *kathurumurunga* leaves, lots of it. [As a remedy] for the mouth cracking.

Quoted above is Matara mama, who has been using medication for a heart condition for nearly ten years. While following biomedical pharmacotherapy, he had experienced cracked lips and mouth ulcers. These he attributed to the *sara* (harshness) of English medicine, a lay notion associated with the Ayurvedic framework of heating (*ushna*) and cooling (*seethala*) effects of substances (Nichter, 1987). As I explained earlier in the chapter, certain effects produced by pharmaceuticals on the body (e.g. heartburn, cracked skin, mouth ulcers, skin rashes) are identified in biomedicine as side effects; though in Ayurvedic terms, these would be evidence of excessive heat. This has led to a popular understanding of pharmaceuticals, or English medicine in general, as producing heating effects in the body.

Sinhala medicine advocates ingesting 'cooling' substances to balance out excessive bodily heat. *Kathurumurunga*[66] leaves, mentioned in the excerpt above, is a traditional remedy known for its cooling properties. Pairing *kathurumurunga* with biomedical pharmacotherapy, therefore, is an instance of hybridising English and Sinhala medicines. Other households reported similar practices where *kathurumurunga* was substituted by alternative 'cooling' substances such as king coconut water. In the case of Matara mama quoted above, the therapeutic hybridity is more striking, since the Sinhala medical remedy for excessive heat is recommended by the same biomedical practitioner who had prescribed the pharmaceuticals.

Other hybridising practices can be captured under what is termed in anthropological literature as 'indigenisation' of pharmaceuticals. These involve creative adaptations of biomedical drug usage reported in non-Western settings, which often conflict with biomedical prescription (Haak & Hardon, 1988). Similar practices emerged through household interviews in the present study. To illustrate, when discussing remedies for wounds and minor injuries, some participants spoke of "*thuvala velana karal*" (capsules that dry up wounds) that were capable of healing any flesh wound quickly. This I figured out to

[66] *Sesbania grandiflora*/ vegetable hummingbird

be a reference to the widely used antibiotic Amoxycillin. People would break open a capsule of Amoxycillin and spread its contents on the wound, comparable to applying some ointment. While this is not a biomedically sanctioned practice, interview participants attested to its effectiveness in healing a wound quickly, which explains its popularity in the households.

Therapeutic hybridity and sense making

Hybridity in therapeutic categories also manifested at the conceptual level through the framing of one within an explanatory framework of another. This was alluded to in Matara mama's case discussed previously, where biomedical pharmaceuticals were regarded as harsh or heating on the body, a notion that is clearly Ayurveda-inspired. A particularly insightful instance of conceptual hybridity was mentioned by Sumith ayya, which involves English medicine and supernatural healing. As he explained, his (biomedical) practitioner had drawn an interesting parallel between English medicine for arthritis and the supernatural method of tying a 'promise thread', i.e. a charmed thread that signifies a promise (to a malevolent spirit that possesses a person) that a *thovil* (exorcism) ceremony will be performed at a definite time in future.

> …there're people who [behave like they're] gone mad. We've seen people who're possessed [by spirits] and talk like their dead relatives. So, when you tie a [charmed] thread [on their hand] until you can perform a *thovil* a few months later, such people may remain normal until then. Like that, I was told that this [illness] was a demon. Taking medications was like doing something like [tying a 'promise thread'] for the demon. [The doctor] explained it that way so that I could understand. It is like keeping [the illness/the demon] hidden inside the body. But sometimes it may escape and that's when you feel the pain.

Sumith ayya has arthritis, for which he had sought biomedical pharmacotherapy. However, taking medicine would not guarantee that the condition would always be controlled, as there could be an occasional flare-up. In explaining the nature of arthritis, the doctor had drawn the above comparison with supernatural healing. Accordingly, arthritis becomes a demon inside the body, while the biomedical treatment is the 'promise thread' that would keep the demon subdued. The potential of the demon escaping the bond and wreaking havoc is, in turn, compared to the possibility of an arthritic episode.

English medicine being popularly sought for physiological illness symptoms and supernatural methods accessed only in specific (often supernaturally caused) conditions, there appeared to be less hybridity in praxis between these two therapeutic categories. However, the parallel drawn between treatment of

arthritis and controlling a demon seems to be a productive way of drawing on a popular traditional health idiom to make sense of the biomedical.

Practitioners and therapeutic hybridity

Several examples above involved biomedical practitioners who deployed non-biomedical knowledges as required in their biomedical practice. Previous literature from Sri Lanka notes a trend among traditional practitioners to use biomedical techniques and/or prescribe biomedical pharmaceuticals. Incorporating elements of biomedicine into Sinhala medicine has been viewed as a response to the increasing popularity of biomedicine, through which traditional practitioners try to cater to patients' preferences for pharmacotherapy and thus to retain the demand for their services (Waxler-Morrison, 1988; Wolffers, 1989). In the present context, there were a number of practitioners accessed by the participating households who offered treatment that hybridised Sinhala and English medicines, as well as Sinhala, supernatural and religious therapeutics.

Among the popular practitioners, there were two who amalgamated Sinhala and English medicines in their practice. One was Lunuwila nona, a traditional practitioner who was known for prescribing either Sinhala medicine or biomedical pharmaceuticals[67]. People could request what they preferred, or Lunuwila nona would prescribe what she figured was the more appropriate choice based on the patient's circumstances. As Sujatha akka said, "She'll give us pills anyway. She knows we do tea plucking in the fields". To paraphrase, their lifestyle made it impossible for them to adhere to the behavioural modifications required in Sinhala medicine, knowing which Lunuwila nona would always prescribe them English medicine whether they asked for it or not.

The second practitioner whose practice hybridised Sinhala and English medicines was Mudalali, a local healer who offered treatment free of charge. He confided in me that he had a gift for healing and was a self-taught amateur in both traditional medicine and biomedicine. Mudalali acted on his instincts in creatively mixing-and-matching therapeutic interventions from both modalities, often handing out pharmaceuticals for immediate symptom relief and prescribing *kasaya* herbal potions as long-term treatment. There were many householders who appreciated the efficacy of his eclectic treatment (and its cost effectiveness) and regularly sought treatment from him.

Buddhist monks who functioned as healers should be noted here as a special group that complicated therapeutic categories. Many households participating in the present study mentioned seeking

[67] Lunuwila nona's private practice is described in detail in chapter 6.

treatment from some *veda hamuduruwo*[68] or another. There are many Buddhist monks in the country who, in addition to their expertise in religious doctrine, are also known to excel in traditional medicine and/or astrology. Apart from conducting religious activities such as *bodhi puja* and Buddha veneration in the temple, they were popularly sought out as therapeutic practitioners as well. As mentioned earlier, Kalu mahaththaya, the local healer who was well-known for Sinhala medicine, *mathirili* as well as horoscope reading, had been a monk for years before derobing into a lay life.

Discussion

This chapter considered what emerged as therapeutic practices during household interviews. I presented the popular therapeutic practices first by categorising them based on four therapeutic modalities identified in the literature, and then recasting them as hybridising practices that merged across therapeutic categories. The four modalities were English medicine, Sinhala medicine, Buddhist religious healing and supernatural healing; whereas in reality, therapeutic practices appeared as hybrids of, for example, English-Sinhala medicines or Sinhala-Buddhist-supernatural therapeutics. The significance of therapeutic hybridity in terms of making sense of treatment as well as the role of practitioners in hybridising therapeutic categories were discussed.

Following this chapter's elaboration on therapeutic practices, I would first construct the meanings of ill-health as enacted in the participating households. In doing so, I would suggest that the diversity of therapeutic practices that address ill-health concerns potentially indicates the multi-faceted nature of ill-health itself. Practices associated with English medicine and Sinhala (herbal) medicine were predominantly accessed for conditions that manifest as bodily symptoms. These were most often originated through 'natural' causes, such as humoral imbalances in the body, ingested food, and exposure to inclement weather. Supernatural and/or religious methods were called for when there was suspicion of any 'supernatural' involvement in the origin or prolongation of illness, such as malefic planetary alignments or the gaze of a malevolent spirit. Apart from the natural and the supernatural, the social may also be a cause for illness: eroding of social relations due to jealousy and enmity were identified as *as-waha kata-waha*, or motivated the mobilisation of supernatural forces to sabotage others' lives through malefic *adurukam*.

As hinted at throughout the chapter, an event of ill-health was often made sense of as some combination of natural, supernatural and social elements. To illustrate, an illness/condition may manifest as bodily symptoms (e.g. various aches and pain, fever, difficulty in breathing, loss of appetite) which may point to

[68] A Buddhist monk known to be a skilled traditional medical practitioner.

a physiological or 'natural' cause; yet that does not preclude a simultaneous involvement of supernatural causes (e.g. malefic spirits, planetary alignments) and/or social causes (e.g. *as-waha kata-waha*). Addressing such potential multiple causality of ill-health, understandably, would call for an integration of diverse therapeutic approaches. This is corroborated by previous literature in Sri Lanka that explain lay conceptualisation of ill-health along a framework that integrates Ayurvedic, Buddhist and supernatural theories of illness causation and cure. A classic example is presented in Amarasingham (1980)'s study of one young woman's illness and treatment seeking trajectory.

According to Amarasingham (1980), at the time of the illness onset, the 19-year-old had been facing an important school examination, involved in a romantic relationship that her parents did not approve of, and had had some supernatural sighting that had shocked her. The illness which manifested as strange behaviour, wild imaginings and sleeplessness was diagnosed and treated in multiple ways by an array of therapeutic practitioners. Her horoscope readings indicated that she was living through a 'bad' phase; an *adura* (exorcist) explained that some sorcery had brought the gaze of *ririyaka* ('blood demon') on her; an Ayurvedic practitioner diagnosed her with *va -pit unmada*, meaning a humoural imbalance due to excessive 'wind' and 'bile' in the body; and the biomedical diagnosis was of paranoid schizophrenia, which was communicated to the family in colloquial terms as "a weakness of the brain".

Regardless of their obvious divergence, these multiple conceptualisations of one event of illness are all accepted by the family. As Amarasingham (1980) points out, their sense making is enabled through identifying the continuities of logic that thread across the different accounts. In this case, the family makes use of the implicit notions of 'excess' and 'imbalance', which are essentially of Ayurvedic origin. To illustrate, excess of emotions, overtiring of the brain, increased susceptibility to supernatural elements and excess of bodily humours are evoked at different points in the treatment seeking trajectory to make sense of the illness and its differential diagnoses.

Where ill-health is originated through the natural, the supernatural and/or the social, therapeutic endeavours that seek to bring about good health also integrates these dimensions. Ingestion or application of remedies, herbal or pharmaceutical, and consuming food items known to be of medicinal value are among the most common therapeutic practices. Blessings of Buddha and the gods are sought, and malefic forces are placated through various supernatural and religious rituals, which serve either as treatment in themselves or as means of ensuring success of other therapeutic interventions. Moreover, restoration of health is often brought about through collaborative effort. One has to do certain therapeutic practices such as the ingestion of medications by themselves; however, one's family, friends and/or neighbours may seek to get one's horoscope read, propitiate gods at renowned shrines and perform *bodhi puja* to confer blessings towards a speedy recovery from illness.

The exploration of meaning in therapeutic practices continues in the following chapter. There, I examine how the therapeutic understandings and approaches are situated and enacted in the participant households.

CHAPTER 5: THERAPEUTIC PRACTICES: SITUATEDNESS, RELATIONALITY AND FLUIDITY

In the previous chapter, I outlined the four popular therapeutic modalities (English medicine, Sinhala medicine, supernatural healing and religious/spiritual healing) that could be identified as being used in the participant households of Pitawella. I also demonstrated the porosity of these categories by following therapeutic practices that threaded across multiple modalities, creating therapeutic hybrids. This hybridity, I have suggested, is an essential feature in the local therapeutic landscape.

This chapter continues the present study's exploration of therapeutic meaning(s) as enacted within the participant households. The chapter begins with the multiple possibilities contained in the Sinhala term *beheth,* a keyword in the household interviews conducted in Sinhala language for the present study. This I consider as suggestive of the multiplicity and fluidity associated with therapeutics. The subsequent section builds on the multiple ontology argument of Annemarie Mol (2002) in analysing the contexts within which therapeutic practices are enacted in households as therapeutically meaningful, or abandoned and delegitimised as devoid of therapeutic meaning. Through these I highlight the diverse entanglements and relationalities that shape the enactment of therapeutic practices as situated, relational and fluid.

Medications as *beheth*

Household interviews in the present study involved the consenting members of participating households joining in to discuss their medication use and therapeutic practices. They were encouraged to share with me their therapeutics-related experiences as well as to bring out whatever medications of theirs that they wished to show me. Dew et al. (2014), in their study into household medication use in New Zealand, do not define in advance what they mean by "medications", instead relying on the research participants' understanding of the term. Following a similar method, I simply used the Sinhala word[69] *beheth* (used in common parlance to indicate medications and therapeutics in general) without defining its meaning for the purpose of the study. Accordingly, the accounts of therapeutic practices co-constructed during the interviews were based on the participants' conceptualisations of therapeutics, which they associated with the word *beheth*. The objects and practices that were described, and at times shown, to me during these interviews would signify what the interlocuters understood as being of therapeutic value and how

[69] As detailed in chapter 3, all fieldwork interactions and research interviews were carried out in Sinhala language, the first language of the research participants as well as mine.

those were used by them for therapeutic purposes. In other words, these discussions centred on the Sinhala term *beheth*.

Madura English – Sinhala dictionary translates *beheth* as "drugs, medication, medicine" (Kulatunga, n.d.). Based on my understanding of Sinhala language as a native speaker, *beheth* can either mean some (item of) medication, or the therapeutic modality, as dependent on context. For example, in household interviews, *ingrisi beheth* (English medicine) may refer to pills or to biomedicine in general. In colloquial use, *beheth gannava* (literally, taking medicine) could mean using medications, as well as seeking therapeutic treatment from a healthcare provider. *Beheth*, on the other hand, also refers to chemicals: *beheth gahanava* gives the unequivocal meaning of spraying insecticide or herbicide (in an agricultural setting). In this sense, *beheth* is semantically associated with synthetic material and/or toxicity. Accordingly, I would suggest that this term approximates the healing/harming potential captured in the term *pharmakon*.

When translating the interview transcripts to English, the most contextually appropriate meaning had to be retained per each iteration of the term *beheth*: which meant that the English translation became a more 'purified' version devoid of the shadows of potential meanings that would be conjured by the original Sinhala word. While I believe the English translation has thus been deprived of some depth, this remains an essential evil associated with any translation.

"[T]o imagine a language means to imagine a form of life" (Wittgenstein, 2009, §19); or, as some scholars have interpreted this aphorism, a language embodies the essence and the particularities of a way of life (Biletzki & Matar, n.d.). In the case of *beheth*, its semantic multiplicity and the embodied *pharmakon*-like potential to heal/harm incarnate the multiple meaning(s) of therapeutics in the households that are discussed in this chapter.

'Being therapeutic' as relational and fluid

Whereas the households participating in the study reported diverse therapeutic practices in their everyday life, it was clear that these were neither regarded nor approached in the same way. Even the same medication or practice in relation to a given illness could, under varying circumstances, be either welcomed as therapeutic, or avoided as dangerous. My observation was that a therapeutic practice 'being therapeutic' (or otherwise) often occurred within particular settings in which the given practice was enacted, so that their therapeutic quality would emerge as contextual and contingent.

While the situatedness of (social) practices is generally acknowledged in contemporary social scientific literature (Nicolini, 2012; Schatzki et al., 2001; Shove et al., 2012), it has also been proposed that the

situationally contingent enaction(s) of a practice may give rise to a multiplicity of meaning(s). In her seminal work, Annemarie Mol (2002) explores how the biomedically diagnosed disease "lower-limb atherosclerosis" is variously enacted in different spaces within one hospital in the Netherlands. For example, in the outpatient clinic, atherosclerosis manifests as pain in a leg experienced when walking and is measured by a doctor checking the pulse and blood pressure in the leg; in the pathology department, it is a thickening of an arterial wall as manifested in the slice of an artery of an amputated leg, which is mounted on a slide and observed through a microscope by a technician. Mol points out how these different enactions that were observed in the different (intra-hospital) settings were produced within the dynamic relationalities of disease, bodies, knowledges, technologies particular to each setting.

It follows that the various enactions of a phenomenon, each of which may constitute different meanings that are situated in their particular contexts, can be conceptualised in terms of ontological difference(s). Mol (2002), on identifying the diverse ways that the disease atherosclerosis was enacted, rejects the usual approach of considering them as different 'perspectives' (i.e. ways of seeing and understanding) on the same phenomenon. Instead, she points out that the different enactions of the phenomenon inevitably leads to the enacted phenomenon 'being' different, as opposed to 'being seen as' different, in the different settings. In other words, due to being differentially enacted in different spaces, atherosclerosis itself becomes rendered (ontologically) multiple. However, this multiplicity does not entail a fragmentation of the phenomenon, as the divergent enactions are all identified unproblematically, across the hospital, as one disease, i.e. atherosclerosis (Mol, 2002).

In this section, I draw on Mol (2002)'s notions of situatedness and multiplicity in examining a number of specific contexts within which household therapeutic practices occur. In some of these contexts and relationalities, these practices become therapeutic and legitimate means of seeking health; while in others, the practices are devoid of therapeutic meaning. Through this analysis, I wish to point out how the therapeutic potential of a given practice is often fluid and situationally contingent.

Prescription and expertise

Household interviews revealed that certain therapeutic practices nearly always occurred within the sanctioned confines of expert prescription and guidance. Despite being very popular and frequently sought, lay householders would not perform these practices by themselves. I would suggest that, in such cases, the enaction of the practices as therapeutic is enabled most often as relational with the epistemic authority granted to relevant practitioners/experts. To illustrate, I draw on two popular therapeutic practices: ingesting biomedical pharmaceuticals and harnessing the occult for therapeutic purposes through *adurukam* (exorcism, sorcery).

Biomedical pharmaceuticals

Where everyday illnesses were concerned, biomedical pharmacotherapy was undoubtedly the most popular treatment choice among the interlocuters from Pitawella. However, self-medication with pharmaceuticals seemed quite rare among them, similar to the findings of a comparative study of urban and rural districts in Sri Lanka by Wijesinghe et al. (2012). Nearly all the participants of the present study denied using pharmaceuticals on their own initiative. Even when they had received biomedical treatment for a similar condition previously, they opted to consult the biomedical practitioner again rather than use pharmaceuticals of their own accord. Though people may have medications at home that were left-over from a previous prescription and had not yet been disposed of, they admitted being reluctant to use them. Such reluctance may extend even to contexts where self-medication has been sanctioned: for example, Menik akka had been advised by her regular biomedical practitioner to be prepared for an emergency by having medications available at home for her asthmatic son, yet she preferred to take the child to the doctor whenever the illness flared up.

The few participants who reported self-medication with pharmaceuticals, too, would frequently do so on the guidance of a community pharmacist. For minor pains or everyday illnesses, such as toothache, headache and *pinas*[70], people may seek the recommendations of a pharmacist instead of a biomedical practitioner. Since the pharmacist would immediately issue them the required over-the-counter pharmaceuticals, it was a convenient and more economical alternative than going for a medical consultation when the condition was perceived to be of low severity, as corroborated by Wijesinghe et al. (2012). Further, it appeared that the study participants considered pharmacists an epistemic authority comparable to biomedical practitioners, as well as being more approachable and easier to access than the latter, as will be discussed in chapter 6.

To understand the householders' reluctance to use pharmaceuticals of their own accord, let us consider the following interview excerpt:

> We might mix up [the pills] or something, you never know. We won't know which pills are for which illness. Medications are toxic anyway, aren't they? You might get an allergic reaction for it. We may not know for whom the pills were for, for me or for someone else. The dose may differ according to age, too. The adult dose is not given for a child. We can't keep all those things in mind either. So, out of any leftover pills, we'd only keep Panadol. That we know [how to use].

[70] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

Sumith ayya's argument for the risks of self-medication are based on two main premises: pills being—by default—toxic to the body; and his lack of knowledge on pharmaceuticals and how to use them properly for healing purposes. The first of these, i.e. the notion of toxicity or harshness (*sara*) attributed to English medicine, was discussed in the previous chapter; therefore, I now take up the second.

The claim of illiteracy on biomedical pharmaceuticals was voiced by most of the study participants, including those who, like Sumith ayya, access biomedical treatment on a regular basis. Central to it was their not being English literate, which impeded them from deciphering the medical prescription (written in English) and finding out about their medications[71]. In fact, almost none of the participants, including long-term medication users, knew the names of pharmaceuticals that they used: they could only refer to their medications based on the physical properties (colour, shape, size) or the condition that they were ostensibly prescribed for (e.g. "*pinas* pills", "phlegm capsules").

Given that these people were highly conscious of their limited knowledge on pharmaceuticals, the very act of using them—while perceiving them as toxic substances—is an indication that people place their trust in the practitioner or the pharmacist. For them, it is through such an epistemic authority that the perceived toxicity of pharmaceuticals can be mitigated, and the healing effects materialised, which would justify people being extra cautious about using pharmaceuticals without such guidance. Therefore, while pharmaceuticals have permeated these households, they may be considered as foreign material not quite integrated into the flow of everyday life. (The presence of English medicine in the home is further explored in chapter 7.)

'Adurukam' and other supernatural practices

Similar to biomedical pharmaceuticals, supernatural healing practices were popular among the participating households. As described in the previous chapter, *mathirili* (charms) was performed for the likes of indigestion and menstrual pain, *santhikarma* (rituals of benediction) to alleviate potential misfortune caused through cosmic forces, and *adurukam* (sorcery, exorcism) for conditions such as spirit possession. Though people were quite knowledgeable regarding how these were performed and how a cure was brought about, they never attempted these practices by themselves. Where supernatural healing was deemed necessary, householders would always call in a relevant expert. For *mathirili* and *santhikarma*, the most sought-after practitioner was Kalu mahaththaya the local healer; for *adurukam*,

[71] This could be a major issue that impacts on health literacy, as demonstrated through a study on people attending a cardiology clinic at the National Hospital of Sri Lanka (Perera et al, 2012).

people often invited an *adura* (exorcist/sorcerer) from another village paying him[72] a considerable fee[73] for the service.

The reluctance of lay householders to meddle in supernatural matters was largely due to a heightened sense of risk and ambiguities of outcome. Supernatural healing, for them, was imbued with an ever-present pharmakon-like potential to heal/harm. *Adurukam* (exorcism/sorcery) was particularly significant in this regard. While there were many instances of *thovil* (exorcism ceremonies) being performed to cure people of spirit possession and *thanikan dosa*[74], on the other hand, there were also cases where events of ill-health were associated with supernatural rituals. For example, Sumith ayya toyed with the idea that his heart disease could be the result of a *santhikarma* (ritual of benediction) gone wrong.

Household interviews also pointed to instances of wilful harm being done through *adurukam* (exorcism/sorcery). When discussing the *disti* (spirit possession) of her daughter, Sujatha akka openly accused their neighbour, an *adura*-apprentice, for performing *adurukam* on the girl to sabotage what had promised to be a brilliant academic career. The case of *kodivina* (malefic charm) that deprived Matara mama of the ability to speak, which was described in the previous chapter, is also relevant here. As I was informed during their household interview, some time prior to the onset of his illness, Matara mama had hired an *adura* to perform a *santhikarma* (ritual of benediction) on him. However, in its stead, the *adura* had apparently done a malefic *kodivina*. When a second *adura* had explained this, Matara mama immediately hired him to remove the *kodivina* and to reverse its malefic effects onto the alleged perpetrators.

These cases shed much light on the heal/harm potential, and the associated risks and ambiguities, of *adurukam* as well as supernatural healing in general. Even a ritual of benediction could backfire, or be performed otherwise by a villainous *adura*, bringing harm onto the unsuspecting person who seeks blessings from it. *Adurukam* can also be employed intentionally to cause harm to others, through envy or enmity, or as retaliation. While its potential draws people to seek *adurukam*, they are also aware of its associated uncertainty and risk that pose them much concern. Consequently, people would call on an expert *adura* that (they believe) they could trust, in order to mitigate the undesirable outcomes.

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[72] All *adura* mentioned in household interviews were men.

[73] As mentioned by the participants, an *adura*'s fee would vary depending on the services provided. In any case, it would be several thousand Rupees. (As a comparison, a biomedical practitioner's fee, covering consultation and medications, would be around 200 to 500 Rupees.)

[74] Literally translatable as 'misfortune of aloneness' (Obeyesekere, 1969), this refers to a heightened state of vulnerability to the influence of (malevolent) supernatural forces.

It was also observed that people very often sought an *adura* from afar, even where similarly competent practitioners were available in the community itself. Menik ayya, a supernatural healer living in Pitawella whom I interviewed, was in fact quite bitter that his neighbours would not call on him for their therapeutic needs. As he explained to me, his services were highly demanded elsewhere, and he regularly travelled as far as Galle (approx. 60 km away) and even Colombo (125 km away) to perform *adurukam*. He framed it in terms of his neighbours being jealous of his professional success and the (relative) economic stability that he enjoyed.

Based on household discussions into harnessing the occult, I would suggest that, potential jealousy aside, people may not be keen to seek the services of an *adura* who is already personally acquainted with them. Getting any *adura* to perform *adurukam* would mean allowing him to unleash the powers of the occult over oneself and one's family, which, given the ambiguities of outcome, would mean taking a considerable risk. In addition, if the *adura* lives in the same community, there is also a likelihood that he may harbour some unspoken grudge against the intended recipient of *adurukam*, in which case there is near certainty of coming to harm through the supposedly-therapeutic process. Therefore, I would suggest that ensuring the lack of previously established personal relations with an *adura* is a way in which people try to deal with the risks and ambiguities associated with *adurukam.*

Practitioners establishing their epistemic authority

With regard to both biomedical and supernatural healing practices, householders perceived much potential risk; therefore, they counted on the prescription/guidance of relevant experts and practitioners. In both these cases, therefore, therapeutic practices gain legitimacy in households when mediated by the epistemic authority of experts.

Literature asserts gatekeeping practices of biomedical practitioners that serve to maintain their professional authority, which is captured under the theme of 'medical dominance'. Willis (2020) explores medical dominance as extended over medical professionals' own work, over other health professions, and over health-related matters in general. It is produced and sustained through subordination of other (health) professions and non-biomedical knowledges, limitation of their scope, and excluding them from gaining legitimacy (Willis, 2020).

Similarly, practices of gatekeeping as enacted by supernatural healers were observed in the present study. I interviewed three practitioners in the community who performed some kind of supernatural healing: Kalu mahaththaya, Mahasen mama and Menik ayya. Out of them, Kalu mahaththaya had

systematically studied Ayurvedic medicine, astrology and *mantra sastra*[75] during his years as a Buddhist monk. Both Mahasen mama and Menik ayya had been apprenticed to relatives who practised as traditional/supernatural healers, following which they had mastered the art through self-study of old books and ola leaf manuscripts[76]. These esoteric knowledges have traditionally passed down through generational transmission or from master to apprentice (Bulathsinghala, 2020). This allows the knowledges to be restricted to specialist circles, inaccessible to the general population, thus safeguarding the practitioners' claims to epistemic authority.

Household interviews also pointed to how the practitioners constructed and maintained their epistemic authority when working with 'patients', claiming due respect from the community. Consider the following excerpt where Matara mama and Matara nanda speak about the ritual carried out on behalf of Matara mama.

> Matara nanda: … We were told to make sweetmeats for the *thovil*. Seven types of sweetmeats, forty from each type. They must not be tasted by anyone [before being offered at the *thovil*]. So, my sisters, well, they have big mouths! They said, "why should you make the sweetmeats so big for the god? Make them smaller". That *adura*…
>
> Matara mama: The moment he tasted [the sweetmeats], he said so!
>
> Matara nanda: He said, "they've said such-and-such things when preparing the sweetmeats"!
>
> Researcher: Did he, really?
>
> Matara mama: Yes. [He] rejected everything [that we had prepared]
>
> Matara nanda: [He] rejected them all. Made us prepare sweetmeats anew!
>
> Matara mama: … There are people [like him] who do it right. There are also fraudsters, who won't detect things like that. They'd just do their business and leave. [If that had been the case,] we would've been swindled, because we wouldn't have got good results.

A *thovil* (exorcism) ceremony requires much preparation, among which is the making of various food items as offerings for supernatural beings whose assistance/blessing is sought. In order to be thus

[75] Literally, the 'art' of performing *mantra*, meaning charms, enchantments.

[76] Ola leaf, a type of palm leaf, was used in Sri Lanka from ancient times until the 20th century and the proliferation of paper. Many historically significant documents, ancient texts (and also horoscopes) exist in the form of ola leaf manuscripts. (https://www.cultural.gov.lk/web/index.php?option=com_content&view=article&id=62%3Aola-leaf-conservation&catid=34%3Aleft&Itemid=72&lang=en)

offered, the food items must not be 'polluted' in any way. As described above, the irreverent banter of women when preparing food had apparently made it unsuitable as an offering. Here, the *adura* exhibits his authority as the expert in-charge of the proceedings by rejecting the offending food items and ordering those to be prepared again. In addition, the *adura* had not been present when the food was being prepared; so that his knowledge of what had happened there astounds the householders. They have attributed it to the *adura*'s powers of clairvoyance, and therefore, consider it as evidence of his prowess. Indeed, it is clear from the excerpt that Matara mama is convinced of the *adura*'s authenticity as an expert in the occult, and therefore, of his epistemic authority.

Familiarity and experiential knowledge

Traditional herbal remedies, as described previously, have remained integrated into the everyday life of Sri Lankan households for generations. They were implicated in entirely different relationalities within the participant homes, when compared to biomedical pharmaceuticals and supernatural therapeutics. It was discussed in the previous chapter that the lay understanding of traditional herbal remedies that emerged through interviews was distinctly different from that of pharmaceuticals. To recapitulate, where English medicine was considered harsh and toxic, Sinhala medicine—derivative of herbs and plants—would be perceived as benign and nurturing. Its perceived risk being low, herbal remedies were generally used more readily and with less caution in the households, and often without any kind of prescription or guidance from a practitioner.

Household interviews indicated that people very often used traditional remedies for a variety of common illnesses and related symptoms, such as cold, cough, *pinas*, stomach ache, toothache, muscle pain, body aches, cuts and bruises; which is strongly supported by previous research in the country (Liyanage, 2000; Weerasinghe & Fernando, 2011; Wolffers, 1988). Such remedies often involved consuming herbal infusions and/or applying herbal extracts, for which the ingredients were sourced from the surroundings. Most remedies derive from the medicinal qualities of spices that are used in everyday cuisine (such as turmeric, coriander), or locally available herbs and plants (e.g. ginger, aloe vera, gliricidia).

The popularity of certain remedies within the community should be understood through their significant presence in the local landscape, and the resultant familiarity to the people. A case in point is that of *makulatha* sap, which was deemed to be the best treatment for cuts, even for deep lacerations that might otherwise require suturing. *Makulatha*, or gliricidia, is ubiquitous as shade trees in tea plantations, in which most of the participating householders work. Many of the injuries mentioned during household interviews had occurred in tea plantations, while trimming tea bushes, clearing the ground or putting up a fence. Gliricidia, therefore, becomes a very convenient remedy for any such cuts or abrasions. In fact,

many participants reported using the same sharp tool which caused the injury (often a 'tea knife[77]' or *manna* knife) to peel off a few inches of the skin on the closest gliricidia tree to extract the sap and applying it immediately onto the—still bleeding—wound. While the participants of this study have experienced the healing efficacy of *makulatha* sap, its wide spread use in this region also seemed to be associated with its easy availability: for *makulatha* sap does not appear to be among the better-known traditional remedies elsewhere in the country[78], where the tree is not as commonly found.

Further, having taken an active part in every step from sourcing the ingredients to preparing the remedies, the people themselves have accumulated a wealth of traditional medical knowledge within their households and their community, which gets transmitted generationally. Many adult householders spoke of traditional remedies that they were given as children, such as coriander infusion for the common cold, which they continued to administer to their own children. Accordingly, traditional remedies can be viewed as enmeshed within household relationships, caring practices and shared knowledges that transcend time and space. (These aspects are discussed in chapter 7.)

Panadol

'Panadol' is a trade name for Paracetamol, an over-the-counter analgesic widely accessed in the country. Unlike other biomedical pharmaceuticals, Panadol was always mentioned by name during interviews by participating householders. It emerged as a popular home remedy, an essential medication in the household, together with traditional remedies such as coriander or *kadum-bidum* oil[79]. Most householders regularly used Panadol for relief from bodily aches and pains they experienced as a result of labouring in tea plantations and elsewhere. This has created much experiential knowledge about Panadol within the community, which clearly distinguished it from other biomedical pharmaceuticals.

> Mahasen mama: Panadol works for any illness
>
> Mahasen nanda: You can take a tablet of Panadol for anything.
>
> Mahasen mama: …for headache, for a cold, for whatever you get.
>
> Mahasen nanda: Even for body aches…

[77] The small knife used for pruning tea bushes, hence the name. It is an extremely sharp tool and is used for various other purposes, such as toddy tapping.

[78] This assumption is based on my personal knowledge as a Sri Lankan of the traditional medicines popularly accessed as home remedies, also supported by the absence of *makulatha* (*Gliricidia maculata)* among the popular remedies cited in the previous research studies into traditional medicine use in the country (Weerasinghe & Fernando, 2011)

[79] Traditional medicinal oil to be applied as treatment for sprains or fractures

The above excerpt, taken from the interview at Mahasen household, illuminates how the versatility of Panadol for treating common everyday ailments has led to its frequent use in the home. Familiarity of its efficacy has inspired their trust. Therefore, unlike other biomedical pharmaceuticals, people actively self-medicate with it at home. Punchi nona, quoted below, further illustrates how Panadol is ranked among the common remedies in her household. According to her, taking Panadol for relief from fever is as reliable a remedy as the traditional remedies of coriander-and-ginger or *paspanguva*[80] for the common cold:

> When you give [coriander] boiled together with some ginger, a common cold will be cured. Or [you can boil] a packet of *paspanguva*. But that won't work if there's high fever. Then you have to give Panadol.

This way, Panadol appears to have transcended the biomedical domain into the everyday life within the home. It, therefore, appears to be an exception to all other English medications. As Mahasen mama put it, "[Panadol], too, is like *banvelgeta*". Drawing a parallel with *banvelgeta*, a traditional herbal panacea for aches and pains, clearly demonstrates the status of Panadol as a trusted home remedy.

To summarise, the use of traditional herbal remedies and Panadol in the home appears to be organised in distinctly different ways from that of biomedical pharmaceuticals and supernatural healing. Such differences could be approached, on the one hand, as matters of differential epistemic authority. In the case of English medicine, the householders acknowledged their lack of relevant expertise and looked to the practitioners as experts to guide them. Where Sinhala medicine and Panadol are concerned, however, the householders consider themselves sufficiently knowledgeable due to generationally transmitted knowledges and/or previous experiences with the medication. Such reliance on one's own knowledgeability or expertise has been theorised as 'self-ascribed epistemic authority' (Ellis & Kruglanski, 1992).

On the other hand, I have suggested that the differences of enacting therapeutic practices also hinge on the perceived risk, uncertainty and/or ambiguity of outcome(s) with regard to the therapeutics in question. Biomedical pharmaceuticals and *adurukam* were looked upon as highly volatile in terms of their outcome(s), whereas people were more or less confident about the (positive) effects of traditional remedies and Panadol. This shows that the pharmakon-like potential of medications to heal/harm would shape, to a great extent, the enaction of relevant therapeutic practices in the household.

[80] Five herbs to be boiled together to prepare a potion. A very common remedy for colds. Nowadays these herbs are available for purchase in ready-to-boil packets.

Contestation by dominant knowledges/practices

In terms of therapeutic practices, literature points to how mainstream or hegemonic knowledges continue to contest and delegitimise less powerful others (Arseculeratne, 2002; Dew, 2021; Hardiman & Mukharji, 2012). This may lead to the devaluation of certain practices and repudiation of their therapeutic qualities. In the present study, this was clearly observed in the cases of traditional remedies and supernatural healing, when challenged by biomedical expertise and Buddhist religious faith, respectively.

Biomedical surveillance and traditional remedies for children

Several interlocuters in Pitawella spoke of their experiences regarding traditional remedies—such as *kalka*[81] and oils—administered to infants and toddlers. These served either as tonics to prevent potential ill-health and to promote bodily functions such as digestion, or for curing illnesses common among very young children. However, such remedies were rejected outright within the contemporary biomedically-oriented fully subsidised neonatal care administered by the state. While it was clear that traditional remedies had not entirely disappeared, their delegitimisation within the biomedical framework has nevertheless significantly affected their presence within the households.

Public health midwives (PHM), trained by the state to implement antenatal and neonatal care services at the community level, were reported (by many research participants) as strongly denouncing traditional therapeutic practices. Being authorised to visit every household where there were pregnant women or new-born infants, PHMs were intimately involved with the everyday life within these households, over which they maintained close surveillance. Sujatha akka, quoted below, speaks of how the (biomedically sanctioned) authority of midwives could permeate the household to root out traditional therapeutic practices:

> *Aney* (alas!) those days, when a baby got a cold, we'll apply a bit of *batu* oil, and it'll subside. But now, we can't do anything like that. … Even if such [medicines] are there at home, we keep them out of sight. If someone sees them, then [the information] travels from one person to another, and finally that *Miss* [public health midwife] will scold you in front of all the parents at the [neonatal] clinic.

While she believes in the efficacy of traditional remedies as part of good neonatal care, Sujatha akka is also aware of their illegitimacy in the contemporary biomedical framework and the potential negative

[81] *Kalka* mentioned here is a kind of tonic given to infants. *Kalka* is sold (by practitioners and at Sinhala medicine pharmacies) in the form of crushed herbal ingredients rolled into balls. As the participants explained, a tiny bit of *kalka* is dissolved in a few drops of breast milk and fed to the infant once a day.

repercussions of being identified as using them. In response, Sujatha akka has adopted a covert stance of resistance. She continues to use traditional remedies for her grandson, while concealing the practice—and the relevant remedies—from (biomedical) surveillance. However, there were other households that, faced with a similar dilemma, had chosen otherwise: those people no longer administered traditional remedies to their infants.

Interestingly, the household surveillance that Sujatha akka speaks of, involves more eyes than that of the PHM, with anyone from the community that visits their home being posed as a potential 'informer' and therefore, a threat. In this regard, using traditional remedies becomes a dangerous practice, entailing the risk of public humiliation. Traditional remedies have thus been reconfigured as objects of potential social stigma, to be hidden away and only used secretively in the home.

Sujatha akka's account also touches on an important benefit of traditional remedies: they empower householders, particularly the mother, in caring for an infant. The perceived efficacy of medicinal oil to alleviate mild discomfort experienced by an infant, for example, has made it possible for such concerns to be managed within the household itself. Being thus self-reliant in terms of the infant's health is crucial in order to hold together the messy everyday realities of a mother, which are complicated with household chores, work in tea plantations, and caring for children (including the infant).

With traditional remedies disputed in neonatal care, biomedical alternatives will have to be sought. However, English medicine can hardly be substituted for traditional home remedies for minor health concerns of an infant, given that people in this community are reluctant to self-medicate with biomedical pharmaceuticals (as discussed earlier). The need to rely on biomedicine, therefore, manifests as an increase in seeking treatment from biomedical healthcare providers. Caregivers of young children (particularly the mothers) spoke to me of frequent visits to healthcare providers offering biomedical treatment, whenever their infants and children were sick. This trend was observed and often criticised by elderly householders. As Jaya mama put it,

> When a child is affected by worms, you can boil *gotunati* and *waladasaal* together [and give that remedy], it will cure the condition. But our mothers [nowadays] are used to go to the pharmacy to get some pills for the child. … Forget the child; [that treatment] makes the mother feel better!

Young parents (or, most often the mother, who would likely be considered as bearing the greater share of care responsibilities for the child/ren) could be blamed by their elders for seeking biomedical treatment for the children. As reflected in Jaya mama's words, such disapproval was often based on the older generation's perception that seeking English medicine was becoming more of a fashionable trend than a means of getting the children cured, through which the younger generations were gradually

distancing themselves from traditional practices. As for Jaya mama, he mentioned using English medicine only rarely, and could not reconcile himself to biomedical hegemony through which traditional therapeutics were being undermined.

Among the participants of the study, there certainly were proponents of traditional medicine such as Jaya mama and Sujatha akka, who took a stance of resistance (be it overt or covert) to biomedical hegemony and continued the traditional practices. However, the broad currents of biomedicalisation in the country (described in chapter 1) is such that its effects were observable even in the rural homes in Pitawella, where there is a high uptake of traditional herbal medicine in general. The gradual disappearance of traditional remedies from neonatal care in the households is one such manifestation.

Buddhist religious faith and supernatural healing

Supernatural healing methods were discussed as a popular therapeutic alternative accessed by people in Pitawella; yet, it was also clear that these were not universally accepted in the community. Several householders conveyed varying degrees of doubt as to the efficacy of resorting to the occult as a means of healing. Among the different types of supernatural methods, much scepticism was directed at *adurukam* (exorcism, sorcery), expressed both as a critique of its inauthenticity as a therapeutic method as well as the dishonesty of its practitioners. Consider the following quote from Kasun, who appeared to be a strong critic of *adurukam*:

> We do *bodhi puja* for Lord Buddha. We have faith in [Buddha's teachings] and it's something that a whole world believes in. [But] there's nothing like that in what these [supernatural practitioners] do! Those [supernatural beings being appealed to], they could be dead relatives or even *pretha*[82]. Why should you bring [such troublemakers] into your home? I don't believe in those [methods] actually. That is what [those *adura*s] do, they bring [spirits] from elsewhere and dump them in your home, to earn their living!

Kasun was extremely critical of supernatural healers who perform *adurukam*, accusing them of being money-minded and swindling people who are desperate for a cure. In addition, such healing itself, according to him, is a petty fraud that sharply contrasts with the truthfulness and universal acclaim that he unquestioningly attributes to Buddhist religious practices. There were others who expressed their mistrust of supernatural methods in a similar manner. Quoted below are Patty mama and Patty nanda:

[82] The dead who are yet unborn into a new birth. Buddhists consider most *pretha*s to be insatiable beings, who in their previous birth had craved after material things and continue to do so in their present state of limbo.

Patty mama: There's no demon that can defy Lord Buddha's teachings, that's what is said. There's no demon that did not surrender to Lord Buddha.

Patty nanda: I don't believe in *thovil* (exorcism), I don't believe in fortune telling. I only believe in Buddhism. I no longer believe in horoscopes either.

As demonstrated in these examples, the critique of harnessing the occult as a therapeutic modality was often constructed in opposition to Buddhism, bringing out an apparent conviction of Buddhism as encapsulating universal and undeniable truth. It was insightful that these people, who acknowledged their strong religious faith, maintained a clear distinction between the religious and the supernatural, constructing them as 'pure' categories (c.f. Dew, 2016) that are separable from each other. This approach, incidentally, aligns with the so-called "protestant Buddhism" in Sri Lanka (Gombrich & Obeyesekere, 1988), whereby the adherents are said to uphold the Theravada Buddhist canonical tradition and denounce the popular practices of Buddhists that involve the propitiation of deities and so on.

Contrary to the 'purifying' attempts of these participants, my observations on therapeutic practices as detailed in the previous chapter suggested the religious and the supernatural therapeutics to be closely entwined. To recapitulate, I explored household therapeutic practices that merged with and blended diverse elements that would generally be considered as affiliated to different therapeutic modalities. Based on such 'hybridising' practices that seeped through and blurred the boundaries of the two categories, I pointed to the religious and the supernatural as inexorably linked. Previous literature suggests that supernatural healing should be situated in a Buddhist religious framework that involves karma and rebirth, and where the Buddha tops the cosmic hierarchy as the supreme power (Obeyesekere, 1969). Some scholars, such as Hettige (1991), would even classify religious methods and supernatural methods together into a 'supernatural' therapeutic category since they both harness the powers of cosmic forces towards improving health.

Further, there appeared to be a gradient of acceptance among the householders in terms of the different types of supernatural healing. Many of them attributed legitimate therapeutic value to *mathirili* (charms) and *santhikarma* (rituals of benediction), even while denouncing *adurukam* (exorcism, sorcery). As explained in the previous chapter, *mathirili* involves chanting of *mantra* often as a catalyst for a therapeutic intervention based in Sinhala medicine, and s*anthikarma* is more or less an adaptation of Buddhist religiosity into a supernatural framework. While these two methods thus gain (some) legitimacy through close associations with Sinhala medicine and Buddhism, respectively, such is not the case for *adurukam*. Though deriving from a broadly Buddhist framework, the crux of *adurukam* involves appealing to and placating potentially malefic supernatural forces such as demons and spirits of the

dead, which deviates from Theravada Buddhist religious doctrine. I would suggest that it is this divergence that is built on by the householders when criticising *adurukam* as a fraudulent practice.

Malpractices and lack of practitioner integrity

The earlier quote by Kasun on *adurukam* pointed to another significant context that may influence the enaction of therapeutic practices; that is, the mistrust engendered in households due to malpractices by practitioners. Quoted below is how he expressed it:

> [*Adura* would say] you must do this and that. You know [what happened with] the family next door? That girl, she had some ordinary illness. How much did they spend [on *adurukam*]! They even sold their land [to cover the cost]! They did as many things as they could. [They must have spent] thirty-five thousand, forty thousand [or] forty-five thousand [Rupees]! … As parents, when [someone says] something is wrong with their child, they can't have any peace of mind, they have to do whatever it takes [to cure the child], even selling their lands for it.

Here, Kasun's emphasis is on how the *adura* (exorcist) had manipulated their neighbours to continue with *adurukam* as treatment, deceiving them with promises of a cure for their daughter. Allegedly, they even had to sell their land to cover the expenses: an unwilling last resort indicative of dire financial hardship, especially in a community such as Pitawella where everyone dreams of owning land and cultivating one's own tea plantation. Kasun, a parent himself, empathised with the parents who had been forced to choose their daughter's health over their dream of an economically stable future; and he blamed the *adura* for swindling them. The potential of practitioner dishonesty was admitted to even by those who believed in supernatural healing. For example, Matara mama (quoted earlier) highly praised the *adura* who had cured him of a speech impediment; and at the same time, he considered himself fortunate to have come across an authentic practitioner instead of a fraudster.

Dishonesty on the part of practitioners, and the resultant unmaking of therapeutics, was also relevant where Sinhala medicine was concerned. Quoted below is Kalu mahaththaya, a local healer offering services related to Sinhala medicine, *mathirili* and astrology:

> There are medicine shops where they substitute *thibbatu* roots for *batu* roots, or even places where they shave off the broom stick and sell the peelings as white sandalwood! Yes, I was told by someone who saw that happening. In one Sinhala medicine pharmacy shop, there hadn't been any white sandalwood available. So, the shopkeeper had gone inside, shaved off thin slivers of wood from the broom stick, and sold those as white sandalwood. What's the use of boiling that up and drinking it? Such fraudulence will destroy Sinhala medicine. … Nowadays [medicine]

> is practised for money. Earning money has become the priority [for practitioners] and it detracts the quality of their practice. That is why Sinhala medicine has deteriorated like this.

Kalu mahaththaya did not practise medicine as a livelihood and treated patients free of charge, thereby following his ancestral practice of medicine as service. However, he expressed being painfully aware of the malpractices of those who offer Sinhala medicine-related services, which he attributed to their faulty prioritisation of money. Focus on short-term profit, according to him, diminishes the quality of the treatment being provided and has affected the quality standards of Sinhala medicine as a whole. Decline in the quality of therapeutic treatment, and the resultant unsatisfactory outcomes, naturally erode people's trust, thus potentially affecting the enaction of therapeutic practices.

Long-term illness and karma

Where therapeutics cannot permanently cure an illness, as in the case of conditions that are biomedically termed chronic or long-term illnesses, people are obliged to follow therapeutic practices for an extended period, and often throughout their lifetime. In the present study, there were 11 householders who self-identified as long-term therapeutic users for conditions such as arthritis, diabetes, hypertension, kidney disease, oral cancer and heart conditions, as well as for generalised body aches. They understood that, for them, the use of medications could only offer a temporary respite and that they needed to maintain their health through regular use of therapeutics. Being Buddhists, many of them deployed the religious teachings on karma to make sense of their prolonged ill-health. That is, they considered their ill-health as being caused due to bad karma and therefore as "*karuma leda*" (karmic illness). Such reasoning, as I observed, had the potential to shape the enaction of therapeutic practices within the specific contexts of chronic illness.

One chronically ill participant in the study was Sumith ayya. He was diagnosed with a heart condition and arthritis, and was being treated with biomedical pharmacotherapy. However, he had recently decided not to follow the prescribed medications for arthritis. As described in the previous chapter, Sumith ayya's doctor had explained to him that the medications can only offer a temporary and uncertain respite from the painful condition—which was phrased as hiding the illness inside the body. Accordingly, he was aware that using the medications would not stop the recurrence of arthritic episodes in future. This, when supported by his medication-related concerns in general (which will be discussed later), had led him to forego the prescribed medications:

> I might get [the pain] again, with or without the medicine. You can never know. It all goes with one's karma, that's how.

Karma related teachings in the Theravada Buddhist doctrine emphasise the centrality of one's actions and their consequences, in this birth as well as during previous births, in determining one's present and future life. Karmic causality is popularly drawn on as a means of making sense of disaster, misfortune and/or suffering. Such reasoning, for example, has been noted among the Sri Lankan survivors of the Indian Ocean Tsunami in 2004 (de Silva, 2006; Levy et al., 2009), as well as in terms of accounting for disability and illness (Liyanage, 2017; Obeyesekere, 1976), and chronic conditions such as diabetes (Amarasekara et al., 2014).

Similar to Sumith ayya, several other participants in the study drew on karma in making sense of chronic illness. Given below is an excerpt from the household interview with Patty mama and Patty nanda. Both of them have experienced chronic ill-health (as discussed in chapter 5).

> Patty mama: If you have brought along any [bad] karma [from a previous birth], you will have to undergo [the effects of] that sin somehow or other. …
>
> Patty nanda: That is how we think of it now. That it must be due to the sins we have done in previous births.
>
> Patty mama: So, [we] will have to end it [by suffering for it]. Can't end it through medicine.
>
> Patty nanda: No [you can't]. In a way, you shouldn't [get cured through medicine] either. I mean, the karma must be undergone, right?
>
> Researcher: But there is also karma that can be altered…
>
> Patty nanda: [Yes, but] for that, you must perform highly meritorious deeds, [and] in a grand scale.

The above exchange between Patty mama, Patty nanda and me (as the researcher[83]) illustrates how a framework of karmic causality may be deployed to make sense of chronic illness. It should be noted that the Theravada Buddhist doctrine mentions both good karma and bad karma as bringing good and bad consequences, respectively; and that there is also the potential of one's karma being altered through diverse other factors. However, the popular lay reasoning tends to draw on bad karma and the inevitability of their negative effects, hence becoming a rationale for resigning oneself to negative circumstances over which one (seemingly) does not have any control.

In the interview excerpt above, the potential karmic causality of his illness, and its associated

[83] As I come from a Buddhist background, I am very familiar with the Theravada Buddhist doctrine as being taught in Sri Lankan schools as well as generally accepted in the lay community.

inevitability, leads Patty mama to feel that perhaps therapeutic treatment cannot cure him. In addition, where illness (or any misfortune) is approached as brought about through bad karma as consequences of one's past (mis)deeds, there is an element of personal responsibility associated with it. To put it in simple terms, chronic ill-health could be viewed as a kind of punishment for misdeeds performed in this life or in a previous birth. This line of reasoning leads Patty nanda to wonder aloud that perhaps one is supposed to live with illness-induced suffering as it is brought on due to karma and not seek to alleviate the suffering through therapeutic treatment.

In the present study, the participants who spoke of their ill-health as due to bad karma had initially sought (and some even continued to seek) therapeutic treatment. Their resorting to karmic causality appeared to be a means of accepting the inevitability of continued ill-health. Where karmic causality was mobilised, chronic ill-health was often made sense of as an inevitable phenomenon and over which one had no control. It could also be associated with a moral obligation that aligns with a religious notion of doing penance, as expressed by Patty nanda. If illness-associated suffering is thus inevitable and, indeed, constitutes a moral obligation that one should fulfil, it casts doubt on the possibility (even the appropriacy) of a cure through therapeutics. As persons who deployed karmic causality as an explanatory framework, Sumith ayya gave up his arthritis medications, while Patty mama and Patty nanda find medications to be useless and potentially a moral concern. These are indications as to how therapeutic practices could become redundant and invalidated through religious discourse.

Discussion

This chapter explored how the diverse therapeutic practices identified in the study were enacted variously within the participant homes. Based on household interviews, I analysed the diverse contexts within which different therapeutic practices were projected as meaningful (i.e. therapeutic) or as devoid of therapeutic sense. Accordingly, I pointed out that some therapeutic practices 'became therapeutic' in relation to the expertise (or prescription) of competent practitioners, while others gained meaning through their familiarity to and experiential knowledge of the householders. On the other hand, certain practices were delegitimised in contexts of being disputed by dominant knowledges, as well as where practitioner integrity was questionable. Popular belief in the karmic causality of ill-health was also important in that it might sometimes render therapeutic practices redundant in cases of long-term illness.

Mol (2002) demonstrates how the disease atherosclerosis appears to be strikingly different from one setting to another, since 'what the disease is' is enacted differently within the different relationalities of bodies, machines, technologies and biomedical knowledges. These diverse enactions of the disease are

argued to be indicative of the disease's multiplicity (Mol, 2002). In this chapter, I explored how therapeutic practices may be variously enacted in households, and how their therapeutic potential varied across such different enactions of the same practice. To illustrate, ingesting biomedical pharmaceuticals is a risky practice that involves potential toxicity; but where they are prescribed by a doctor or a pharmacist, they offer an efficacious cure. Panadol, too, is a pharmaceutical, though its use is organised differently to that of other pharmaceuticals and will be efficacious even without a prescription.

Following this, I suggested that the therapeutic potential was shaped within certain relationalities (of bodies, medications, knowledges) within which therapeutic practices occurred in households. To continue with the same illustration as before, perceived lack of one's biomedical literacy as well as notions of potential toxicity and risk that were associated with English medicine would lead people to be guided by practitioners ascribed with (biomedical) epistemic authority. Whereas in the case of Panadol, people have had extensive experience with the pharmaceutical, and used it regularly and without any kind of biomedical advice. This way, therapeutic practices, shaped within different materially-mediated relationalities, could be therapeutic, useless or even dangerous: which signals the variability and fluidity of their therapeutic potential(s).

The argument on therapeutic potential(s) as multiple, fluid and contingent resonate closely with the observations I made at the beginning of the chapter. There, I reflected on the multiplicity of possibilities captured within the Sinhala term *beheth*, a keyword in the household interviews that I carried out in Pitawella village. To recapitulate, *beheth* would semantically align with pharmakon: it constitutes potential to heal and/or harm, depending on its context of occurrence. Given the centrality of the term *beheth* in terms of capturing what the participants identified as therapeutic practices during the household interviews, I would consider multiplicity and fluidity of therapeutic meaning(s) as a significant feature in household therapeutic practices that were revealed through the present study.

Returning to what constitutes the therapeutic potential of therapeutic practices, it was interesting to note the contexts through which different practices became 'therapeutic'. To illustrate, biomedical pharmaceuticals and supernatural healing, which could generally be considered incommensurable in terms of their knowledges and general scope of application, were both manifested, in participant homes, within the sanctions of professional expertise. The reason being, they were both approached by householders as involving high risk that needed to be mitigated through epistemic authority accorded to practitioners. Similarly categorisable together were traditional remedies (such as coriander infusion, *makulatha* sap) and the biomedical pharmaceutical Panadol. Neither of them required professional expertise to sanction their use, as they have been regularly used for years in the households and, therefore, were considered as home remedies by the community. In this light, I would suggest that the

householders' understanding of and approach towards the given therapeutics would be key to making sense of how their therapeutic potential is configured in the participant households.

Trust in therapeutic practices

A central concern that threaded through the analysis of therapeutic practices in this chapter, is that of trust. Enactions of therapeutic practices in the household were underpinned by trust in its various nuances. To paraphrase, a given practice being therapeutic in the household was inevitably linked to a certain degree of trust (among the householders) that the practice could potentially lead to a positive health outcome. This trust, however, was hardly absolute, as it emerged through the dynamic relationalities that contextualised the therapeutic practice itself.

Given the inherent complexities of a diversified therapeutic landscape, a useful conceptualisation of trust is offered by Rodrigues (2016). Her study is based in Maputo, Mozambique, where the therapeutic landscape comprises of biomedicine, traditional and herbal medicine, Traditional Chinese medicine and homeopathy. Rodrigues (2016) points out how seeking treatment in this diversified landscape involves trust as formed of three significant 'layers': trust in medical systems, trust in the practitioners, and trust in the experiences of others. In addition, the different layers are said to intersect and influence each other. These would manifest as variable therapeutic practices among the people.

To illustrate householders' trust in therapeutic practices as it was manifested in the present study, I would like to draw on the findings in relation to Sinhala medicine. Nearly all the participants expressed trust in Sinhala medicine as an effective therapeutic modality. Indeed, the trust in Sinhala medicine was also entwined with historical, national and personal relevance: it was often associated with the glorious pre-colonial past of the country and, for some participants, their own nostalgic memories of happier times (as will be discussed in chapter 7). This trust was sustained, in most households, through their familiarity and positive experiences with traditional remedies, particularly in terms of home remedies that they used regularly.

However, the same degree of trust in Sinhala medicine was not inspired where the contemporary practicalities of treatment seeking were concerned. People were aware of the potential fraudulence of healthcare providers, and this introduced some scepticism regarding the therapeutic outcomes. More broadly, the general undermining of traditional medicine within the biomedicalised healthcare system in the country also appears to have eroded people's trust in Sinhala medicine. One example of it was the gradual disappearance of traditional remedies that used to form an important part of neo-natal care in households, influenced by their repudiation in the biomedical framework. In their stead, biomedical

treatment was becoming the norm. It is also likely that the deterioration of trust in Sinhala medicine is, at least partially, reflected in the general downward trend in seeking Sinhala medical treatment across the participant households, which is corroborated in the literature (Liyanage, 2000; Weerasinghe & Fernando, 2011; Wolffers, 1988).

Elusiveness of (good) health

In the previous chapter, I highlighted the multi-faceted nature of ill-health as encompassing the natural, the supernatural and the social, thereby making a case for therapeutic practices to be similarly diverse and hybrid. The discussion on karmic illness in this chapter added more dimensions to ill-health, such as a cosmic relevance as well as a (religiously-defined) moral obligation. (The Buddhist religious implications on ill-health and the use of therapeutics will be taken up again in chapter 9.) In concluding this chapter, I would like to return to the ambiguities of health/ill-health in relation to household therapeutic practices.

Medications and other therapeutic practices are sought with an aim to improve and/or maintain one's health, thus to distance oneself from what is perceived as a state of ill-health. However, therapeutic practices do not always work as expected in ordinary life (Mol, 2008). Medications may become 'toxic' to the body, *adurukam* may go awry, and practitioners may swindle the 'patients'. As such, therapeutic practices themselves are risky practices through which an existing state of physiological, psychological and/or social wellbeing may (further) deteriorate. Where attempts at improving/maintaining health may, on the contrary, endanger it, we are given a glimpse into the uncertainty, fragility and elusiveness of health and life itself (Das, 2015a, 2020; Mol et al., 2015).

Given these risks, undertaking a therapeutic practice becomes an act of (some) trust in the therapeutic potential of a given practice, as discussed above. A therapeutic practice's 'being therapeutic', as I have demonstrated in this chapter, is shaped in specific relationalities, and is therefore situationally contingent. The same medication, or the same healing ritual, may be therapeutic in one iteration though dangerous in another. This multiplicity and fluidity of therapeutic potential, along the lines of the heal/harm properties of *beheth,* points to the need to mitigate the harms and optimise the 'goods' of therapeutic practices. Therein lies the fragile hope of improving on the present state of (ill-)health, which is what motivates therapeutic practices in the first place.

The exploration of household therapeutic practices across chapters 4 and 5 has emphasised their diversity, hybridity, fluidity and situationally contingent nature. Building on these, the following chapters explore how people navigate their therapeutic landscape and tinker with therapeutic practices in seeking a localised 'good' outcome.

CHAPTER 6: NAVIGATING THE HEALTHCARE LANDSCAPE

This chapter is organised around the Pitawella community's experiences of treatment seeking from the different healthcare providers available: public hospital(s), private medical practitioners, and community pharmacies. The household interviews revealed a diversified therapeutic landscape where treatment seeking spanned biomedicine and traditional therapeutics in the public and private sectors of healthcare provision. The primary healthcare providers preferred among the Pitawella community were often private (biomedical and/or traditional) practitioners. While accessing curative treatment for minor or acute illnesses from a public healthcare institution appeared to be quite a rare practice, on the contrary, many people undergoing pharmacotherapy for chronic conditions, as well as all those seeking in-patient treatment, attended public hospitals. Functioning on a different plane are community pharmacies. There were three of them in Neluwa town that were frequently accessed by the participating households.

The chapter is divided into sections in terms of the various experiences of accessing treatment: at public hospital(s), from private practitioners, of traversing the public–private healthcare divide, and from community pharmacies. Drawing on these findings, I discuss what I understand as the drivers of treatment seeking practices in Pitawella community. Through this I suggest how the people creatively manoeuvre and 'tinker' within the circumstances of everyday life for a satisfactory treatment seeking experience, with a view to restore/maintain health as a local and contingent 'good'.

Treatment seeking from public hospitals

In chapter 1, I provided a general overview of the public sector healthcare in Sri Lanka. To recapitulate, under the 'free health policy', all health services in the public sector are fully subsidised at the point of delivery. There being no institutionalised system of referral, a person may access services at any public healthcare institution of their choice in the country. On the other hand, the inadequate state investment and resultant resource shortages, as well as the over- and under-utilisation of urban and peripheral facilities respectively, can be identified as major challenges that undermine the efficacy of the public sector healthcare services.

For the participants in the present study, the most convenient place to access public sector healthcare was Neluwa hospital, which is located around seven kilometres away. It is a divisional (Type C) hospital[84]

[84] Public hospitals are hierarchically categorised based on their functions, scope and resource strengths, as National hospital, Teaching hospitals, General hospitals, Base hospitals and Divisional hospitals. The latter is further divided into Types A, B and C. Neluwa hospital is a divisional hospital of Type C.

that has an out-patient department (OPD) and limited capacity for in-patient treatment. It was found that only two households (out of the 20 participating in the study) regularly accessed the public hospital OPD for treatment for minor illnesses; and only one of them, i.e. Menik akka's household, mentioned the hospital OPD as their preferred primary healthcare provider. On the other hand, three of the eleven self-identified long-term medication users in the present study accessed public hospital services regularly to manage their chronic conditions, though not for everyday health concerns. Where in-patient care was concerned, however, nearly all households reported accessing the public hospital(s).

Features of treatment seeking experiences in the public sector

Fully subsidised treatment

The few households that regularly or sporadically attended the public hospital were principally motivated by its treatment being free of charge. Menik akka, a regular attendee to the hospital OPD, was satisfied with the treatment that she and others of the household received there. While the perceived effectiveness of treatment probably led them to trust the hospital as their primary healthcare provider, their practice of accessing the hospital had been initiated during their long years of financial precarity before her husband secured a good means of income (as a traditional performer/exorcist) a few years ago. For example, Menik akka recalls walking to and from the hospital, seven kilometres each way, with her sick children (very young at the time) as they could not afford to hire a tuk-tuk. Herath akka, another participant, stated her reasoning more explicitly:

> [Earlier] I got medicine from S-- mahaththaya. [Yesterday] I didn't have money to go to a private [practice], so I went to the hospital.

While most households avoided seeking primary care services at the public hospital for their minor illnesses, this trend was reversed in terms of apparently severe conditions requiring intensive or in-patient treatment, such as chest pain or a serious injury. All hospital admissions mentioned during the interviews involved public hospitals, and no participant spoke of ever receiving in-patient treatment at a private hospital. The pivotal factor in this regard appears to be the potential cost of treatment. In-patient care at a private hospital, especially if extended over a number of days and/or if it involves technologically sophisticated treatment and testing, would mean a considerable fee as out-of-pocket expenditure[85]; whereas equivalent care at a public hospital (though perhaps differing in degree of flexibility and perceived quality, as discussed later) would be free of charge. Given the economic precarity of many participant households, a substantial private hospital fee would simply not be

[85] As mentioned in chapter 1, a vast majority of Sri Lankans do not have access to any form of health insurance.

affordable. Therefore, the householders' first choice for intensive and/or in-patient care would, understandably, be the public hospital.

Trust in the public healthcare system

It was also noted through the interviews that the participants nearly always accessed public healthcare in cases where the perceived risk was high. This includes conditions that appear serious enough to warrant hospital admission, which were mentioned previously. While cost is definitely an important concern that motivates people to seek public healthcare services on such occasions, it could arguably also be a matter of trust.

Consider the following interview excerpt where Thilani, a young mother, reasons out why they sought treatment from the public hospital OPD for their toddler.

> Thilani: Because the fever didn't go down at all that day. [The child] was having high fever for three or four days.
>
> Researcher: That's frightening, isn't it?
>
> Thilani: Yes, that's why [we went to the public hospital OPD]

This discussion between Thilani and me (as the researcher) is situated in our shared experiences of a mother's anxiety over a young child's illness, as well as the awareness of persistent fever as a potential symptom of numerous tropical illnesses, including Dengue, which causes wide-spread mortality in the country every year. In this context of heightened risk, unabated fever of a young child becomes "frightening" to their caregivers. Thilani's response on this occasion had been to take the child to the public hospital. It should be noted here that their preferred primary care provider is a private practitioner, from whom they had initially sought treatment for the sick child. However, as the fever continued and the risk of serious illness became apparent, the parents had opted for the public hospital.

While most householders did not access public healthcare services on a regular basis, they still indicated a sense of trust in the public healthcare system as catering to their wellbeing. This notion was clearly expressed by Manori akka when explaining why she bought micronutrient supplements for her children. A contemporary initiative by the Ministry of Health has introduced the weekly provision of iron, folic acid and Vitamin C supplements to school children. However, as mentioned in several household interviews, these were distributed rather sparingly in schools around Pitawella.

> They don't give [the pills] every week. Like now, these days. When there's no medicine, [the school] stops giving them. So, [I] bring iron tablets and give them to the children once a week.

It appears that Manori akka, quoted above, understands the shortages affecting the distribution of fully subsidised 'medicine' (meaning micronutrient supplementation) as a fact, and does not blame the school, or more broadly, the state which funds this (preventive) public health service. Instead, she decides to buy the supplements herself for her children.

> [I buy them] because, well, it's good [for the children]. That's why they're given those at school.

Not being formally educated, it is likely that Manori akka does not grasp the public health rationale behind providing these supplements to school children country-wide; however, as it is a government-backed public health initiative, she believes that it is 'good for them'. This implicit trust, in this instance, motivates her to the extent of bridging the gap of public healthcare provision with out-of-pocket expenditure on her part.

Inconvenience and low accessibility of services

Many common reasons stated by people for not frequenting the public hospital can be summarised in the theme of difficulty of access. Neluwa hospital is the closest public healthcare institution for people in Pitawella to seek curative primary care services. Its out-patient department (OPD) is open on weekdays from 8.30 to 12 noon, then from 2 pm to 4 pm, and on Saturday from 8.30 to 12.30. These hours clash with the regular workday of daily waged labour (usually from 8.30 to 4 pm) for those who work in the tea factory or local tea plantations five or six days a week.

In addition to the potential disruption to a workday (and the resultant loss of income), one needs to factor in the logistics of travelling—within the hospital OPD work hours—to Neluwa town, around seven kilometres away, on a route with limited public transport. As for the regular attendees to weekly/monthly clinics at the hospital, they need to be there before the clinic commences at 8 or 8.30 am; but ensuring a place at the front of the queue necessitates reaching the clinic as early as 5 or 6 am. For Menik akka, who regularly accesses the hospital OPD, it involves taking the "school bus"[86] back and forth, leaving home around 5.30 am and returning past 4 pm. Though lamenting the waste of an entire day, she prefers this option which costs less than 30 Rupees, when compared to taking a tuk-tuk from Pitawella to Neluwa town, a 20-minute trip that costs around 600 Rupees (one-way)[87].

[86] The bus driven by Sumith ayya to Neluwa and back. It passes Pitawella around 6 am, with the aim of dropping children off to schools on time. Schools in Sri Lanka start at 7.3 0am.

[87] It should be noted that the wage earned by a person for a full day of work in a tea plantation or a tea factory is around 1000 – 1200 Rupees.

The inconveniences associated with resource shortages in the public health sector were also mentioned by the participants. Lengthy wait times and medicine shortages in the hospital dispensary appeared to dissuade many people in Pitawella from accessing the public hospital.

> ...when I went [to the clinic], they don't have medications. They'll give a few pills and tell us to get the rest elsewhere [from a pharmacy]. It cost me around one thousand [Rupees] for one week, for these capsules that go in my inhaler. … If you have to spend over one thousand [Rupees] in one go, then what's the use of going [to the hospital]?

Quoted above is Dolahe-gedara nanda, who had stopped attending the regular clinic at the Neluwa hospital. What has discouraged her from accessing public sector services is not actually the cost of medications mentioned here: she would be paying an equivalent amount for medications at the private medical practice that she was attending at the time of the interview. Rather, it was her disappointment at having to pay for medicine where she expected to receive fully subsidised healthcare. Had this expectation been met, she would have been content to undergo the minor inconveniences associated with attending a crowded clinic in the public hospital; whereas, having to incur out-of-pocket expenditure for her treatment, she is not.

Seeking public hospitals further away

While Neluwa hospital, as a divisional hospital, was avoided due to such shortcomings, some people voiced positive opinions about larger and better-equipped public hospitals further away, where they had found the quality of service and the facilities to be relatively superior. Some examples were U- base hospital (around 20 km away from Pitawella), B- base hospital (55 km) and K- teaching hospital (60 km). Bypassing the primary healthcare network to access secondary or tertiary healthcare institutions (i.e. base hospitals, teaching hospitals) becomes possible in the absence of an institutionalised referral system in Sri Lanka, as explained previously.

In any case, seeking treatment from distant public hospitals was not a very popular trend in Pitawella, as reflected in household interviews. The considerable distance to reach a better equipped hospital (often 20 to 50 km, as noted above) was conflated with the lack of good transport alternatives which hinders casual long-distance travelling for the community. This meant that the research participants accessed such healthcare institutions only rarely or as a desperate measure.

Dissatisfaction with patient care

Overall, a common grievance of many participants who accessed public hospitals was the unsatisfactory quality of care they described receiving. This could be resultant from resource and personnel shortages

and/or even carelessness and lack of attention of the staff. For example, as recounted at the Mahasen household, several years ago Mahasen mama was admitted to H- district hospital (around 10 km away) suffering from a severe asthmatic episode. Then, unhappy with the care he was receiving there, Mahasen nanda (his wife) had him discharged and admitted to U- base hospital. There, the doctor who attended to Mahasen mama had exclaimed in shock on seeing the (record of) medications that he had been administered at the previous hospital. Describing this incident, Mahasen mama claimed that he did not trust (public) hospitals any longer and vowed he would never go there again.

Instances of (biomedical) diagnostic and/or treatment failure reported from households, many of them involving public hospitals, were also cause for much dissatisfaction among the participants. In Patty mama's household, there were not one but two such cases. His wife Patty nanda had suffered for over 15 years from a urinary tract condition. During this time, she had, starting from the public hospital's out-patient department, sought treatment from every possible treatment provider but to no avail. Finally, the latest biomedical specialist that they channelled[88] had recommended a minor surgical procedure, through which she had been completely cured. Given how quickly the condition was resolved with the surgical procedure, Patty nanda and her husband believed that years of suffering could have been avoided if she had received attentive professional care in the first instance. As indicated below, they explain that she had not been sent in for any diagnostic tests nor medical scans despite the obvious failure of prescribed medications to relieve her symptoms through the years. This, in retrospect, is noted as neglect on the part of the doctors accessed through public hospitals as well as through the private sector.

Patty mama: [My wife] kept on [ingesting] medications all that time. And [the doctors] only found out what the matter was after 15 years!

Patty nanda: … They didn't do any tests [on me] all that time. I went to, how many specialists? None of them told me to get even a scan done. Not even one.

Patty mama: She'd tell her problem, and they'd give medicine. … To think that she suffered so long for something [as easily fixable] as that! It's possible that I, too, have some very minor illness, it's just that it's not been diagnosed yet.

At the time of the research interview, the household was undergoing the ordeal of a second event of undiagnosed long-term illness. Patty mama was suffering from debilitating headaches and generalised body aches, which he dated back to the time of the traumatic suicide of their son, five years ago. In

[88] 'Channelling', as I have explained in chapter 1, is the process of making an appointment with a specialist in the private sector.

wondering whether the diagnosis failure in his case was due to a similar inadequacy of professional care as that which had caused 15 years' suffering for his wife, Patty mama indicates his doubts of the efficacy of the healthcare system. Such mistrust and frustration arise through the unsatisfactory treatment seeking experiences that his household has undergone.

Structural violence, rigid policies, unempathetic staff

Being ill-treated by the public hospital staff was, in fact, a common experience among the participating households that had accessed public health services at some point. Such events, as disclosed in household interviews, most often implicated hospital attendants, security officers and/or nurses, and rarely, doctors. Similar patient grievances have been noted in previous studies elsewhere in the country (Liyanage, 2000). In the present study, it appeared that regular attendees to public hospitals had resigned themselves to ill-treatment and verbal abuse by the staff. Consider the following quote from Sumith ayya, who regularly attends a clinic at the public hospital where he is prescribed his cardiac medications:

> [I] have to attend [the clinic] once a month. If I can't make it, [the attendants] put my *potha*[89] aside [at the next clinic]. Doesn't matter even if you get there very early in the morning [for the next clinic], they'd put your *potha* aside and give priority to others [who had been there last month]. They deserve priority, that's only fair. But it is due to some reason that you would've missed a clinic, right? … If I missed the clinic one day and went to the following month's clinic, [the attendants] would push my *potha* aside and scold me. They scold you, the attendants. They yell "you didn't attend [the clinic]" blah, blah, blah. I can explain [my reasons] but they won't believe me.

This particular experience of Sumith ayya involved a family health crisis that was unfolding at the time. His wife was to be discharged from a hospital (some 50 km away) following residential treatment for knee-cap dislocation. With her being unable to walk, Sumith ayya was planning to pick her up from the hospital, and to search for a 'walker' to aid her mobility at home. These plans conflicted with the monthly clinic that he was expected to attend. As a regular at the clinic, he was bitter in his awareness that any extenuating circumstance would not be met with empathy there. This meant for Sumith ayya much anxiety over the difficult choice of attending the clinic over tending to his sick wife and prolonged discomfort for the invalid as she waited for him for almost five hours after being discharged.

[89] *Potha* (meaning 'book') refers to the record of case history and treatment. Every patient attending a clinic is expected to maintain a 'book', in which the medical officer at the clinic would note down the patient's biweekly/monthly medical reports and the prescription.

To make sense of the lack of empathy and the erasure of the personal in the clinic as related by Sumith ayya, his experience needs to be contextualised to the general setting of a monthly clinic at a public hospital. As pieced together through my own experiences as well as details gleaned from household interviews, there may well be over one hundred patients attending some hospital clinics. People might have arrived as early as 5am or even spent the night somewhere nearby in order to get an early appointment. Until the patient's appointment number is called and they walk into the consultation space to be examined, the doctor(s) remain invisible to the patients. A handful of attendants are in charge of managing the thronging people, who range from docile to unruly in their impatience to finish their medical appointments and leave. The attendants give out appointment numbers several hours ahead of the commencement of the clinic, queue the patients up to go in when called, and supervise their receiving of medications from the hospital pharmacy. During this process the attendants' institution-granted authority may be exercised to enforce the compliance of the 'lay' people as well as to patronise, chastise or favour.

The rigid procedures and paternalistic monitoring enforced at public hospital settings may serve to increase patients' conformity if at least by creating in them a desire to avoid being publicly scolded, as in the case of Sumith ayya. On the other hand, their very inflexibility may lead many others to avoid treatment altogether. For example, both Mahasen mama and Nita akka had avoided biomedical treatment for long-term conditions (asthma and high blood cholesterol, respectively) due to their strong dislike of public hospital clinics as they had experienced themselves. Rathu ayya, another participant of the study, had been an out-patient and an in-patient at Neluwa, K- and U- hospitals during one week of being treated for an injured foot, and his experience has turned him strongly against accessing public hospital services. Talking of his negative experience with hospital staff, rigid hospital policies and his sense of feeling completely helpless, he summed it up with:

> I hope I'll never have to stay in hospital again! It was... *ayyo*![90] … The worst part [of being injured] was staying in the hospital. It disgusted me of this whole *sasara*[91].

The debt of 'free' healthcare

It should be noted that, though participants of the present study voiced (during household interviews) their dissatisfaction of the care received at public hospitals, there was hardly any indication that they had raised the issue at that point at the hospital, let alone made a formal complaint. The general approach

[90] Exclamation indicating misery, disgust, distress, pain, anger

[91] "*Sasara epa wuna*" is a common Sinhala idiom indicating an overwhelming disgust of something. Probably derivative of Buddhist lore: Prince Siddhartha is said to have left his royal inheritance to seek an ascetic life after having become disgusted of the *samsara/ sasara,* i.e. worldly life, cycle of birth and death.

among a majority of the householders was one of silently enduring the ill-treatment or indignities at the hospital and trying to avoid any further dealings with the hospital, unless one was obliged to attend regular hospital clinics like Sumith ayya was.

Writing of patients' experiences of accessing 'free' healthcare in a public hospital in Thailand, Seo (2016) posits the discourse of 'free' care as a gift and as a debt. The hospital staff expect the patients to be patient and wait for their turn; and the patients themselves rarely demand more attention than what they are given. This is reflected in the endless waiting that occurs in hospital spaces: in-patients waiting for a referral for life-saving treatment, out-patients suffering in pain and waiting in line to see a doctor. Seo (2016) uses the Thai term "kreng jai" to capture the complicated feelings—hesitation, consideration towards staff, embarrassment, indebtedness, humility—that cause people to become docile patients at the hospital. Where care is considered a 'gift' from the benevolent state (as opposed to funded by the taxes that they themselves pay) and/or from the hospital staff, patients do not consider themselves entitled to good healthcare: instead, they feel "kreng jai" (Seo, 2016).

In the present study, too, the participants accessed similarly 'free' services at the public hospital. Feelings of indebtedness, similar to "kreng jai", were reflected in their becoming silent recipients of the paternalistically-administered 'gift' of healthcare. That is, on the one hand, they were already disempowered in the hospital settings as poor and less educated people, and on the other, they did not feel entitled to demand better care for themselves in a situation where provision of care was a 'gift'. What they did do was, as mentioned above, avoid the public hospitals whenever possible. Some people sought alternate means to improve their treatment seeking experience at the public hospital, as discussed below.

Circumventing the system

On occasion, regardless of their treatment seeking preferences, people relied on public sector healthcare services. Household interviews indicated certain ways in which people had manipulated the situation and the available resources to achieve a satisfactory outcome for themselves. One such 'method' was mentioned by Sumith ayya when recounting his experiences of the hospital clinic:

> But there are cunning people too, who keep on pestering the staff until they take up their *potha*[92]. They'd keep on asking again and again, so that that person (staff) can't attend to their work. … There are also some people who don't even get a number. They'd just slip through. Others may scold them, but they won't say a word, just smile and move away. Not even

[92] Book containing medical records

> embarrassed. There're all kinds of people. What we do is, we'd stick to the rules and get our work done.

Identifying himself as a rule abiding person who had to undergo much inconveniences at the hospital clinic, Sumith ayya distances himself from the "cunning people". He criticises them for being inconsiderate of the hospital staff and other persons attending the clinic by not conforming to the behaviour expected of a 'patient'. On the other hand, these 'others' can be viewed as challenging the rigid system enforced at the hospital clinic. They, in their "pestering", "slip[ping] through" and "[un]embarrassed" behaviours, manipulate the system and manage to slip through its cracks in order to seek medical treatment on their own terms.

In fact, many narratives of successful treatment seeking in the public sector involved some manner of transgressing the system. This was quite often done with insider help. Consider the case of Sarika, who was recommended surgery for a potentially malignant growth in her thyroid gland. While her household usually preferred private health services, it was not a feasible option on this occasion, as it would have cost them a substantial out-of-pocket expenditure of over "three lakhs" Rupees. Yet, at the time that she was diagnosed in 2018, the earliest date that she could have undergone the surgery at the K- teaching (public) hospital was in 2023: all possible dates being already booked for five years ahead. This dilemma was, however, resolved in a highly satisfactory manner, through the intervention of a cousin who worked as a nurse at the hospital. As Sarika's husband Roshan recounts:

> We got [the surgery] done in one month, because that Rani was there [in the hospital staff]. … [Rani is] the daughter of my mother's older brother. She got us a date within one month… She worked in the same ward as the [specialist that we were seeing].

Following the surgery, Sarika was expected to attend monthly clinics at the same hospital to manage her recovery. Sumith ayya's experiences, discussed previously, indicated the inconveniences and hours-long wait times associated with attending hospital clinics; whereas Sarika and Roshan could avoid such negative experiences through the insider support of the cousin, which greatly facilitated the process for them.

> There was no problem at all. [Because my cousin Rani] is there. No need to go early and wait in the queue [to get an appointment number]. We leave here around seven or eight [in the morning]. As soon as we get there, [Rani] will take us to see the doctor and get our work done. That makes things very easy for us.

This experience of satisfactory treatment seeking, unfortunately, proves to be the exception when considering the plight of a majority of persons who have neither any insider support in the public hospital system nor the financial stability to afford private sector health services.

Roshan: I hear that now[93] they give dates [for surgery] in 2025.

Researcher: Really? How many people must there be in the list [awaiting surgery]!

Roshan : It's hopeless. Patients are dying [while awaiting surgery] …

Sarika: When I was in the hospital, there was one person. Same condition [as me]. But hers was visible, the neck [swollen]. Even her lungs were affected by then… probably someone who was in the list [awaiting surgery].

Roshan: Well, yes, there are [many] poor people. We got [the surgery] done in one month, because that Rani was there [in the hospital staff]. Otherwise, it'd have been 2023 for us, too.

To summarise, in this section I have presented the findings on how treatment seeking experiences were often organised when the research participants engaged with the public sector healthcare services, particularly the public hospital(s). It was highlighted that the availability of fully subsidised healthcare attracted (some of) the participants; yet there were, conversely, many factors that undermined the effectiveness of the services, so that treatment seekers were often dissatisfied. I also pointed out certain ways in which the people may circumvent the system drawing on their own networks and resources, in an effort to seek a more satisfactory treatment seeking experience for themselves. In the following section, I turn to the treatment seeking experiences in the private sector.

Treatment seeking from private practitioners

Where most participating households avoided public healthcare services, they sought private medical practitioners to fulfil their primary healthcare needs. In fact, private practitioners were the preferred primary healthcare provider for 19 (out of the 20) households interviewed[94]. They included biomedical practitioners, traditional medical practitioners, as well as those who straddled different medical traditions and therefore had a more eclectic practice.

[93] This interview was carried out in March 2019

[94] The Menik household was the one exception: and the details of this 'deviant case' was discussed in the previous section.

These private practices being vastly different in terms of their scope and operations, I first present ethnographic sketches of the two most popularly sought out ones as identified through household interviews, i.e. those of Kodagoda mahaththaya and Lunuwila nona. These accounts are pieced together from household interviews and supplemented by my own observations during fieldwork. Following these, I explore several trends of treatment seeking practices as pertains to the private sector.

Kodagoda mahaththaya's private practice

Almost every participant household reported at least one incident of treatment seeking from the biomedical practitioner known as Kodagoda mahaththaya, while many stated that he was their preferred source for primary healthcare. As some participants reminisced, he has had his private practice in Neluwa town for over two decades. Not being employed in the public sector (allegedly retired from government service, according to some), Kodagoda mahaththaya was available every day at his clinic from 8.30 am till late night.

> [His private practice] occupies a shop space on the ground floor of the two-storied public market building, which is located next to the main bus station in the heart of Neluwa town. When you enter the market building from the side entrance (little more than an alley) and walk along the narrow unlit corridor, the doctor's clinic is the first thing you see. While the clinic itself is on your right, the waiting area spills from the clinic's entrance (with a wooden bench along the wall), into the corridor (which leads to the shops further on) and a five-seater bench on your left. Old peeling posters (in Sinhala) advertise two kinds of birth control pills, a cosmetic face mask, and the annual regional Buddhist religious procession. Pigeons roost in the exposed roof beams above. It is dark, dingy and quite claustrophobic. However, the space is hardly ever empty: the waiting benches occupied mostly by women with children and the elderly, and the doorway and the corridor blocked by people milling about, either waiting to see the doctor or to pay and receive the medications post-consultation. (Fieldnotes, 16.02.2019)

It was clear, both through participant interviews and from my observations, that Kodagoda mahaththaya's private practice consistently drew a large crowd of patients. The cornerstone of his success appears to be the attractive combination of low fees and treatment that is perceived as highly efficacious. In fact, his are the lowest fees currently charged by a private practitioner in Neluwa, being 180 Rupees per consultation, which also covers the cost of the prescribed medications that he dispenses himself.

Kodagoda mahaththaya has also garnered a reputation for providing a fast cure for any illness. He is known to prescribe *sara* (harsh, strong) medicine of which just one or two doses will provide relief, but which, on account of being *sara*, is considered not suitable for children and for those with a weaker constitution. Research participants often talked of the potency of Kodagoda mahaththaya's treatment, emphasising its potential to work well on some people but to make others suffer and its instantaneity of effect in either case. Accordingly, people referred to him as "One shot", evoking the action hero of a popular Sinhala movie who overpowered any opponent instantly. As explained humorously by Gunapala mama:

> [All it takes is] just one dose [of his medicine]. If it works, well and good. Otherwise, you'll end up [as a cadaver] at Manju (the funeral florist)'s place!

Sunimal mama, like many other participants of the study, has every confidence in Kodagoda mahaththaya as a practitioner and the medicine that he prescribes:

> His medicine is *sarayi*. That's why, even for this [recurrent skin condition on the legs], I feel an instant relief the moment I take the pills. [I feel it] as soon as the pill passes through here (points to his throat). … Even if I go abroad, I'll have to come back here to get treatment for my legs!

Through the years, Kodagoda mahaththaya has developed his own characteristic practices of consultation and dispensation of medicine, as described by several of the interview participants. Since he works alone without an assistant, his methodical process is aimed at managing the work by himself. Accordingly, having examined three patients in a row, Kodagoda mahaththaya would move to the dispensary section of the clinic to fill those three prescriptions, call the three patients (now in the waiting area) to the payment counter where he would take their fees (180 Rupees by default) and hand over the medications; after which he would move back to the consultation room to examine the next three patients. Another of his customary practices, as explained by Sunimal mama, was as follows:

> [Kodagoda mahaththaya] gives the first dose [of the medicine] to be taken then and there. If we'd rather not, then we can say, "No doctor, I'd go home and take it". That's happened to me many times. He asks whether I'd take [the first dose] there and I say no, I'd rather take it at home. I always say no, because I'd hate to drink from that glass of water. There may be a thousand patients there a day, but only one glass of water!

Further details of this private practice came to light through household interviews. For instance, the practitioner was known to issue prescriptions—and dispense medicine—by proxy. As reported by Timira, his mother used to go to Kodagoda mahaththaya to get medicine for her asthmatic husband and produce

the empty medicine envelope[95] from the previous visit, based on which a refill would be issued. For acute but minor illness events, informing him of the symptoms and the age of the patient would suffice. In addition, as Kasun explained, Kodagoda mahaththaya had performed a range of services including minor surgeries, treating wounds and even tooth extractions, though these were discontinued by the time I did my fieldwork.

Lunuwila nona's private practice

This (gendered) sobriquet derives from this practitioner being based in Lunuwila, a town nearly 8 km from Pitawella, and her being one of the few women working as therapeutic practitioners (*nona*) in the area. Popularly sought by participants in Pitawella, Lunuwila nona has lived in the locality for decades, where the murder of her husband several years ago has become a part of local oral history. In addition, her private practice is unique due to its eclectic nature: while she is said to have trained as an Ayurvedic practitioner, she offers treatment in English medicine and/or Sinhala herbal medicine.

> The private practice is located in a retail shop-like space on the ground floor of her house, at the Lunuwila junction on Neluwa – Lunuwila main road. Since the two single plastic chairs serving as the waiting area are already occupied, I wait on the roadside with my host couple (who were there for a consultation). The entire clinic and dispensary, including the consultation space, is open and clearly visible from the road. On *nona*'s table, there are a stethoscope, (the box of) a blood pressure monitor, and several volumes on Ayurvedic medicine. Large digitally-printed stickers with "May the *Getabaru* god[96] bless you!" (in Sinhala) are pasted on the walls. Several glass-panelled wooden cupboards display a range of commercially manufactured Ayurvedic products, in labelled dark glass bottles or colourful packaging, available for purchase. Calling my hosts in, Lunuwila nona addresses them as *ayya* (older brother) and *akka* (older sister) and engages in small talk: about the ongoing drought, the tea plants dying, about my hosts' three (grown-up) children and their families. "Who is the patient today?" she asks. "We'll take a prescription for him, but both of us will use the same medications", laughs my hostess. The practitioner laughs with her. (Fieldnotes, 19.01.2019)

Having accompanied my hosts on a visit to Lunuwila nona, I was particularly struck by the latter's easy conversation style and familiarity with her patients' family background and personal concerns, which

[95] As will be described later in this chapter and again in chapter 7, the healthcare providers accessed by the study participants most often dispensed pharmaceuticals in paper envelopes.
[96] A regionally significant god, said to wield power over Southern Sri Lanka

enabled her to maintain excellent rapport with them. My observations were confirmed during household interviews, where people appreciated the personal touch that she brought into the consultation. For example, Sujatha akka, a participant who frequented Lunuwila nona's private practice, was eloquent in her praise:

> Even if you go there at night and call her, she'll open the door and give you medicine. Regardless of what time it is. You don't get that [kind of treatment] everywhere. … She talks well and knows everyone. We know that we can trust her. Whether you have money with you or not, she'll give you medicine. That's the most important thing. A poor man may not always have money at the ready. When someone tells her, "*Nona*, I don't have money today. Please give me medicine, I'll pay you later", she'll give him medicine.

For those who prefer traditional herbal medicine like Matara nanda, Lunuwila nona's private practice is one of the few alternatives available within a reasonable distance from the village. As mentioned by some participants, Lunuwila nona might also offer a choice of either biomedical or traditional medical treatment, depending on the patient's preference or needs. Quoted below is Matara nanda:

> She'll [examine you and give what medicine is the best]. Or if we want to get better quickly, [she'll] give English medicine. Or if we say, "*Nona*, give us Sinhala medicine", then she'll even prescribe *kasaya* (herbal potions).

Whereas Matara nanda prefers traditional medicine and has received treatment accordingly, Sujatha akka receives biomedical treatment. According to the latter, it is not even necessary to inform Lunuwila nona of what kind of medicine she would like, since the practitioner is well aware of her living circumstances and, therefore, which medicine would be suitable:

> She will give us pills anyway. She knows we do tea plucking in the fields. When you take Sinhala medicine, you shouldn't touch water, drink cool water or bathe. … That's not very practical for us [because of the rough life we have].

Another interesting practice of Lunuwila nona involves that of giving medication-related instructions in the local idiom, which I observed during the consultation mentioned earlier. Dispensing three medications (pharmaceuticals), she put them all in the same paper envelope. She had scribbled on it the following instructions in Sinhala: "2 white tablets 4 times a day. 1 capsule 3 times a day. Yellow tablet once a day" (Fieldnotes, 19.01.2019). These instructions are in the common parlance of the people who, being unfamiliar with the foreign-sounding names of pharmaceuticals, identify them by shape, size and/or colour (as described in chapter 5). Putting multiple pharmaceuticals into the same envelope could be economical on her part and more convenient for her patients to manage than multiple envelopes

each containing one kind[97]. Using the local idiom for medication-related instructions, on the one hand, could potentially be an effective way of ensuring the patients would use them as instructed with less chance of confusion. On the other hand, it confirms Lunuwila nona's own positioning within the local community rather than distance her from them, contributing to her strong appeal as a practitioner that her patients could easily relate to.

Following these accounts of popular private medical practices, I would like to point to some salient features of private practices as expressed during household interviews.

Features of treatment seeking from private practitioners

Convenience, flexibility, cost-effectiveness

Most interview participants affirmed that private practitioners, though charging a fee, provided a convenient treatment seeking experience. Generally, they offered time flexibility with early opening and extended work hours. This allowed people to fit their treatment seeking activities around their daily work routines and, in case of children, their schooling. Many participating households reported their preference to seek treatment in the evening, having completed the day's work; and this meant that public healthcare services were not accessible for them anyway. In addition, there was often fewer patients at a given time at a private practitioner's, ensuring the wait time to be less than in a public hospital out-patient department. Such attributes of private therapeutic practices were often mentioned, and highly appreciated, by the householders.

Further, most private practitioners in the area offered a one-stop solution for treatment seeking. They dispensed the prescribed medications post-consultation, saving people the need to go to a pharmacy to fill the prescription. For this, their clinics were equipped with a dispensary section manned by the practitioners themselves. As a special case, Kodagoda mahaththaya had reportedly even performed dental services earlier. While dental treatment being offered by a general practitioner is a clear violation of the state regulations on private practices[98], it had been welcomed by the people: there being no private dental practice in Neluwa town, all patients must otherwise attend the dental clinic at the public hospital.

[97] However, dispensing multiple medications in the same container goes against the WHO guidelines for good pharmacy practices (Athuraliya et al, 2016).

[98] Guideline 6 of the Private Health Services Regulatory Council states that a SLMC (Sri Lanka Medical Council) registered dental surgeon is a basic minimum manpower requirement for the provision of dental services http://www.phsrc.lk/content/files/guidelines/Guidelines_on_Grading_Dental_Practices.pdf

Lunuwila nona, though a traditional medical practitioner, also offered the flexibility of multi-modal treatment to her 'patients'. Trained in Ayurvedic medicine, her diagnosis would be framed accordingly; but if the treatment seeker preferred biomedical pharmaceuticals, she would prescribe them those instead of traditional medicines. In such a scenario, her diagnosis and prescription would attempt to bridge the incommensurability of contrasting medical traditions. Despite the popularity of biomedical pharmaceuticals in Pitawella, they continue to be perceived as unfamiliar and risky objects in households (as discussed in chapter 5; see also chapter 7). In this context, Lunuwila nona's intervention gains further importance; for she becomes an intermediary who imports the unfamiliar biomedical pharmaceuticals into the familiar territory of an Ayurvedic framework, rendering them intelligible for her patients within an Ayurvedic diagnosis.

While the convenience of treatment seeking may attract many of the research participants towards private sector providers, financial concerns associated with it would continue to feature significantly in their preference of providers. This may explain the overwhelming popularity of the private practice of Kodagoda mahaththaya, who specialises in providing maximum value for the money spent by the patients. Firstly, he charges the lowest fee by a biomedical practitioner in the area, i.e. 180 Rupees, to cover both the consultation and medications. This is a fixed fee and known to everyone in the community. Secondly, he is known for dispensing *sara* (harsh, strong) and efficacious treatment. Many interlocuters of the study guaranteed that only one or two doses of "his medicine" can cure any illness without any need for follow-up consultations. Accordingly, Kodagoda mahaththaya's private practice is largely favoured by people who seek a quick and less expensive cure.

Maintaining good relationships

In addition, several participants spoke of their cordial relationship with their preferred private practitioner. Roshan's household should be especially noted, since they considered it worthwhile to choose a practitioner who communicated well with them even where a more economical alternative was available. When asked whether they would seek treatment from Kodagoda mahaththaya (whose fees were the lowest), Roshan laughed: "Oh no, no! we don't go to him!". As he put it, their preferred biomedical practitioner, N—mahaththaya, was "a bit better than others [in Neluwa], [because] you can talk with him".

Among the practitioners widely accessed by Pitawella community, Lunuwila nona was one who seemed to cater well to the communication needs of people. As a resident in the locality, she drew on her embeddedness in the social network to build excellent rapport with people. Her consultations exuded the comfortable familiarity of a social visit. The trust she inspired in her patients is at least partially

derived from her being looked upon as being of the community, as reflected in Sujatha akka's words: "She talks well and knows everyone. We know that we can trust her."

On the whole, however, a need for good communication with the practitioner did not emerge as a priority for many participating households when choosing a healthcare provider. Most of them preferred Kodagoda mahaththaya's private practice due to its attractive combination of low fees and efficacious treatment over other available practitioners that invested in providing more personalised care for the patients. Roshan's household (mentioned above) was an exception in that they shunned the cost-effective alternatives in their need of good communication with the practitioner, but it should be noted that their living circumstances were quite different from the rest of the participants in the study[99]. This potentially highlights how, for many people in Pitawella, the relationship aspects of a medical consultation are eclipsed by other concerns associated with treatment seeking, primarily its cost and efficacy.

Following this discussion on treatment seeking in the private sector, the next section explores treatment seeking experiences across the public and private sectors in the healthcare landscape.

Movement between the public and private sectors

The participants of the study frequently navigated the public–private divide of healthcare provision, which appeared to be a common practice in treatment seeking. It should be noted that here I focus on accessing biomedical services, as crossing the public–private divide in relation to non-biomedical services were hardly mentioned by the participating householders. This is not entirely surprising, since, as noted in chapter 1, the healthcare system in Sri Lanka is highly biomedicalised, with traditional/Ayurvedic medicine being only a minor presence. In fact, there is currently no data available on non-biomedical services in the private sector (*Annual Health Statistics 2019 Sri Lanka*, 2021).

The public and private sectors of biomedical healthcare provision could be viewed—at the institutional level—as potential alternatives; however, they appear to converge into one hybrid system at the practitioner level. As mentioned previously, 83% of medical officers and 99% of medical specialists who work in the private sector are also employed in the public healthcare services (*Annual Health Bulletin 2017*, 2017). Among the private practitioners accessed by the participating households in Pitawella, there

[99] Roshan and his wife Sarika, as salaried employees in the private sector, were an exception to the vast majority of participants whose livelihood involved cultivating tea. While they continued living in the community where Roshan had been raised, they had completed secondary education, worked in town, and represented a higher socio-economic status than their neighbours.

were three medical officers of Neluwa hospital. They have their own private practices in Neluwa town itself and work there after the hospital hours. In addition, all the medical specialists 'channelled' by the interlocuters via the private sector were found to be employed in public hospitals and/or university medical faculties[100].

Accordingly, many biomedical practitioners work in the public hospital (or other public healthcare institutions they are affiliated to) during the usual office hours, out of which they are available for (fee levying) consultations at a private practice. As they are active in both public and private sectors, the people who seek treatment from them could access them at either setting. For Manori akka, similar to many others, this means traversing the public–private sector divide on an as-needed basis, depending on the time of day:

> If it's in the morning, we go to the hospital. If it's in the evening, then we'd go to a private practice [of a medical officer who works at the hospital out-patient department].

Private practices continue functioning throughout the weekend, when the public hospital out-patient department is open only half a day. Apart from this, there are other biomedical practitioners not affiliated to the public sector, like Kodagoda mahaththaya who is available full time at his private practice. In this view, (fee-levying) private sector providers appear to complement the (fully subsidised) public sector, ensuring an uninterrupted healthcare provision for the people.

'Channelling' a specialist

Access to biomedical specialists via private sector is known as 'channelling' (as described in chapter 1). This has also led to a close, if informal, integration of the public and private sectors of healthcare. Biomedical specialists or consultants are most often involved in secondary or tertiary level care at public hospitals, where they function as heads of hospital wards for in-patient care. In addition, most of them are available to be consulted at private sector healthcare institutions, where any person can self-refer to a specialist consultation through the advanced booking process of 'channelling'. As Sumith ayya narrates, 'channelling' a cardiologist and attending the public hospital clinic are seamlessly woven into his treatment seeking process.

> When I got very sick [with the heart condition], I was admitted to the [public] hospital and received treatment. They also got me a *potha*[101] to attend the clinic. I was told to do an 'echo

[100] In Sri Lanka, university medical education is provided exclusively by state universities.

[101] *Potha* (meaning 'book') refers to the medical records of the patient, which remains with the patient and must be produced at the clinic.

> test' (echocardiogram) and show the reports [to the doctor at the clinic]. In the meantime, I channelled a doctor, a consultant. Got the 'echo test' done by him at a private hospital, and he wrote down the test report on the *potha* itself. When I went [with the *potha*] to the clinic, the doctors there also looked at the test results. That consultant is the chief [at the hospital clinic].

On his experiencing a "heart attack", Sumith ayya was admitted to the public hospital, and was enrolled as a patient for the monthly clinic conducted by the hospital for long-term management of his heart condition. Getting the echocardiogram done at a public hospital would have been free of charge: but given the limited availability of the facility in the public sector, Sumith ayya opted to get it done for a fee in the private sector. For this purpose, he 'channelled' a cardiologist, who (whether he was intentionally sought or not) was the consultant cardiologist in-charge of the hospital clinic.

This medical specialist, while moving between the public and private sector frameworks, embodies his authority as a consultant in the public hospital. During the private consultation, the echocardiogram results were inscribed by the cardiologist in the *potha* issued by the hospital clinic; the *potha* was later taken to the hospital clinic to be noted by the medical officer subordinates of the 'channelled' cardiologist. As a caveat, it should be mentioned that, unless a patient 'channelled' the consultant himself (as Sumith ayya did), there is only a slim chance of their ever getting examined by the consultant in-charge at a hospital clinic. Accordingly, medical specialists' mobility across the public-private sector divide appears to forge pathways intersecting the two sectors of healthcare, which their patients can avail of for a more convenient, flexible and potentially more satisfactory treatment seeking experience.

Conflicting interests across the public-private divide

At the same time, patients' traversing the public and private sectors on an as-needed basis may not always be encouraged by the healthcare providers of either sector. For example, consider the following incident faced by Menik akka, whose family regularly attends the public hospital out-patient department (OPD) for their primary healthcare needs. Once when her six-year-old son fell ill, they had to seek treatment from a private practitioner as it was a public holiday and the hospital OPD was closed. There are three medical officers serving in the Neluwa hospital OPD, and Menik akka took her son to the private practice of one of them. The following day, feeling her son's condition had not much improved with the treatment received, she took him to the hospital OPD. The medical officer who happened to examine the boy was not the one that they had sought treatment from the previous day, and he exploded: "You've taken treatment [elsewhere], but it hasn't worked, so, did you then remember the

hospital?" She remained quiet throughout the session, submitting herself to the ordeal of being scolded publicly[102], in order to receive treatment for her son.

The medical officer's outburst seems to highlight his displeasure at having to sort out a case potentially mishandled by another practitioner, and more so because it has taken place in the private sector. He clearly disapproved of the patient's choice of a private practitioner as the first port of call and the hospital as a last resort (overlooking the fact that the hospital OPD was closed at the time the child fell sick). In addition to abusing his power as a medical officer by yelling at a patient, his derogatory attitude towards the private sector also exposes him to be hypocritical, given that he himself has a private practice in Neluwa. Explaining the incident, Menik akka attributes it to professional jealousy of medical practitioners: "These doctors work together [in the hospital] but they don't like it when people go to [a colleague's] private practice".

Promotion of private practices

Patty mama: I've been treated mostly from hospital OPDs and so on. There, they will write the prescription before we even say what the symptoms are!

Patty nanda: Yes. Especially at U- hospital OPD. [The doctors] write the prescription before we can say what the problem is. … That's in the OPD. But when you go to their private practice, they will examine you well.

Quoted above are Patty mama and Patty nanda, reflecting on their treatment seeking experiences across the public and private sectors. The gradient of patient-orientedness in public and private sector healthcare as implied here, is supported by research into patient satisfaction in the country. It is reported that, though public sector primary care tends to offer equivalent or slightly superior clinical services, the private sector takes the lead in terms of the perceived quality of care (Rannan-Eliya, Wijemanne, Liyanage, Jayanthan, et al., 2015; Russell, 2005).

Additionally, the interesting observation made by Patty nanda points to a discrepancy of the quality of care provided by the practitioners when accessed in different (public and private) settings. In fact, it was a common grievance across households that medical practitioners generally provide a better-quality service in the private sector than they do at the (public) hospital. As mentioned previously, a large

[102] By "publicly", I allude to the general nature of a medical consultation. In the out-patient department of public hospitals, as I have observed, several medical officers are seated at different tables in one large room, with the door open. There are several consultations going on at a given time in the room. In addition to these doctors and the patients, there would be those who have accompanied the patients, nurses, attendants, as well as other patients who are waiting queued up just outside the room. Therefore, a medical consultation in a public hospital is certainly not a confidential interaction between a practitioner and a patient.

majority of the medical staff engaged in private healthcare provision are salaried full-time employees in the public sector who work in the private sector during their spare time. While the number of patients treated by them does not reflect in the monthly salary that they draw as public sector employees, it would directly impact on the income earned from a private practice: hence the complaint that doctors try to attract patients to their (fee levying) private practices by offering better quality of service there.

In the case of Dolahe-gedara nanda (quoted below), it is the physical difficulties of attending the monthly clinic at the public hospital that are drawn upon by the doctor when building a case for the superiority of care he could offer at his private practice:

> [The doctor] told me, as I couldn't go to the clinic [at the hospital], to come to him to get medicine. … When I go to the market [on Saturday], I go to get medicine too.

An elderly woman following long-term pharmacotherapy for asthma, Dolahe-gedara nanda is registered for the monthly clinic at Neluwa hospital, where she receives treatment (including medications) free of charge. However, she finds it physically difficult to cope with the crowded spaces and the lengthy wait time involved with seeking treatment at the clinic. Further, the frequent medication shortages at the public hospital's pharmacy (discussed earlier in the chapter) would mean that she gets her prescription only partially filled. This calls for an additional trip to a community pharmacy in town, where she needs to spend nearly 1000 Rupees to purchase medications for one week. It is in this context that one of the hospital's medical officers had suggested that she attend his (fee levying) private practice instead of the hospital clinic.

At the time of the research interview, Dolahe-gedara nanda was going to the private practice of the above-mentioned medical practitioner every two weeks. The ethicality of the doctor's suggestion is questionable, particularly in view of its apparent self-interest of promoting his own private practice. For Dolahe-gedara nanda, however, the switch to the private sector was quite satisfactory, given her disillusionment with the public hospital clinic. She finds it simpler and more convenient to seek treatment at the private practice. The practitioner's fee does not bother her either, as hospital clinic attendees are also regularly obliged to incur out-of-pocket expenditure for medications. Compared to the fallacy of free healthcare in the resource-poor context of Neluwa hospital, she is more satisfied with the convenience offered by the fee-levying private practice.

To summarise, it was discussed here that crossing the public–private divide was regularly practised by the participants of the study in order to seek a more convenient, flexible and satisfactory treatment seeking experience. However, caught between their wishes and the medical professionals' personal interests, the eventual trajectory of treatment seeking may become complicated, as I have indicated.

The following section explores treatment seeking at community pharmacies, which is another popular practice in the community.

Treatment seeking at community pharmacies

There are three community pharmacies in Neluwa town that were popular among the research participants in Pitawella, as distinguishable from the dispensaries that exist as part of a private medical practice and the numerous small shops/groceries that sell over-the-counter pharmaceutical products. Given that the Neluwa hospital and most of the private medical practitioners dispense medications for the prescriptions they issue, people do not often need a pharmacy to fill a prescription, unless necessitated by a medication shortage at the hospital dispensary or the private medical practice. Yet, as revealed in household interviews, people do access community pharmacies quite frequently for their treatment seeking needs.

For Mahasen nanda, who sought a cure for her husband's toothache, the process of seeking medicine at the pharmacy was a convenient alternative, a hybrid between a medical consultation and purchasing goods at a retail store counter.

> When you go to the pharmacy and ask whether they had any medicine for [a particular condition], then they'd give you. Most often they don't give medicine just like that from a pharmacy. If it's a serious condition, they don't issue medicine without a doctor's prescription. … They'd ask for the age [of the patient] and give medicine accordingly. There are certain medications that you can buy at a pharmacy. You can get deworming tablets from the pharmacy too, without a prescription. They'd give instructions on how to take them.

Similar to Mahasen nanda, quoted above, many householders considered the pharmacy a first port of call for conditions perceived as relatively minor and easily curable with some pills, such as a toothache or headache. In making the decision to seek a pharmacist in the first instance (as opposed to a medical practitioner), therefore, the self-assessment of the seriousness of the condition becomes crucial. In any case, as Mahasen nanda notes, the scope of the services provided by pharmacy is delimited and guided by biomedical prescription: a pharmacist will not recommend medicine if the patient's condition is 'serious' and warrants medical attention; nor will they dispense certain medications without a medical prescription.

Features of community pharmacy services

It is important to note that community pharmacies (and their staff) are clearly differentiated from other healthcare providers accessed by the Pitawella community. During household interviews, there were frequent mentions of a "pharmacist friend" or "*nangi*[103] at the pharmacy". The kinship and familiarity imbued in such terms stand in clear contrast to the common practice of referring to medical practitioners and (most) hospital staff as "*mahaththaya*" (sir) or "*nona*" (madam/lady), signalling the much closer relations that many people have with community pharmacies than with the other healthcare providers. As those employed at the community pharmacies were mostly residents in the locality, some of the participating households were acquainted with them at a personal level. In any case, it is highly likely that the pharmacy staff would be familiar with, and possibly even share, the living circumstances and approaches to health and illness which shape the treatment seeking practices of Pitawella community.

The affinity with their customers, either at a personal level or on more general terms, may explain the flexibility of services carried out at community pharmacies that were revealed in household interviews. For Nagama akka who did not have enough money to fill her prescription, the pharmacist was willing to dispense the number of pills needed for a single day, since that was all she could afford at the time. When Ishani asked for "*pinas*[104] pills", or Timira wanted to buy "capsules that dry up a wound", their pharmacists knew exactly which medications they needed, being well-versed in the lay and 'indigenised' uses of pharmaceuticals (Haak & Hardon, 1988).

As for Manori akka and Punchi nona, they had undergone comparable (though unrelated) experiences of accessing emergency pain relief medication from a pharmacy when shopping at the Saturday market in Neluwa. On their complaining of a severe headache to the pharmacy staff, they had each been given "one pink coloured tablet" to ingest immediately, which had cured the headache and enabled, each of them, to carry on with their work. This kind of casual, affordable and patient-centred service was hardly mentioned with regard to other healthcare providers. On the other hand, it is also likely that the people rarely expected similar empathetic understanding from medical practitioners as from a friendly pharmacist and did not seek their assistance in such circumstances.

[103] Kinship term meaning younger sister, which is often extended to any girl/woman adjudged to be several years younger than oneself with whom one has a close relationship.

[104] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

Risky pharmacy practices

While the above-mentioned examples of seeking community pharmacy services appear to be largely aligned with the regulatory framework on the dispensation of medications[105], other more controversial instances were also discussed during household interviews. Studies into community pharmacies in Sri Lanka report common practices that undermine good practice guidelines, such as dispensing prescription-only medications without a prescription, refilling expired prescriptions, inadequate labelling and packaging of medications, providing inadequate medication-related instructions, and handling of medications by unqualified staff (Balasooriya & Kommalage, 2019; Manchanayake et al., 2018; Sakeena et al., 2019). Such instances, when narrated by participating householders, were often constructed as conveniences of seeking medicine at the community pharmacy.

As frequently mentioned during household interviews, a common practice of the research participants when buying medications was to produce the empty medication packaging (labelled soft-plastic packet, paper envelope or blister pack) to the pharmacy instead of a prescription. Where there is no prescription, the empty medication packaging from earlier would serve as evidence of previous treatment, thereby substituting for the missing prescription. This allows, however, the possibility of borrowing used-up medication packaging from a friend and producing it to the pharmacy in order to access medications for oneself, as Kasun has done. During his work as a labourer at a construction site, Kasun had developed an itchy rash, which he called a "cement allergy". His colleague had recommended a topical cream that he had been prescribed by a doctor and found effective, also lending the empty tube so that Kasun could successfully access a 'refill' from the pharmacy. I was shown this tube of topical cream during the household interview. Though purchased over the counter, it was an antibacterial classified as prescription-only medicine (Schedule IIB) under the country's regulatory framework for medicine. This incident, therefore, resonates with the findings on potential antibiotic misuse through community pharmacies as reported in the country (Sakeena et al., 2019; Zawahir et al., 2019).

Enabling personalised medication practices

Dispensing medications without a prescription at community pharmacies is said to potentially enable self-medication with pharmaceuticals (Wijesinghe et al., 2012). In the present study, it was observed that most householders were reluctant to access pharmaceuticals that were not prescribed for them, as these were looked upon as toxic and risky substances (chapter 5). In fact, it was only a handful of participants,

[105] As per the "Guideline on good pharmacy practice (GPP), October 15, 2019", published by National Medicine Regulatory Authority of Sri Lanka

including Kasun mentioned above, who reported ever having accessed unprescribed medicine on their own accord. However, there were many instances of people using pharmaceuticals based on a pharmacist's suggestion. Since they trusted the pharmacist as a biomedical expert (similar to a doctor or a nurse), they were not anxious about potential harm of such medicine (as discussed in chapter 5).

In addition, community pharmacies offer people an opportunity of accessing medications on their own terms, which is not permitted in other biomedical settings. Quoted below is Sumith ayya, who avoided the course of medications prescribed as treatment for his second episode of arthritic pain.

> When I got [an arthritic flare up] again, I went back to the doctor, and he wrote a prescription for another course of medications. But those are very *sara* (harsh) medications. I buy medications from that pharmacy in Neluwa. I told [the pharmacist] that I was not in as much pain as earlier, that it's a bit less now as I was taking [medicine], and that I'd fill the prescription if the pain becomes unbearable. So, I didn't buy [the whole lot], but bought only the vitamins [that were prescribed]. … I thought I'd buy those medications if I got the pain again. Usually, pharmacies don't fill an old prescription, like when it's 6-7 months old. But you can talk to a pharmacist known to you, and get it done. That's what I thought I'd do, so I didn't buy them immediately. Medications are toxic to the body, aren't they, medications are toxic. So, I didn't take them, and that worked. I might get the pain again; you can never know. It all goes with one's karma, that's how.

During the arthritic flare-up mentioned here, Sumith ayya did not get the prescription filled except for the "vitamins", which he differentiated from the other prescribed pharmaceuticals ("medications")[106]. His rationale for avoiding (the rest of) the prescription is situated in two locally popular narratives regarding illness and medicine: English medicine as being harmful to the body (discussed in chapter 4), and one's karma from previous births as a determinant of (ill)health in this life (chapter 5). While concerns of toxicity would discourage ingestion of medications, viewing illness as inevitable consequences of previous karma would lead one to consider pharmacotherapy pointless, especially given the potential of future episodes despite following the medications as prescribed.

Such considerations of a (lay) person, regardless of their importance in framing their medication practices and overall approach to health, often remain unvoiced within a medical consultation; whereas they are more likely to be expressed and even accommodated within the greater flexibility offered by a community pharmacy. In Sumith ayya's case, it is the possibility of filling the prescription even months

[106] As a caveat, I would like to point out that, though Sumith ayya differentiates between 'vitamins' and 'medication', this was a rare case. For most participants, all pharmaceuticals were 'medicine'. For example, Manori akka, who bought iron supplement for her children (as described earlier in this chapter), referred to it as medicine.

later that permits him to act on his beliefs and forego the prescribed pharmacotherapy. He chose to live with the arthritic pain until it subsided rather than ingest more of *sara* (harsh) medications that provide him only temporary symptomatic relief; and he ultimately feels that he had chosen well. This way, in the space of their mutual understanding with the community pharmacist, a medication seeker can gain more control over their medication use and access them on their own terms.

Having explored treatment seeking from different healthcare providers available in the healthcare landscape in Pitawella, these findings are brought together in the following discussion, where I situate treatment seeking practices in relation to the everyday lives of the participants.

Discussion

This chapter explored the findings of the present study in relation to people's treatment seeking practices and experiences, where they navigated the diversity of the therapeutic landscape constituting public and private sector healthcare services. In terms of primary healthcare needs, many households preferred to access private practitioners in search of the flexibility and patient-oriented services that were offered; however, this trend was reversed where either long-term care was involved, or the condition was perceived as requiring in-patient or intensive care. In such cases, the public sector services were sought, where fully subsidised healthcare is made available through the country's free health policy. Community pharmacies, too, can be identified as an important service provider in their affinity to the community. They rendered medications, particularly biomedical pharmaceuticals, more accessible to the people and facilitated more personalised use of medications.

Prioritising convenience, flexibility and cost-effectiveness

Despite the universal free healthcare policy in Sri Lanka, an emergent trend is that of an increasing share of out-patient primary care being handled by the fee-levying private sector providers; which, given the lack of health insurance, leads to greater out-of-pocket health expenditure for the people (*Annual Health Bulletin 2017*, 2017; Pallegedara, 2018). This trend has been featured in the present study, through the overwhelming popularity of private practitioners as primary healthcare providers among the participating households. Seeking treatment in the fee-levying private sector appears to be a counter-intuitive practice given the low income and financial precarity of a majority of the research participants; however, the popularity of the private sector needs to be contextualised within the greater affordances of convenience and flexibility that it offers.

For the people in Pitawella, treatment seeking means a suspension of daily life, requiring them to be removed from their work for at least half a day and travelling to the nearest town. With most of them being daily wage earners, it is of essence for them to reduce the time and financial cost involved. While public hospital out-patient department does offer treatment—and medications—free of charge[107], it lacks in terms of convenience, accessibility and quality of care based on participants' experiences. On the contrary, the private practitioners that were popularly sought by people displayed clear understanding of the local needs and had adapted accordingly. Participants appreciated the conveniences that were offered by private practitioners, such as extended open hours, dispensing medications following the consultation (which saved them an extra trip to a pharmacy), and the flexibility of choosing a therapeutic modality that suited them.

Overall, seeking cost-effective treatment appeared to be the principal trend in most households. This can be summed up in the vast popularity of Kodagoda mahaththaya's private practice: his fees (180 Rupees by default) were the lowest charged by a local private practitioner, and he has a reputation for providing a quick cure, hence the sobriquet "one-shot". On a broader level, the differential patterns of treatment seeking that are observable between primary care and in-patient/intensive care also appear to be organised on a rationale of cost-effectiveness. When seeking treatment for a minor illness, people appreciate the conveniences and flexibility offered by private practitioners and are willing to pay a fee for the consultation. However, where the condition is perceived as serious enough to warrant in-patient and/or intensive treatment, the fees to be incurred in the private sector would be substantially high; in which case people would understandably opt for the fully subsidised treatment at the public hospital. The participants of the present study often reported unfavourable experiences of the quality of care provided in the public sector which generally dissuaded them from seeking treatment from public hospitals; yet these concerns were eclipsed by the more pressing matter of affordability of healthcare with regard to in-patient and/or intensive treatment.

Less emphasis on practitioner-patient relationship

A good rapport with a medical practitioner as well as receiving attentive and personalised care are often noted as motivators for seeking private sector healthcare services in Sri Lanka (Abeysinghe, 2008; Russell, 2005). Similar relational benefits of the private sector were mentioned by the participants of the present study. Further, several householders framed their preference of a particular practitioner along relationship factors, particularly good communication. Those who sought the services of Lunuwila nona,

[107] This may not always be the case: due to medication shortages in rural/peripheral hospitals, people may have to buy the prescribed medications from a pharmacy, as discussed previously.

for example, always noted her easy communication style, background knowledge of the community, good rapport with patients and empathetic understanding of their economic hardships.

However, the findings of this study indicate that relationship needs were not prioritised by a majority of households when seeking treatment: most households opted for the most cost-effective alternative over a potentially more relationship-oriented practitioner. Reporting similar findings in a study into two neighbouring communities with contrasting socioeconomic status, Liyanage (2000) observes that a good doctor-patient relationship is more of a concern for upper or middle-class patients than for the impoverished working class, whose priorities are dramatically different.

Sachs's (1989) study into treatment seeking in a rural hospital in Sri Lanka explores the apparently low priority given to relationship needs by the patients. As it is, the wide gap between a biomedical approach and the patient's illness perception renders it virtually impossible to develop mutual understanding within the space of a medical encounter. Nor is there much time for rapport building, given the number of patients who await to see the doctor. The patients' and doctors' attitudes towards their interaction are also incommensurable: patients expect the doctor to 'fix' their health concerns, and the doctor sympathises with the patients viewing them as poor and illness-ridden. However, the medical consultation concludes with the prescription of medications, which serves to fulfil both parties' (unvoiced) expectations. Accordingly, the prescribed medications seem to fill the communication void and become symbolic of the doctor's care for patient wellbeing, thus displacing the relationship needs that the patients may otherwise have expected to get fulfilled (Sachs, 1989).

While Sachs (1989) explores treatment seeking in a public hospital context, the present study takes into account both public and private sector healthcare services, as does Liyanage (2000). Private healthcare services have been on the rise since the introduction of an 'open economy' policy in 1977 so that, despite the lack of official statistics on the private sector (*Annual Health Bulletin 2017*, 2017), one may safely assume that a greater array of healthcare alternatives is available at present than there was in the 1980's. However, the participants in the above studies (Liyanage, 2000; Sachs, 1989) and those from the Pitawella community face more or less similar difficulties as underprivileged rural people living in economic precarity. For them, regardless of the proliferation of treatment alternatives in the country through time, treatment choices are limited by their affordability. Accordingly, many would be content to receive cost-effective treatment that is accessible in a relatively hassle-free manner. Good communication with the healthcare provider may therefore be appreciated as a 'bonus', though not a priority; or as Sachs (1989) reasons, relationship needs may be compensated for by the symbolic value of the prescribed medicine itself.

Dealing with (ill)health within everyday circumstances

As discussed thus far, treatment seeking practices explored in the present study are embedded in the everyday realities of economic precarity and therapeutic diversity experienced by an under-privileged village community. People prioritise on cost-effectiveness when seeking treatment, since they wish to spend as little as possible on treatment so as to lessen its impact on their household budget. They may seek a practitioner who is reputed for providing a quick cure, as regaining good health soon is necessary to continue working, so that the household income is not disrupted. Within the constraints and contingencies that form their everyday life, the study participants try to deal with their household's health concerns as effectively as possible. Such instances of pragmatic organisation, negotiation and trade-off resonate with care practices as involving "a sticky combination of adaptability and perseverance" (Mol, 2008, p. 79). Given their limited means, it is through incessant 'tinkering' with (sick) bodies, medications, technologies and circumstances that they can strive towards a local and contingent 'good', or satisfactory, outcome(s) (Mol et al., 2015).[108]

It was discussed in the chapter that people come across various challenges in the diversified healthcare landscape, to which they respond in various ways. To illustrate, one such demanding setting is the public hospital. It is experienced by participant householders as being resource-poor, rigid and oppressive, in addition to any potential obligations that they may feel in receiving the 'gift' of 'free' healthcare (Seo, 2016). The most common way of dealing with these complications is to avoid them altogether, as many householders do by seeking alternative healthcare providers in the private sector. However, people may sometimes have to access treatment at public hospitals, often as way of fulfilling healthcare needs on a limited budget; in which case they creatively use whatever resources they have. Examples discussed earlier include "pestering" the hospital staff at a clinic and using the staff-privileges of a cousin to get a surgery scheduled at an early date. Alternatively, people might also passively accept unfair or harsh treatment from the staff and submit to the hospital's structural oppression.

Further, the findings point to the significance of informal social relations when navigating the therapeutic landscape. This was manifested, in the present study, in different forms. For example, people may seek a healthcare provider who is 'a local' and maintains a close personal relationship with them; obtain assistance of 'an insider' in the healthcare system, such as a cousin in the hospital staff or a "pharmacist friend"; or rely on a personal acquaintance who would recommend some efficacious medicine through their first-hand experience (also discussed in chapter 8). On such occasions, the informal social network is mobilised to facilitate the treatment seeking process. It is drawn upon, as a resource, to compensate

[108] On the other hand, the nature of treatment seeking as described in this chapter may also point to the limitations of the notion of 'tinkering', as I discuss in chapter 9.

for the inadequacies and challenges of the healthcare system and to enable a more satisfactory outcome—or, a local and contingent “good” (Mol et al., 2015)—for the treatment seeker within the rather constrained everyday circumstances of the Pitawella community.

Following this chapter’s exploration of treatment seeking, the next chapter focuses on therapeutic practices as situated in space(s) and time(s) within the home.

CHAPTER 7: SITUATING THERAPEUTIC PRACTICES IN HOUSEHOLD SPACE(S) AND TIME(S)

Practices involve spatial and temporal organisations of bodies, things and knowledges (Reckwitz, 2002; Schatzki et al., 2001). Therapeutic practices that emerged through the ethnographic interviews for the present study were similarly organised, situated in and/or flowing through time(s) and space(s) within households and in the community. This chapter aims to shed light on the spatio-temporal features and organisations of therapeutic practices in households in Pitawella community.

The first section of the chapter is on the spatiality of therapeutic practices. The storage and emplacement of medications are explored, which reflect their shareability or exclusivity of use, as well as the potential of risk and notions of responsibility. The second section takes up the temporal dimension of therapeutic practices, navigating the currents of care practices over/in/through time within households and the community. Their duration, continuity and disruption are explored, through which therapeutic practices emerge as bridging the time-gaps between the past and the present, as well as of different generations. In the final section, I pick up the recurrent threads of risk and responsibility to be examined further in their relevance for therapeutic practices.

Therapeutic practices and their spatiality

Medications present in the home are often found in strategic locations that reflect their entanglements with the household. Through their New Zealand based study, Hodgetts et al. (2011) suggest the emplacement of medications to be indicative of the design of households as therapeutic spaces that facilitate medication regimes, as well as of the social lives of medications as they become implicated in household relationships. During household interviews for the present study, the participants were asked about the emplacement and storage of medications within their home. They were encouraged—where they were found willing—to bring their medications to show me during our discussion and to photograph where they were usually placed in the home.

All participating households had some medications available to be used in case of minor ailments that might occur during the course of everyday life. Given the physically exhausting work that many of the participants performed in tea plantations under the scorching sun, they regularly experienced headache, body ache and back pain. Frequent incidence of common cold, hay fever, *pinas*[109] and related respiratory

[109] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

symptoms were attributed to the heavy rainfall and relatively colder weather[110] in the region. While such conditions were often managed within the household using medications available at hand, others which may be identified as requiring further treatment—such as fever, severe stomach-ache—were also at least temporarily dealt with within the home.

Accordingly, the households displayed a variety of medications for everyday ailments, including Panadol, pain relieving balm and lotions (such as *Siddhalepa*, Wintageno) and diverse medicinal oils. Many condiments and spices used in everyday cooking (such as coriander, turmeric, cumin seeds) also doubled as medicinal ingredients for traditional home remedies that would be prepared as and when required, as did the roots, leaves or fruit taken from plants and herbs commonly grown in home gardens (such as ginger, aloe vera, *karapincha*, king coconut).

Spatiality of shared medications

Where the emplacement of everyday medications is concerned, the main rationale appeared to be that of easy access and convenience. In different homes, shared medications (such as Panadol, balm and medicinal oils) would occupy differing degrees of prominence as they sit on a table, in table drawers, on cupboard shelves, stuffed into a small compartment of the TV stand or on the decorative cabinet in the hall (see Figure 1 below). While the visibility of medications thus varied from one house to another, they were always found in the common spaces shared by the whole household.[111] Participants constantly mentioned the need for easy access for everyone in the household as the organising principle underlying the emplacement of medications in those particular locations. Quoted below is Mahasen nanda, speaking of medications for everyday use available in their household:

> For us, it's the *Siddhalepa* and Panadol. They're kept in a drawer. Inside a plastic bag in a drawer. Nothing unusual there. If we get medicine, English medicine, that'd be kept in a 'cup'[112].

Here, by "English medicine", she refers to any medications prescribed by a biomedical practitioner. They are not considered as freely shareable within the household (due to having been prescribed for a particular person's illness), hence their being kept spatially separated from the shareables. While English

[110] Pitawella is situated approx. 100 metres above sea level and records around 4000mm of average annual rain fall, whereas the larger part of the Galle district, bordering the Indian ocean, is at an elevation of 0 – 8 metres with annual rainfall of 2500 – 3000mm. These differences are reflected in the relatively low temperature (22-27 degrees Celsius) when compared to the average of Galle district (25 – 30 degrees). (Dept of meteorology, Sri Lanka)

[111] This excludes households with young children, which displayed different patterns of emplacement, as I discuss later on.

[112] This refers to an empty plastic carton

medicine was generally stored this way, the practice is clearly different where Panadol is concerned. This was, in fact, mirrored in nearly all participating households. Though a biomedical pharmaceutical (therefore, technically an English medicine), Panadol was ubiquitous in local households as a popular and trusted cure for all sorts of aches and pains. The resulting familiarity of use and trust in its efficacy, as well as its shareability, has led to Panadol being categorised among the everyday medications, dislodging it from the category of "English medicine". (The case of Panadol as a home remedy was discussed in chapter 5.)

Figure 1

Everyday medications in shared spaces in the home

Storing medications: packaging, containers

In the participating households, medications that are brought home (as opposed to medications prepared at home, such as herbal remedies) nearly always remained inside the original packaging that they were dispensed in from a pharmacy, a private practice of a medical practitioner or the pharmacy of a public hospital. Pharmaceuticals such as those in tablet and capsule form did appear in blister packs in some homes. But most often they were tied up in single-use plastic bags, sealed plastic packaging (which has since then been torn open to take medications out), paper envelopes prepared as medication holders, or even simply folded in a small piece of paper; these being the packaging which the medications had been dispensed in (see Figure 2 below). On the packaging, hand-written in Sinhala by the pharmacist or the dispensing practitioner, were the instructions on prescribed dose and frequency of

medication intake. Syrup and ointments, purchased in the manufacturer's original packaging of bottles and tubes, would remain so. Their dosage instructions were often scribbled on the inside lid of the enclosing cardboard packaging or pasted on the bottle's label itself.

Figure 2

Medication packaging and labelling

Plastic cartons for paint or ice cream, single-use plastic water bottles and glass liquor bottles, empty and well-cleaned, were repurposed as medication containers in most households (see Figure 1 above). Medicinal oils, dispensed by traditional practitioners as well as those prepared at home, were often stored in glass liquor bottles and sometimes in plastic bottles. Where there were several kinds of pharmaceuticals available, the medication-enclosed packages/envelopes, bottles and tubes were found stored inside a larger container: a(nother, larger) single-use plastic bag or a plastic carton with a lid (often called "a cup"). This medication holder is essentially a strategy aimed at organising and compartmentalising: it ensures that the medications themselves, still in their original packaging (which contains the dosage instructions in Sinhala), did not come into touch with the likes of spare coins, old batteries, bits of paper and dust—material odds and ends of everyday life—that inhabited the same space inside a drawer or on a table.

It was interesting to observe that, apart from one or two instances, the labelling and instructions in Sinhala did not indicate the name of biomedical pharmaceuticals enclosed within the packaging nor their expiry date. This corresponds to the wide-spread inadequacies of medication packaging and labelling reported in the country in comparison with the World Health Organisation's guidelines (Athuraliya et al., 2016). Receiving dosage instructions in Sinhala is crucial for medication users in Pitawella, most of whom are not English literate. However, the absence of other important details from Sinhala labelling appears to be a selective omission on the part of the dispensing medical practitioner or pharmacist, even when allowing for their busyness in attending to a large number of patients which prevents them from spending much time on each case.

The incompleteness of Sinhala labelling translates into an incomplete and fragmented knowledge about pharmaceuticals within households. The research participants were generally aware of how the medications were to be taken, though the latter were referred to as "white pills", "small pink tablets" or "*pinas* tablets". The date of expiry, too, was unknown, though people were aware that expired medications could be "toxic"[113]. In their pragmatic approach towards medications, people may not be unduly anxious about not being properly informed on what they consume: for, on the one hand, it is the norm for them to leave medication-related matters to the expertise of biomedical practitioners and pharmacists; on the other hand, following the given instructions on medication intake would generally ensure the desired outcome for them even without additional knowledge. (This was discussed in relation to epistemic authority, in chapter 5.) However, this meant that, within the home, pharmaceuticals remained unnamed and alien substances always associated with potential risk. Storing medications in empty ice cream cartons, in this light, seemed as much a means of enveloping them within the mundane in the household so as to symbolically neutralise their risk, as of keeping them apart from coming into contact with the everyday life surrounding them.

Spatiality of traditional remedies: The kitchen and the home garden

Where traditional home remedies are concerned, the kitchen becomes the point of focus. Many home remedies for minor everyday illnesses such as stomach-ache, indigestion, cold and cough are prepared using regular condiments and/or spices used in daily cuisine, which, therefore, are readily available in any local kitchen. These would be boiled in water over the kitchen's wood fire to prepare infusions which are then administered to the sick. Other remedies take the form of regular curries or side dishes to

[113] All of the participating households responded to the potential risk of consuming expired medications in the same way: by disposing of any left-over medications by throwing them out immediately with the other rubbish into landfill.

accompany the local staple diet of rice; and their preparation is subsumed into the routine of cooking carried out thrice daily. Examples include the *kathurumurunga* leaf curry and *thebu* leaf *sambol*[114], trusted remedies to cure mouth ulcers and to lower blood sugar levels, respectively.

There are also many common home remedies for which the herbal extracts are usually sourced from the plants grown in the backyard. When considering the common layout of houses in the community, the kitchen is often presented either as an annexe to the house or a separate section located to the rear of the living quarters of the house. Accordingly, the kitchen gives direct access to the backyard, making it convenient to pick the required herbs and bring them to the kitchen, where they can be prepared to be administered as home remedies.

Ensuring the availability of medications is a main reason that promotes the wide-spread practice of maintaining a home garden of medicinal herbs. Easy access to a fresh supply of herbs and plant extracts was very useful to the households, given their regular dependence on traditional remedies for everyday ills. A few households, such as Nita akka's and dolahe-gedara, boasted of extensive herbal gardens containing a variety of common as well as rare plants, which they would share with anyone needing them for medicinal purposes (Figure 3). All others had, at the very least, several plants of medicinal value necessary for everyday home remedies, such as ginger, aloe vera and *karapincha*. These would be found either planted on the ground or in flowerpots in the backyard in close proximity to a rear entrance to the house that leads to the kitchen. This can be identified as a strategic emplacement, since the kitchen is where the herbs and plant extracts will be processed and prepared into home remedies.

Figure 3

Home herbal garden of dolahe-gedara

[114] A salad prepared by adding chopped onions, chilli and scraped coconut, and eaten with a meal of rice.

Children, medications and risk

In households with young children, the dominant rationale of organising medications was often one of ensuring children's safety. Adults were concerned about the dangers of children getting hold of medications and ingesting them, which had led to practices of keeping medications out of their reach: on high shelves, in closed boxes and inside lockable cupboards. Consequently, medications in such contexts have become less visible, less easily accessible and removed from shared spaces within the household where they were looked upon as a risk.

Interestingly, the perceived risk of medications in the hands of children may vary between biomedical pharmaceuticals and herbal medicines. During the interview at Manori akka's household, her 6-year-old son kept on asking her to allow him a sip of the store-bought herbal cough syrup that was brought out to show me. As soon as Manori akka gave in, the boy immediately put the bottle to his lips and took a long drink of it, which indicated it to be a familiar practice for him. On discussing medication storage, it was mentioned that shared medications were kept in a cupboard. Having noticed the boy's eagerness for the syrup earlier, I asked whether he would try to reach the medications in the cupboard, to which Manori akka responded with:

> Maybe he does! Other medications, I mean, what we get from the hospital, those are kept on a high shelf where he can't reach them. They are put in a box with a lid. … We don't keep medications like Panadol [lying around] like that. [They say] this won't be harmful even if he drinks it.

Here, it appears that the narratives of naturalness and beneficence generally ascribed to traditional herbal medicine are extended to commercially manufactured herbal medicines as well. Accordingly, the latter is considered (relatively) harmless in comparison with English medicine. The relative degrees of perceived risk involved with them is reflected in the different storage practices in Manori akka's home: while the cough syrup is kept in the cupboard within reach of the boy, the "medications like Panadol" are enclosed within a box and kept apart on a high shelf.

The emplacement of Panadol as revealed in the above quote also underlines an interesting paradox regarding the perception of its associated risk. In chapter 5, I pointed out that Panadol was singled out from among English medicine and identified as more of a home remedy, similar to traditional herbal remedies. This was reiterated earlier in this chapter, where it was indicated that Panadol often appeared among the casual shareable medications in households in the company of bottles of herbal oil and tubs of *Siddhalepa* balm. But in Manori akka's home, Panadol was literally bundled together with other English medicine and kept out of easy reach inside a closed box placed on a high shelf. It is clear that, in this home with a young child, Panadol too is viewed as a potentially dangerous substance.

Medications for long-term use

In the present study, there were 11 participants (from eight households) who self-identified as long-term medication users. The health conditions that had prompted their medication usage include epileptic seizures, arthritis, heart conditions, knee-cap dislocation, diabetes, hypertension, high blood cholesterol, asthma, thyroid diseases and oral cancer. Apart from one participant who used *kadum-bidum*[115] treatment (for knee-cap dislocation) and two who reported experimenting with diverse therapeutic approaches (for arthritis and oral cancer), others were currently following biomedical pharmacotherapy.

Every long-term medication user was acutely aware of their dependence on regular medications, which they understood in varying terms as being pain-free, maintaining a normal life, or simply being alive. Their ill-health could distance them from participating fully in the household, isolating them from others who did not share their plight. As Nagama akka lamented, "the others don't have this kind of chronic conditions, it's only me who is burdened with this." The isolation of the chronically ill within the household was mirrored in the arrangement of their medications: while the shareable medications were all kept together in the common spaces of the home, the medications for long-term use would be segregated and often placed in decidedly personal spaces such as "on the bedroom table", "in the [going-out] bag", "on the bed-side table". Surangi akka, recovering from knee-cap dislocation and learning to move around the house using a walker, has her regular medications secured in a plastic bag and tied onto her walker (see Figure 4).

Figure 4

Surangi akka's medications enclosed in a plastic bag and tied to her walker

[115] Traditional orthopaedic treatment

Single use plastic bags were ubiquitous as medication holders (see Figure 5), providing a less expensive, convenient and space-saving solution for long-term medication users. Medications dispensed by a medical practitioner or a pharmacy would almost always be placed inside these plastic bag/s at the point of purchase. Enclosed in them the medications would reach the home, and possibly remain inside them for the duration of storage within the home. Those who needed to manage several different types of pills would keep them in different plastic bags, all of which would be inside a bigger plastic bag. The transparent yet non-permeable boundaries of the plastic bag serve to keep the enclosed medications visible but unexposed, protecting them from the elements and preventing any risk of mix-up with other pharmaceuticals available in the home. For example, Matara mama and Matara nanda, an elderly couple both of whom use multiple medications for chronic conditions, each had a plastic bag full of their own medications.

Figure 5

Single use plastic bags as medication holders

Place and situated routines

For long-term medication users, a main preoccupation was the need to maintain the prescribed medication regime. To illustrate, anti-epileptic medication has become an essential part of maintaining normalcy in Ruwani's life as a young mother of an infant. In the case of Sarika, having been told of the painful muscle cramping associated with missing a dose of thyroxin therapy, she was determined not to miss her daily dose which is prescribed to be taken on an empty stomach. These women, like other long-

term medication users, have used strategic emplacement of medications to ensure that they do not forget their medications (Hodgetts et al., 2011). Ruwani's pills are placed "in a cup" (plastic carton) on the table in her bedroom. Sarika would set her alarm clock to wake up at a definite time in the morning and place her pills and a glass of water next to it on the bed-side table, so that she can take her daily dose as soon as she gets up from bed.

Developing a medication routine is a key strategy to be reminded of one's medications (Hodgetts et al., 2011). Routines are often strongly rooted in certain spaces. Quoted below is Sumith ayya, who has weaved his cardiac medications into a post-dinner routine so as not to miss his daily dose:

> When I'm at home, I always have dinner and then take the pills. [After dinner,] I bring a glass of water in my hand when I come here [to the living room, where the medications are stored in the cabinet]. Then I'd take the pills and then move on to other work. It's a habit. [But] when I am away on a trip, I'd be with other people. The pills will be in the van, but I might get into a chat after dinner and forget to take them. Then I might go to sleep without taking them. That is when I'm away. But when I'm at home, it's like that.

As a driver, Sumith ayya has to spend an occasional night away from home when providing transport to a group of people going on an overnight trip. While his medication routine works perfectly when he is at home, it is not as effective when he is away; possibly due to it being strongly embedded in his household, in the physical space of the living room and the embodied practice of carrying the glass of water and walking over to the cabinet to get the medications. When removed from the home context, the medications tend to get forgotten despite their being available at hand. Here we may note a significant change to everyday schedule and as well as "a positioning issue" regarding the medications, two issues that Huyard et al. (2019) report as potential causes that disrupt the organised work of long-term medication use.

Mobility of medications

Sumith ayya's medications travel with him "in the van". Similarly, long-term medication users need to plan ahead to maintain their medication intake whenever they travel. Given below is an excerpt from the interview with Matara mama and Matara nanda. An elderly couple, both of them are long-term medication users, for a heart condition, and for hypertension and diabetes, respectively.

> Matara nanda: If we're going away for one day then [we] take enough for… then [we'd] take medications for about two days.
>
> Matara mama: If going somewhere, I don't take this tablet on that day … I've been told to take it once we end the trip.

Matara nanda: [He] shouldn't take [that tablet] before the trip. He should wait until [we] reach the destination and take it there. Time doesn't matter, he should just take it somehow. … We take all the other medications. Not all of it, only as much as will be needed. If [we're] going for one day, then [we] take enough for about two days.

Matara mama: … Even if you ran out of medications, [you] can't just buy it from somewhere.

For them, as for other long-term medication users, mobility of medications is an essential aspect of their own movement. Their preparation for travel would always include ensuring that they carry a slightly surplus supply of their medications in their travel bag. This is in readiness for any unforeseen circumstances, such as a prolonged time away from home or accidentally losing a pill, in their awareness of not being able to purchase their medications over the counter from a pharmacy. Moreover, as detailed during the household interview, travel—for Matara nanda and Matara mama—always meant a social event: either visiting their children's families, going with them on a family trip, or joining a large group of neighbours on a pilgrimage. In this context, their meticulous planning for contingencies and continuing regular medication practices during travel can be viewed as a desire to maintain their health undisrupted so as to emulate the 'normal' of (non-medication dependent) fellow travellers, and thereby to ensure their own anxiety-free enjoyment of the trip as well as of the others'.

Emplacement of medications, risk and responsibility

Proper emplacement and storage of medications is looked upon as responsible behaviour in terms of managing medications in everyday life (Hodgetts et al., 2011). In the discussion into Matara nanda and Matara mama's travel plans, for instance, they consider that carrying surplus medications in the travel bag and planning ahead to ensure the continuity of their medication regimes while travelling to be responsible behaviour on their part as long-term medication users.

Responsibility associated with emplacement of medications can be further explored through the following incident of a child ingesting a biomedical pharmaceutical product in Punchi nona's household. Of her two children, the younger child (5-year-old girl) was described as "having a liking for medicine". She had once climbed onto a chair to reach the medications kept on a table at their home and drunk half of a bottle of syrup before the adults became aware of it. During the interview, Punchi nona was quick to qualify it as a relatively harmless medicine, "just a syrup for phlegm". However, the reaction of her mother (child's grandmother) was more serious:

> [The child's parents] may leave [medicine] lying around, but I'll quickly put them all away in the morning after they leave for work. You can't have medicine lying around. [The child] might swallow them.

It was clear that the elderly woman blamed the child's parents for being careless with medications, which may put the child at risk of ingesting medications; whereas the mother's (Punchi nona) glossing over of the severity of the incident could be her way of coping with the reproach. On the one hand, the misplaced medications had led to a realisation of children's vulnerability to medication-related risks; while on the other hand, they frame the parents as irresponsible and negligent in having exposed the child to such a risk. Consequently, the wayward medications had initiated an important change in the household's care-work and distribution of responsibility: the elderly woman had assumed the responsibility of medication storage, which had earlier been that of Punchi nona's.

An implicit aspect in the above incident is the responsibility of parents towards (the wellbeing of) their children. While Punchi nona and her husband were projected as being negligent parents through their daughter's ingestion of syrup, there were other cases where parents proudly exhibited their children's careful approach to medications. Consider the following example, where Sarika is talking about her 6-year-old daughter:

> The medications are kept in a box inside the cupboard. [Our daughter] can reach it by climbing onto a chair, if she wanted to. But she won't do that. She knows it's medicine. She's been trained to keep things in their proper place, from her childhood. ... She doesn't take things just like that, she always asks first.

Here, the child is presented as being able to reach for the medications but *choosing* not to, which is constructed as appropriate and responsible behaviour (for the child) around medications. Where Punchi nona (and her husband) received blame for putting their daughter at risk of being harmed by medications, Sarika's praise of her own daughter's behaviour underscores a note of personal triumph for herself as a mother who has trained the child to behave in a responsible manner, thus fulfilling her (parental) responsibility.

Differential risk and responsibility

Ishani's son, similar to Sarika's daughter, is said to be responsible around medications:

> When he's told not to touch them, he won't do it at all. He understands. He won't take them for sure. Not even a tablet of Panadol. He's scared. … He's scared, when we say such and such will happen when you ingest [medicine]. Now when he has a cold, he'd say his nose is twitchy, and

> take a bit of this [medicinal] oil and apply it. He does it by himself. Says that eases [the nasal congestion].

In detailing what she praises as responsible medication behaviour in her son, Ishani, quoted above, makes a clear distinction between his access to biomedical pharmaceuticals and traditional medicinal oil. Where biomedical pharmaceuticals are concerned, the child has been instructed (possibly by her) not to reach for them. It is quite likely that the adults have amplified for him the risks associated with their accidental ingestion, creating in the child a fear of handling pharmaceuticals. On the contrary, the boy has free access to the medicinal oil to use it as and when he wants to. Accordingly, the child's fearful avoidance of biomedical pharmaceuticals and his confident use of medicinal oil are both looked upon by his mother as responsible medication behaviour.

It is arguable that the difference between ingestion and external application could have prompted the differential approaches to the two kinds of medicines, though an example from Manori akka's household discussed previously indicated that the perceived risk associated with accidental ingestion of commercially manufactured herbal medicine to be almost negligible. Manori akka, while being careful to keep biomedical pharmaceuticals away from children, would not mind even if her child secretly accessed the herbal syrup and drank from it.

Throughout this discussion of therapeutic practices, I have emphasised their spatiality. Intertwined with their spatial organisation is a significant temporal dimension. This will be taken up in the following section.

Therapeutic practices and their temporality

Therapeutic practices, as identified through the present study, contain a significant temporal dimension. Household interviews in the Pitawella community, though they did not specifically aim at identifying the time factor involved in therapeutic activities, nevertheless pointed towards their temporal organisation. That is, care practices occur at a particular moment(s) in time, embody a certain duration of time, continue over a period of time, and are often (generationally) passed down through time. Accordingly, this section views therapeutic practices through a lens of temporality, exploring their duration, transmission, continuity and disruption within the households and the community.

Long term medication practices as routines

The most obvious time relevance in household therapeutic practices was observed in long-term medication usage. As mentioned in the previous section, there were 11 people from eight households who identified as using medications for an extended period of time. The duration of their medication use ranged from 2–3 months to 15 years at the time of interviewing. For them, regular and timely use of medications means maintenance work on their sick bodies. It requires persistent and ongoing 'tinkering' to keep pain under control, to go on working, to retain normalcy in everyday life, to maintain life (Mol et al., 2015). This was also a life-long commitment, as most of them mentioned having to follow pharmacotherapy for the rest of their lives.

Where regular maintenance work is interrupted, the bodily troubles may resurface and disrupt whatever fragile life-balance that people may have achieved. A good example is the antiepileptic medicine used by Ruwani. She had been taking the medicine exactly as prescribed for over three years when, in May 2019, she had attended a wedding and missed her daily dose. This lapse—a two-hour delay—had triggered an epileptic seizure, the first flare-up since she had started long-term pharmacotherapy. At present, as a mother of an infant, the health stakes were higher than ever for Ruwani. She was determined to adhere to her medicine regime in order to avoid any further disruptive events.

Ensuring that medications do not get lost and forgotten amidst the unfolding events of everyday life is a challenge faced by long-term medication users. Hodgetts et al. (2011) write of routinised medication practices whereby the medications are anchored to daily activities that are performed at a particular time of day. Household interviews for the present study shed light on similar practices of routinisation. In this regard, it might be useful to consider these as spatio-temporal organisations, for medication routines are as much situated in a time-of-day as in a specific space.

To illustrate, I return to two examples of long-term medication practices discussed in the previous section. Sarika's thyroxin pills were prescribed to be taken in the morning as soon as she woke up. The medicine lay on her bedside table, together with her alarm clock and a glass of water. Her day would begin with switching off the alarm on the clock and then ingesting the medicine with the water. As for Sumith ayya, his medicine was prescribed to be taken at night.

> You'd go to bed when you feel sleepy. And this is what comes before [going to bed]. I take the pills before bed, so I'd feel like I have missed something. … I always have dinner and then take the pills.

As Sumith ayya explained, his medication intake is firmly anchored to daily activities performed at night at home. Following dinner, he would immediately walk into the living room with a glass of water, take the medicine out of the cabinet, swallow it with the water, and then continue with whatever other work

at hand before going to sleep. In this case, having dinner, drinking water, habitual walking to the living room after dinner, and even going to sleep and the bed itself are woven into his nightly routine together with the medicine. Accordingly, they would facilitate his adherence to the medication regime and serve as reminders in case he forgot a dose.

Giving time for the body to heal

In any event of therapeutics usage, there would generally be an initial self-assessment of a health-related condition and a realisation that some remedial action is needed (Jutel, 2011). This essentially involves exploring the bodily sensations and symptoms, one's "sensible knowledges" (Gherardi, 2019) of one's own health status as felt, perceived and embodied. Accordingly, an appropriate therapeutic practice would be followed, be it a home remedy or seeking treatment from a healthcare provider.

As revealed in household interviews in the Pitawella community, casual everyday illnesses were generally managed without resorting to therapeutics. The common approach was one of 'wait-and-see'. The conditions that were most often reported in participating households included symptoms of upper respiratory tract infections and fever, in addition to minor injuries, stomach-ache, headache, and general body-aches often attributed to their daily labouring in the tea plantations. For all such ailments, provided the condition was not too severe or disruptive to ordinary life, the householders would generally wait to see if it would resolve by itself. Any minor condition, as they reasoned, would resolve when given time.

If the waiting does not seem to work, people then attempt some traditional remedy prepared at home: infusions of ginger and coriander (for cold and flu), *banvelgeta* (for aches and pains) being among the most popular.

> When you get a cold, *samahan* [works well]. You'd try to cure yourself without getting [medical] treatment, right?
>
> I usually take Panadol several times a week. After some hard labour, you get body ache. Then I'd take Panadol and sleep it off. I don't go for [medical] treatment if it's only a cold or flu.

Mahasen nanda and Sunimal mama, quoted above (respectively), mention some of the most commonly accessed remedies for minor illnesses. *Samahan* is a popular alternative to *paspanguva*, the traditional herbal infusion made up of five herbal extracts boiled together. *Samahan,* marketed as a herbal remedy, is claimed to consist of traditional herbal ingredients, and needs to be boiled as a *kasaya* potion before consumption. Panadol, the biomedical pharmaceutical which has effectively become a home remedy (as discussed in chapter 5), is also used frequently and in nearly all participating households.

Most participants would attempt some home remedy as mentioned above, then continue waiting for their body—and time—to resolve the problem without other intervention. People said they would allow a considerable time interval, potentially between three to seven days, to see if there would be a positive change in their health.

Waiting prior to seeking professional healthcare

Both interlocuters quoted above indicate a clear disinclination to seek treatment from a healthcare provider other than as a desperate measure. This was echoed in every household interview. If people become convinced that there was no improvement despite the passing of time, or that the condition is worsening, only then will a healthcare provider be sought for treatment. While such was the normal practice, the time-gap between the onset of symptoms and seeking treatment may however vary depending on context.

Below is an excerpt from a household interview where Ishani, a 25-year-old woman with a school-aged child, explains the therapeutic practices in their home.

> Ishani: If it's for the child, we'd only wait for one day. [But] for us, we'd wait and wait, then will go [to get medicine] only as a last resort. I usually never go to get medicine. It's very rarely that [I go]. [I] don't get ill. I'd just boil some coriander, or something. I hardly ever take medications.
>
> Child: *Amma* (mother) is very stingy about getting medicine!

Ishani's comment about herself being invulnerable to illness, while not meant to be ironic, illuminates what it means to be ill and in need of treatment from her perspective. She is the primary caregiver of a child as well as of her own mother who has advanced cancer, in addition to carrying out the household chores and working in their neighbours' tea plantations with her husband on a daily basis. Given the substantial responsibilities that she needs to enact to ensure the wellbeing of her family, and the amount of effort and commitment that is required of her every day, she cannot afford to find herself weakened by illness: it simply does not fit into the picture. The child, on the other hand, bluntly attributed her rejection of medicine to financial concerns. His calling her "stingy" drew self-conscious laughter from Ishani (Fieldnotes, 19.02.2019). Through my observations of their home and information confided in me by their neighbours, it was obvious that Ishani's household was, in fact, one of the poorest in the village.

Literature asserts how (ill)health perceptions are tempered by other knowledges such as one's financial concerns, availability and affordability of treatment and logistics of seeking treatment. As Liyanage (2000) highlights through comparable case studies from two communities in Sri Lanka, persons from

different social classes with different resources at their disposal may take drastically different courses of action when undergoing similar health-related conditions. In Ishani's case, her disinclination towards seeking medical treatment for herself (unless as a last resort) appears to be complicated by multiple concerns that are firmly embedded in the context of everyday life in her household.

Children's illnesses

Ishani's words quoted above also highlighted how her household prioritised any illness concern of their child over those of the adults. This was a common trend among the participating households. People reported responding very quickly to children's ill-health, in which case the practice was to seek professional healthcare (almost always biomedical) within one to two days of identifying any illness symptoms. This corroborates previous findings from Sri Lanka on the treatment seeking practices of mother-carers in relation to children's illnesses (de Silva et al., 2001). Consider the following example from Punchi nona's household:

> If [the girl] gets a cold and cough, then she'll most often get wheezing. We had her nebulised too when she was quite small, when she was about 10–11 months old. As soon as she gets a cold or cough, we'd go to get medicine. We don't wait until it gets worse. … If we delay even a bit, it can get very severe.

A common rationale underlying the prompt treatment seeking for children is that of their greater vulnerability: being physically (and possibly mentally) less strong than adults, they are understood as being more prone to contract illness as well as to undergo greater suffering from illness. In the case of Punchi nona's five-year-old daughter (mentioned in the interview excerpt above), she has been identified to have a greater susceptibility to develop severe respiratory infection. Given the loving care and attention bestowed on children within households and in the community as a whole, it is understandable that pain and suffering of a child would be vicariously experienced by the adults as well.

Children's prolonged illness would demand much time and care effort from the adults, leading to their missing out on work, thus affecting the household's income. In comparison, the cost of treatment incurred by seeking out a healthcare provider in the first instance may seem a better alternative. On the other hand, seeking treatment for a dependent child being a responsibility of the carer, the child's (prolonged) ill-health could be perceived by others as a sign of negligence on the part of the carer (Whyte et al., 2002); in which case, prompt treatment seeking would become a social imperative.

Potential severity

Awareness of the potential severity of an illness is also crucial in speeding up treatment seeking from a healthcare provider. This knowledge could be sensed/perceived as well as culturally acquired and tacit in

the practice. As de Silva et al. (2001) observe in their study encompassing 60 villages in Sri Lanka, mother-carers identified children's symptoms of acute respiratory infections or diarrhoea as requiring professional treatment, while those of malnutrition, even when severe, went unnoticed. In the present study, too, symptoms of respiratory infections—particularly *sema* (phlegm)—were a major preoccupation of households with children. They explained *sema* build-up as an inevitable health hazard due to exposure to the cool climate and frequent rainfall in the region, as per the traditional medicine-inspired narrative widely accepted in the country (Nichter, 1987). Awareness of worsening *sema* as causing breathing difficulties often prompted adults to take their sick child to a healthcare provider without delay, as in the case of Punchi nona's household discussed earlier.

From a traditional medical framework, as attested by many householders as well as by the popular traditional healer Kalu mahaththaya, *sema* in children is considered curable before developing into a chronic condition in adulthood; which would further encourage parents and carers to seek (biomedical or traditional) treatment for the children.

Therapeutic practices across time: Linking the past and the present

Household interviews, especially those where elderly householders took part, often involved reminiscences of how care practices were organised in the past. This 'past' dated as far back as nearly 70 years ago: for while many aged participants spoke of their own practices in their youth, some even recollected childhood memories and how their parents had taken care of health-related matters in the household.

Matara nanda: [*Beraliya* trees] grow in deep forests. They bear fruit only once in seven years. [The fruit] looks like the winged seed-pods of *hora*[116], but smaller; the whole thing is the size of a finger. When those fruits fall down, people go into forests to pick them. My father too used to go with others. [After *Beraliya* fruits were gathered,] their wings were removed and the fruits were boiled. Once the fruits are boiled and dried, they can be kept as long as you want.

Matara mama: It's now that all these medications are there. Those days it was only those things.

Matara nanda: Yes, *Beraliya* is very valuable. The trees bear fruit only once in seven years. The fruits get blown far in the wind, spiralling. People go and collect them.

[116] a large tree endemic to Sri Lanka.

Matara mama: During that time, people get together and make an expedition

Researcher: To collect them?

Matara nanda: Yes. Many people.

Matara mama: Now there's not many forests…

Researcher: [There's] fewer forests, so now there's not that many *Beraliya* trees either?

Matara mama: Yes.

Above is an interview excerpt where an elderly couple explain to me about *Beraliya*, a potent herbal medicine for stomach ache. Matara nanda and Matara mama (aged 68 and 80 respectively) explain how *Beraliya* was sourced and used for therapeutic purposes. Their memories bring to light a pre-biomedical past, where herbal medicine and its associated processes had occupied a significant place in everyday life. People used to set out on group excursions to seek rare herbal resources. Once sourced, it also took considerable effort to transform the raw herbal resources into herbal ingredients usable for therapeutic purposes. In the case of *Beraliya*, this involved removing the wings off each seed pod, boiling their core in water, followed by drying in the sun. Such effort, often undertaken as a communal activity, may have potentially contributed towards strengthening social relationships within the community.

Such nostalgic reminiscences throw into sharp relief the contemporary therapeutic practices in the same community, where herbal medicine has been eclipsed by biomedicine. The time-consuming process of preparing herbal medicine, particularly that of sourcing herbal ingredients, was mentioned by many research participants as a reason for avoiding herbal medicine. This supports previous findings reported elsewhere in the country (Liyanage, 2000; Weerasinghe & Fernando, 2011).

Estrangement from nature

In the previous interview excerpt, Matara mama comments on deforestation as having potentially endangered *Beraliya* trees, shedding light on the ravage of the local landscape that has occurred over time. Clearing up forest land for agricultural purposes, most often for tea plantations, is a common practice in the region that has significantly thinned the forest cover (Lindström et al., 2012). Similarly, householders reminiscing about therapeutic practices in the past often invoked the formerly pristine—even therapeutic—quality of the environment as compared to its pollution and degradation in contemporary times. Here, Gunapala mama explains how the muddy soil in the paddy fields has deteriorated over time:

Nowadays, people [spray] chemicals to paddy fields. Now you can't step into a paddy field. Those days, just by working in the paddy field [with your feet in the mud], any wound on your feet

> would get cured. The mud in the paddy field could cure any wound. Now [the mud] contains germs. Insecticide and herbicide. [The mud has become] toxic. Now if you step into a paddy field with a wound on your foot, [it will get worse and] your foot may have to be amputated!

Agriculture, particularly rice cultivation done in paddy fields, has always held economic and cultural significance in Sri Lanka, as rice is the staple food of the population. The contemporary popular farming practice of spraying chemicals into paddy fields is an attempt to increase the crop yield. This however may have negative repercussions. Gunapala mama is elaborating on its environmental impact in terms of affecting the soil: the mud that used to have a medicinal quality has by now turned toxic. Such mutations of the environment and natural resources over time were mentioned by many participants. They lamented the resultant loss of therapeutic quality in natural elements (such as that of muddy soil to cure wounds) which has rendered obsolete the healing practices associated with them. In this regard, human culpability in terms of degrading the natural environment was often stressed.

Critique of modern society

Some participants went further to point out how life itself—including that of human beings—could be endangered through human actions that violated nature. A particularly dystopian view was that expressed by Kalu mahaththaya, where he associated environmental degradation with a rhetoric of unchecked development:

> The country is gradually developing, [but it also] means [its] deterioration. Innovations mean that [new] things instantaneously pop up, they keep on popping up and up and up, [until] they all get destroyed. That's what happens. That causes the downfall of the people. And of the society. That is what happens gradually.

In comments such as the above, there is a general critique of contemporary society and way of life. For Kalu mahaththaya and like-minded interlocuters, the present is marked by an unhealthy obsession with progress and speed, where people seek instantaneous solutions regardless of their long-term consequences. Such critiques were underpinned by a yearning for a nostalgic past, where they remember life as slow paced and people living in affinity with nature. During interviews, biomedicine and traditional herbal medicine often came to symbolise their conceptions of the present and the past: one involving harsh effects and instant action towards a temporary solution, and the other, soothing on the body, nature-friendly, and slower but more durable a cure. (These popular conceptualisations of the different therapeutic modalities were discussed in chapter 4.)

Therapeutic practices linking generations: transmission, continuity and disruption

A number of households participating in the study were composed of three generations of family members, where aged parents were living with their married children, or vice versa. Where this was not the case, the extended family often lived next door or at least in the same neighbourhood. Accordingly, a significant portion of the household work as well as care work (i.e. caring for the children, the aged and the sick) were shared within an extended family.

Older people taking part in the household interviews often talked of transmitting their knowledges of therapeutic and care practices to their youngsters. One such couple was the Jayas. Quoted below is Jaya nanda reminiscing on a traditional remedy that had been passed down through several generations of her family:

> *Waladasal* seeds are fried in a pan and crushed to powder, then mixed with honey, and made into small balls. These you can store in a closed jar. … After bathing the baby, you take out one of those balls with the handle of a spoon and feed it to the baby. It's delicious, made with honey. … My mother used to make it for us [when we were children]. When we were older, mother still made it for our younger siblings, and we used to steal [some out of the jar] and eat. It's delicious, you know! When my eldest son was an infant, my mother always made some for him and sent it over in a jar. She was living just next door to us, you know.

As reflected in this practice of preparing and administering a preventative remedy for infants, Jaya nanda's traditional medical knowing is intertwined with fond memories of a nostalgic past. She was eager to pass on her knowledge to her own three children and grandchildren, as was her husband, Jaya mama. In fact, the elderly couple were delighted that their grandson (their son's son) was being given traditional remedies for *sema* (phlegm), and they took an active part in this process. In Jaya mama's words:

> I boiled [the five parts[117] of *adathoda* plant in water] and poured [the infusion] into a glass. Not more than half a glass. I said, "*Putha*[118], hurry up and drink this like I do, and I'll give you some sugar". Then I told him to open his mouth. As soon as he did, I poured the [infusion] into his mouth, and it was swallowed. He got well with that.

Their joy at being able to mobilise their traditional therapeutic knowledge on behalf of the younger generations is matched by the disappointment they feel where it is thwarted. Jaya family's daughter was a biomedically trained nurse working in a public hospital. In addition, she lived with her in-laws, who

[117] Five parts of a plant refers to leaves, roots, stem, flowers and fruit. These are boiled together to prepare an infusion.
[118] Son; though here the addressee is the grandson.

preferred biomedical treatment over traditional remedies. Talking of her, Jaya nanda says, with obvious regret,

> We tell [our children] how we used to do things, but they won't accept those, *putha*[119]. I'm talking about our daughter. She doesn't accept those, does she, *mahaththayo*[120]? [She says] OK, OK, but… Then, there's her mother-in-law. Well, we can't see [from here what they do], she will take [our daughter] to a doctor. … Well, we have done things according to the tradition, for our children. We don't know whether they will [carry it forward].

Jaya nanda could see through her daughter's vague responses of "OK, OK" to understand her disinclination towards following any suggestions on traditional therapeutic practices. This she attributed, at least partially, to the daughter's biomedical training. Beyond that, Jaya nanda felt the significant influence wielded by the mother-in-law, who was a part of the extended family at her daughter's home. Though saddened by the outcome, it seems that Jaya nanda had accepted the fact that her daughter may not follow the therapeutic traditions that they themselves value highly.

Through an extended analysis of the above quote, we could reconstruct the situation through its implications for intergenerational family relationships. With the mother (Jaya nanda) and the mother-in-law openly partial to Sinhala medicine and English medicine respectively, the two therapeutic modalities and their inherent tensions are transposed onto a power play in family relations where Jaya nanda's daughter (and her marriage) is concerned. The mother-in-law, who lived with the young family, had greater influence on them than the mother: whereas the mother can only advocate traditional remedies over the phone, the mother-in-law would "take [our daughter] to a doctor". Taking up any therapeutic practice, therefore, becomes a political act on the part of the daughter, as it could be interpreted as taking sides.

In this light, regardless of her own therapeutic preferences, the daughter seems to have adopted a rather neutral stance. As Jaya nanda explained, the young woman did not openly dispute her parents' therapeutic practices and vaguely agreed to whatever they would recommend ("OK, OK"). Even where she resorted to biomedical treatment, Jaya nanda had the impression that it was not entirely the daughter's doing: that it was at least partially due to the mother-in-law, whose wishes the young woman was obliged to respect. Consequently, Jaya nanda had more or less resigned herself to a less influential position in terms of the relationship, merely suggesting possible traditional remedies to her daughter. This tentative settlement of differences, as I surmise, could likely be the result of tactful relationship

[119] Term of endearment, addressing me.
[120] Addressing her husband.

management on the part of the daughter, to ensure that her own therapeutic preferences do not create a rift in her relationship with her parents or her in-laws.

Other household interviews suggested how unreconciled differences in terms of therapeutic and care practices may affect intergenerational relationships, particularly where the state-sponsored biomedical framework delegitimises traditional therapeutic practices. Consider the following excerpt from the household interview with Matara mama and Matara nanda. When their son and his wife, who lived in Colombo, had had their first child several years ago, they—the grandparents—had lived with the new family for a year, helping to take care of the baby.

> Matara nanda: [*Kalka* is] given to prevent any *aguna*[121]. It's given to prevent any *aguna* that may happen from anything else that we give the baby. … Nowadays [they] don't give any of those things. It's not allowed. Now they don't allow a bit of water to be given to a baby!
>
> Researcher: Yes. Why do you think that is?
>
> Matara nanda: *Aney* (Alas!) I don't know. I can't imagine why. It's very surprising to us.
>
> Matara mama: Now you don't give anything [to a baby]
>
> Matara nanda: That's what I mean. I feel like *pissu*[122] [when I hear of these things]!

As discussed in chapter 5, the biomedicalised neonatal care system, institutionally accessible throughout the country, strongly rejects most of the popular traditional care practices that have been passed down through generations. Among these is the administration of *kalka* herbal tonic to infants. On the other hand, the contemporary biomedicalised framework widely promotes exclusive breastfeeding. Young mothers are directed not to give any other liquid or solid foods to infants until they are aged at least six months. International reports indicate an extremely high adherence to this practice in the country[123](Agampodi et al., 2020).

As the above interview excerpt demonstrates, the rejection of traditional practices under a biomedical framework remains incomprehensible to Matara nanda. It contradicts and invalidates the generationally transmitted therapeutic knowledges as well as her own experiences of mothering that she herself would consider trustworthy, which she had drawn from and built on through the years while caring for a

[121] A general term for ill-health, misfortune or negative influence.

[122] Mad, crazy

[123] Sri Lanka is reported as the first and only 'green nation' in the world, in terms of exclusive breastfeeding of infants for the first six months of life.

number of infants[124]. This invalidation of knowledges, and the resultant disempowerment, might explain the intense confusion that she expresses as "feel[ing] like *pissu*". A certain degree of resentment also seemed to be directed at the son and the daughter-in-law: they had embraced the biomedical directives in caring for their child, through which they had set aside what she herself—and generations before her—had practised. Feelings comparable to these were conveyed by Jaya mama (quoted in chapter 5), who criticised young mothers for seeking English medicine for children.

With biomedical claims of traditional remedies (such as *kalka* and medicinal oils) as being harmful for infants, those substances are being detached from the relationalities of love and care within which they have been embedded in households for eons. What was previously symbolic of care has been biomedically reframed as dangerous and harmful. With these practices and the related experiential and embodied knowledges thus disputed, they are at risk of being discontinued in households. Such discontinuity may even upset family relations, as I have described in this section.

Discussion

This chapter shed light on the spatio-temporal features and organisations of therapeutic practices in households as identified through the present study. The first section of the chapter focused on the spatial dimension of these practices. Accordingly, I pointed out that the emplacement and storage of different medications in the homes reflected their ownership, convenience of use and accessibility. Different spaces of the home became significant where traditional and biomedical therapeutics were concerned. Further, considerations of therapeutic familiarity, potential risk, vulnerability and responsibility were implicated in how the therapeutic practices were spatially organised.

Analysing the temporal significance of therapeutic practices, in the second section of the chapter, highlighted them as flowing through time and temporally organised within households. Therapeutic practices are passed on generationally, and remain in a state of flux in response to the multiple tensions of different knowledges, worldviews, technological advances and human relationships of everyday life within the household. On the other hand, therapeutic practices may bridge moments in time, between a nostalgic past and the present, between former state(s) of health and present medication-dependent health. In addition, as 'time-bridges', therapeutic practices also become a means of extending the

[124] As the oldest daughter of her parents, Matara nanda had cared for each of her four younger siblings from infancy, while her parents worked in the fields. She also has four children of her own, all of them married and with children by now.

ongoing everyday into an eventual future by avoiding a potential rift of intergenerational relations or even the abyss of untimely death.

In the following discussion, I focus on two themes that recurred throughout the analysis: risk and responsibility.

Risks in therapeutic practices

Risk, in terms of therapeutic practices and their spatio-temporal configurations within the participating households, manifested in two ways. Firstly, therapeutic practices are a means of dealing with risk. I have written of long-term medication practices as maintenance work aimed at managing the risks posed by a sick body. There are also certain preventative practices that aim to avoid potential ill-health. Even those remedies and medications which are taken as needed when one falls ill, can be viewed as means of controlling an illness and the risk of disruption that it poses to everyday life. This way, therapeutic practices often involve "tinkering" actions towards avoiding and/or managing risks of ill-health, health-related disruptions to everyday life, or even death (Mol, 2008; Mol et al., 2015). On the other hand, therapeutic practices themselves constitute risk, as discussed in chapter 5. While long-term medication can control epileptic seizures, the risk of recurrence is always there embodied within the maintenance work. Medications themselves, particularly biomedical pharmaceuticals, were looked upon by the householders in the present study as risky objects. While they relied on the medications for a cure, people were also wary of their potential dangers. In brief, medications were pharmakon, embodying the power to heal and to harm.

The significance of risk in terms of therapeutic practices was such that, most of their spatio-temporal organisation in households was underpinned by an understanding of risk and geared towards managing and/or defusing risk. Here, risk(s) was broadly understood in their potential to affect not only oneself but anyone in the household. To illustrate, the dispersion of medications in a household was organised on the basis of their (perceived) relative risk. For, while the various tubs of balm, herbal oil and Panadol (which I suggest has become more of a home remedy) were found on table tops, drawers and easily accessible nooks, biomedical pharmaceuticals in general, viewed as unfamiliar and risky, were kept away on a shelf or enclosed in empty ice-cream cartons with the lid firmly closed. The perceived risk posed by medications was amplified in households with children. There, the ordering principle for nearly all medications (including Panadol) was one of keeping them inaccessible to the children.

Risk is also managed through the temporal organisation of therapeutic practices. One such example is the medication routines adopted by long-term medication users. Routinising is a deliberate effort to

anchor their medication intake to more-or-less fixed activities of everyday life, thus developing a set pattern situated in particular time(s)-of-day and household space(s) (Hodgetts et al., 2011). This is enacted so as to maintain their regular medication intake in order to avoid the risk of missing a dose, which could entail the potential risk of a relapse. There is also a risk in waiting for therapeutic treatment, as prolonged waiting may sometimes aggravate ill-health. Therefore, where such risk is perceived as high, as in the case of a child being ill, people reported seeking treatment with minimum delay, so as to lessen the risks involved.

Physical or physiological harm is not the only risk involved in therapeutic practices in the therapeutically diverse landscape of Pitawella. The contemporary biomedical dominance and the legacy of coloniality have coloured people's perceptions of Sinhala medicine and English medicine. In this light, traditional medicine has come to symbolise a nostalgic past and adherence to local traditions, whereas biomedicine represents modern progress and technological innovation. Taking up some therapeutic practice, therefore, becomes a political act, potentially a declaration of allegiance or disloyalty, embodying the risk of eroding social relationships. At the household level, entangled in extended family relations, therapeutic practices may well become the grounds for powerplay between a mother and a mother-in-law vying for greater influence over the daughter/daughter-in-law.

Responsibility

Research literature asserts the significant moral dimensions associated with therapeutic practices, particularly (biomedical) medication use. Dew et al. (2015) point out how being subjected to "pharmaceuticalised governance" could be constructed as a moral failing and a sign of a disordered society. Gabe et al. (2016), analysing medication talk on the use of hypnotics, identify repertoires of "deserving patient", "responsible user" "compliant patient", "addict", "sinful user" and "noble non-user". In a more recent study titled "What is wrong with being a pill taker?", Polak (2017) extends the analysis on the moral discourses of medication use. Such scholarship substantiates the notions of moral principles and responsibility where medication use is concerned: that the legitimacy of medication use hinges on a perceived indispensability of drugs, that a legitimate and prescription-adherent use is deemed responsible, while dependence on or abuse of medications is irresponsible.

In the present study, enacting responsibility was observed in manifold occasions of everyday life: for example, in storing medications in a suitable space in the home, placing them away from the reach of children, following long-term medications regularly and on-time, keeping one's (prescribed) medications at hand in case they are needed, prioritising the health needs of the more vulnerable over those of oneself, and caring for the sick. Women, often the wife/mother, were in charge of the bulk of

therapeutic responsibilities in most participating households, from storing medications to preparing herbal remedies. Responsible practices were praised and reinforced in the children, such as where they obeyed the parents' instructions on handling medications. Irresponsibility was deprecated, even where it was observed in adults. A case in point was that of the parents' misplacing a bottle of syrup which their child then ended up drinking.

What, then, is responsible therapeutic practice? In relation to the previous discussion on risk, I would suggest that responsibility emerged where people enacted careful and appropriate management of therapeutic practices in their local contexts, so as to avoid/defuse risk to themselves and to others. This was done in households through small acts of adjustment, calibration, modification—examples of "persistent tinkering" (Mol et al., 2015)—to achieve specific spatio-temporal organisations of therapeutic practices.

The following chapter continues the focus on the home, to explore how therapeutic practices were being adapted and 'personalised' within households.

CHAPTER 8: PERSONALISING THERAPEUTIC PRACTICES

In the present study, therapeutic practices are conceptualised in terms of care practices in everyday life that involve persistent and incessant tinkering (Mol et al., 2015) with bodies, medications and knowledges. Such an understanding of therapeutic practices captures a number of potential meanings.

> To care is to tinker and to doctor. To care is to "quibble," to handle, to adjust, to experiment, to change tiny details in order to see if it works (Winance, 2010, p. 102).

In this chapter, I explore tinkering that is undertaken with an aim to adapt and modify therapeutic practices to suit oneself and the circumstances of one's engagement with therapeutics, which I will refer to as 'personalising' of therapeutic practices. While such adaptations can be identified as a common trend in many situations where people engage with therapeutics, my focus is on how people's efforts at personalising therapeutic practices and their reasoning are constituted in their diversified therapeutic landscape and its inherent tensions, as well as the circumstances of their everyday life.

In this chapter, I present, and elaborate on, the three principal mechanisms of personalising therapeutics that were identified through household interviews. These are seeking therapeutics compatible to oneself, discontinuing therapeutics, and modifying and calibrating therapeutic practices. Following this discussion, I trace the moral and pragmatic rationales that underpin the personalisation of therapeutics within the household.

Seeking therapeutics compatible to oneself

Household interviews brought to light many instances of people seeking therapeutic alternatives that they felt were suitable for them. Such attempts were based on the general understanding that not all medicines would work for everybody, as their degree of efficacy depended at least partially on their compatibility to the person. Compatibility, in this regard, was understood in terms of how they (or their sick body) responded to medications, gauged on the basis of their sensed, perceived and embodied knowledges. People relied on these "sensible knowledges" (Gherardi, 2009) acquired through the body and its senses to determine what worked best for oneself from among different types of therapeutic alternatives (i.e. English medicine, Sinhala medicine).

To illustrate, Patty nanda is an advocate for herbal medicine, and it is her "sensible knowledges" that inform her treatment choice.

> English medicine makes the body feel dehydrated, [makes] the skin dry. But *kasaya* (herbal potions) are not like that: they are good for the body. *Kasaya* is like food for the body. English medicine, on the other hand, is very *sara* (harsh) … English medicine works perfectly well for [my husband]. But not for me. As for me, if I boil a few leaves of some plants and drink [the infusion], even that would work. When I take Sinhala medicine, I can do any strenuous work. But with English medicine, I can't work at all, [I] can't bear to stand in the sun.

As quoted above, Patty nanda describes biomedical pharmaceuticals as harsh on the body, based on sensations such as feeling dehydrated, dryness of skin and being unable to bear the heat of the sun. It is also insightful that she contrasts her experience with that of her husband, who apparently does not undergo similar sensations on using English medicine; which reiterates the personal and embodied nature of one's "sensible knowledges".

Similarly, most householders would speak of their preferred therapeutic modality in terms of which medicine 'worked' for them. For some, as for Patty nanda, their understanding was primarily based on perceived effects of the medicine on their body. There could also be an element of habituation or 'getting used to', expressed by householders in relation to Sinhala or English medicine. This was a process through which one's body becomes accustomed to and responds well to a given therapeutic modality as a result of using it continuously over time, but which, conversely, renders alternate therapeutic modalities less effective. As Mahasen nanda put it, "When your body gets adapted to [English medicine], you can't do without it".

On the other hand, the (in)compatibility of the treatment was often experienced in relation to negative impact on habits and lifestyle. Many people, for example, found that Sinhala medicine prescribed by practitioners and its associated processes of herbal potion preparation and lifestyle modification were difficult to carry out as a part of everyday life. (In/compatibility of therapeutics with lifestyle is taken up again later in the chapter.)

Notions of therapeutic efficacy

The acknowledgement of individual differences in sensed, perceived and embodied knowing of treatment efficacy underpins the traditional Sinhalese notion of *beheth ahanava* ("medicine answering"[125]) (Nichter & Nordstrom, 1989). This refers to the capacity of any therapeutic treatment to be efficacious for a given person. Sinhala medicine addresses the holistic wellbeing of an individual which encompasses their physiological, psychological and social aspects; thereby it positions medical treatment

[125] The original translated term used by the authors

as a ‘personalised package’. Nichter and Nordstrom (1989) identify three factors that determine treatment efficacy in terms of *beheth ahanava*. The first factor is the person’s bodily constitution, or “one's inborn state of being and personal characteristics as influenced by heredity, cosmological forces, and the contingencies of the developmental process” (p. 369); the second is habituation, which is a “typical, accommodated response to a kind of medicine” (p. 369); and the third factor is *atgunaya*, which is explained below. The popular notion of *hiyang* in the Philippines carries a similar sense of medicine’s compatibility to a person (Whyte et al., 2002).

Therapeutic efficacy was also partially constructed as practitioner-related, in that the medications prescribed by different practitioners—even within the same therapeutic modality and for the same condition—may be understood as varying in efficacy. For example, Punchi nona distinguishes between the effects of pharmacotherapy prescribed by different biomedical practitioners based on her own experience:

> … one doctor’s medicine is not like another’s medicine. When [I] get treatment from that R--mahaththaya, I can’t even remain standing. I feel very sleepy and my whole body will be shivering. It works differently on different people. There are some people for whom his medicine works well. For us, it’s a bit too *sara* (harsh).

In elaborating the differential efficacy of treatment, the above quote is framed within the Sinhalese traditional medical notion of *atgunaya*, meaning the exceptional ability of a practitioner to provide highly efficacious treatment. As mentioned earlier, *atgunaya* (‘power of the hand’) is identified by Nichter and Nordstrom (1989) as the third factor that determines therapeutic efficacy in their conceptualisation of *beheth ahanava.* This special healing capacity of a practitioner, however, is hardly universal. Practitioners are reported to have *atgunaya* over specific illness conditions or groups of people, and according to Nichter and Nordstrom (1989), it may at least partially derive from the excellent rapport that a practitioner develops with particular treatment seekers.

In the present study, only a few participants used the term *atgunaya* during interviews, though nearly every household spoke of making treatment decisions based on the differential efficacy of treatment that they experienced from various practitioners. Accordingly, the most popular biomedical practitioner among the households was Kodagoda mahaththaya, whose treatment was deemed so *sara* (harsh) and powerful as to cure any illness with merely two or three doses. (Details of his private practice were given in chapter 6.) However, this very potency of medicine, which made him the preferred practitioner for adults, was considered too harsh for children’s bodies; and parents usually sought some other biomedical practitioner when their children fell ill.

In addition, some participants had very strong experience-based convictions in the *atgunaya* of a certain practitioner, which made them doubt the efficacy of treatment from any other healthcare provider. For example, consider the following event of treatment seeking narrated by Jaya nanda*:*

> When my son [and his family] was living in Colombo, I stayed there for a month to take care of their baby. I was due to return home [to Pitawella] when I got this terrible headache. Couldn't bear the pain! I was vomiting too. … You couldn't travel like that. So, they took me to a doctor nearby, who gave me some pills. That didn't work at all. My son took me again to the doctor in half an hour, then again for a third time. The doctor said I would need [intra-venous] saline. My son was angry now! He said, "Let's go" and we started to drive back [to Pitawella]. We started around five [in the morning] and reached R-mahaththaya's place [in Thawalama] by eleven. He gave me two tablets and some powder dissolved in water [to drink], and told me to wait 10 minutes. That cured me! … All that unbearable pain [was gone]. … In the van, I was lying down in pain, but after [that medicine] I could sit down and talk to my son the rest of the way. It's amazing, but that happens [to me]. … Like that, only R-mahaththaya's medicine will work for me.

A main point in Jaya nanda's story is that she had to travel (meaning, be driven by her son,) all the way back to Thawalama (a small town located 8 km away from Pitawella) from Colombo in order to be cured, a distance of over 120 km. It is conflated with the connotations of the urban-rural divide as well as the associated gradient of therapeutic resources, between Colombo as the capital city, and Thawalama as a peripheral town. Though Colombo is the urban centre where the most sophisticated treatment alternatives are available, her preferred practitioner is located in Thawalama, and only his medicine would work for her.

Household interviews illustrate how people relied on the notions of therapeutic efficacy and their own sensed/perceived and experiential knowledges to ensure the compatibility of treatment with themselves. For instance, it was important for Thilani to take her toddler to several biomedical practitioners to find out whose treatment worked best for him. In Sunimal mama's household (as in many others'), each householder had their own preferred practitioner based on their individual perceptions of *beheth ahanava* ('medicine answering'). While Sunimal mama himself would swear by the biomedical treatment of Kodagoda mahaththaya, his wife always seeks a certain biomedical practitioner in Hiniduma. Their daughter-in-law Sumudu was not very particular about where she got medicine for herself, though she always takes her young son to S- mahaththaya in Neluwa for biomedical treatment or to the local *devale* (shrine) for Sinhala medicine.

Experimenting with herbal alternatives

> I was told to follow medications for cholesterol. I didn't. [Instead] I thought what to do about it. It says on the TV to drink [an infusion of] *karapincha*[126] leaves, to eat a *sambol*[127] of it, and so on. So, I did that. And I didn't go to get medicine. I still have that piece of paper, but I didn't use any of the pills. I [still] don't.

Nita akka, quoted above, was a participant who reiterated her dislike of biomedical treatment and of following (any) medications long-term. When prescribed biomedical pharmacotherapy to control high blood cholesterol[128], she had opted instead to follow a traditional remedy of *karapincha* leaves. It should be noted that Nita akka's diagnosis was based on laboratory tests, prior to which she recalled feeling heavy in the body and often sleepy. Having resisted the biomedical pharmacotherapy in favour of the herbal remedy, she reported feeling fresh and healthy, which she attributed to the efficacy of the herbal treatment in improving her blood cholesterol levels. In making this self-assessment, her trust in the herbal remedy and her embodied sense of improved health have displaced the need for a biomedical confirmation in the form of a follow-up laboratory test.

Like Nita akka, several householders reported seeking herbal remedies as alternatives where they perceived biomedical treatment as cumbersome or not effective. They experimented freely with herbal remedies which they had never used before and had found out through diverse sources (as will be explained later). In doing so, neither did they express any misgivings regarding potential negative outcomes. Such apparent trust in the 'non-malevolence' of herbal remedies, and the fact that none of the household interviews revealed experimenting with new biomedical pharmaceuticals in a similar way, would reflect the participating households' strikingly different approaches towards English medicine and Sinhala medicine. As discussed in chapter 4, English medicine was regarded as synthetic, foreign and imbued with high risk, while Sinhala medicine was constructed as natural and benign substances that fit in comfortably into everyday life in the household.

An insightful case of experimenting with herbal remedies, which was pieced together through multiple household interviews, was that of *kakiri*[129]as a remedy for kidney stones. It was Gunapala mama who first informed me of this method, though it was not based on his own experience. Having suffered twice from the acutely painful renal condition, Gunapala mama was dismayed that it was likely to recur. A biomedical specialist had advised him that the only possible way to avoid kidney stones was to drink

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[126] Curry leaves, *Murraya koenigii*

[127] A salad prepared with onions and chilli

[128] She explained that she was diagnosed at a walk-in community health clinic offering free health check-up and medicine. She had gone there only to accompany her cousin who wished to attend the clinic.

[129] Snake cucumber, *Cucumis melo*

plenty of water; but Gunapala mama felt it was simply too inadequate a method. In the meantime, his neighbour Roshan had shared with him his successful experience with a traditional herbal remedy. This had given Gunapala mama much hope.

> Roshan had [stones] in both [kidneys]. This was after I recovered [from the same condition]. Somehow, he had found some information in a newspaper. Said he ate [*kakiri*] as instructed [in the paper]. Then when he got an X-ray, the stones were gone. … I think it's through *kasaya* (herbal potions) that this [condition] can be cured, [or] like what Roshan had used. He didn't get any [stones] again after that. It seems that *kakiri* gets rid of [kidney stones], like, dissolves them. It dissolves them. I heard about it only recently. Now, of course, I don't need to worry [about kidney stones], I'll know what to do!

Roshan, the neighbour who attempted the *kakiri* method, was a participant in the study as well. When he was interviewed (sometime after Gunapala mama), his first-hand account of the efficacy of *kakiri* fell rather short of meeting Gunapala mama's miracle cure for kidney stones. While Roshan agreed that *kakiri* possibly was effective in getting rid of the kidney stones, he had also been using other traditional plant-based remedies at the same time, such as *akkapana* and *niramulliya*. In addition, at the time of the interview, he was re-experiencing abdominal pain that he associated with a recurrence of the condition; therefore, abandoning *kakiri* treatment, he had proactively moved on to *anoda* (soursop fruit), another well-known traditional remedy.

Seeking information on therapeutic alternatives

In the above example, Gunapala mama's apparent trust in *kakiri* as a remedy is based on a therapeutic experience that a neighbour had shared with him. Similarly, participants in the study frequently spoke of sharing their experiences of diverse therapeutics and of trying out alternative methods suggested by others. To illustrate, Sumith ayya took his wife to an Ayurvedic hospital nearly 80 km away, because a neighbour's mother who had a similar condition had been cured at that hospital; whereas Menik akka had started on Sinhala medicine for her daughter's *pinas*[130] condition on the advice of fellow travellers in the bus from their village to Neluwa town. Accordingly, as revealed through household interviews, the community itself was a very popular and trusted source of information on therapeutic alternatives for households.

[130] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

There may however be significant gaps in such information, potentially due to differential perceptions of therapeutic efficacy and mutual misunderstandings. For example, Gunapala mama's second-hand account presents *kakiri* as the perfect cure for kidney stones; however, Roshan, who had actually used the remedy, expressed a more nuanced view of its efficacy. Either Gunapala mama's enthusiasm for a remedy had led him to misrepresent Roshan's reservations on its efficacy, or the latter's experiential knowing of the efficacy of *kakiri* may have changed during the time interval between talking with Gunapala mama and taking part in the household interview. In any case, such discrepancy points to the fluidity and constant negotiation of information in the community.

Mass media could also be identified as trusted sources of information on alternative therapeutics for households. Returning to Nita akka's case, *Karapincha* as a remedy for high blood cholesterol is not popularly known and the source of information in this regard was the television. She would have watched one of the numerous health education programmes telecast regularly on local television channels, probably one that promoted the uptake of traditional medicine in the household. Such televised discussions, as I have noticed, take up common health concerns that are relevant to many households, drawing on the expertise of diverse traditional medical practitioners who are institutionally recognised and/or formally qualified or those who are popularly sought. As for Roshan, he had (as mentioned earlier) come across the traditional remedy for kidney stones in a newspaper; and Sujatha akka, whose story will be described later in the chapter, had bought a specialised toothpaste after seeing an advertisement on television. Previous research also affirms the significance of mass media in disseminating health-related information in the country (Gunathilake et al., 2006).

Among the participating households, it appeared that only a few regularly accessed newspapers and radio. Watching television, on the other hand, was a daily routine for all. As the research interviews were often carried out late in the day at the participant homes, I observed that most householders were avid viewers of serial drama on television. Further, the television was prominently located in the living room of every home that I visited. It was clear that the television occupied an important place in the households, providing people with light entertainment and a welcome diversion from their everyday concerns. This might explain the frequent mentions of health information seeking via the television.

The widespread use of mass media contrasts with the extremely low access of the Internet for therapeutic information. In fact, it was only in the Jaya household that information seeking online was mentioned, that too being in relation to their son who was living and working in Colombo. The absence of the Internet among the sources of therapeutic information can however be anticipated in a rural community in a developing country like Sri Lanka, where there is low digital literacy and unequally distributed digital resources (Kommalage, 2009). At the time of the interview, none of the participating households had a computer and only a few had an Internet enabled smart phone. In any case, low

literacy in English language and the lack of information available in Sinhala language on the Internet would deter them from seeking therapeutic information online.

To summarise, this section elaborated on what I identified as one mechanism of personalising therapeutic practices: namely, seeking therapeutics compatible to oneself. Compatibility in this regard was understood on the basis of experienced therapeutic efficacy along the lines of traditional medical concepts such as *beheth ahanava* and *atgunaya* that emphasise the need for therapeutic interventions to be personalised to cater to the holistic wellbeing of the treatment seeker. I explained how, in their desire to seek therapeutic compatibility, many people experimented with Sinhala medicine and herbal remedies. In addition, they sought information on therapeutic alternatives from the sources available to them, including their neighbours, and mass media such as newspapers and television.

Discontinuation of therapeutics

Mother : (pointing to Punchi nona) She stops taking medicine after one or two doses.

Punchi nona: I can't take [pills] for so long…

Researcher: Is that because you get gastric pain?

Punchi nona: That too. And after a while, you get too lazy to continue them!

Researcher: You mean, when you're feeling a bit better?

Punchi nona: Yes. I don't take them for very long. After one or two doses, if I feel a little better, then the rest of the medicine [will remain unused].

This excerpt from the interview with Punchi nona's household demonstrates another widely prevalent practice in the community: that of discontinuing medications without completing the prescribed course. While this excerpt indicates a deviation from biomedical prescription, people also mentioned withdrawal from traditional herbal therapeutics that they were prescribed; so much so that the early discontinuation of medications itself seemed to be a norm, rather than an exception, within the community.

In order to shed light on this practice, I examine the most common reasons that prompted discontinuation of therapeutics as revealed through household interviews: these being negative experiences with therapeutics, disruption (caused by the use of therapeutics) to everyday life, and perceiving medications as unnecessary.

Negative experiences with therapeutics

Experiencing negative effects which are attributed to biomedical pharmaceuticals was a common reason stated by the participants for discontinuing medications. Drowsiness, tremors, gastric pain, nausea, lips cracking and so on were among the negative effects that they mentioned as resultant from biomedical pharmacotherapy. These effects were not usually attributed to the particular pharmaceutical(s) that they were using at the time, possibly because a majority of the participants were not able to distinguish between the different kinds of pharmaceuticals prescribed to them other than with reference to their physical attributes (e.g. "those small pink tablets") and the condition that they were prescribed for (e.g. "*pinas* tablets", "phlegm capsules", "[breast] milk tablets"). Instead, the negative effects they experienced were attributed to biomedical treatment in general, in support of the shared understanding that 'English medicine' was *sarayi* (strong/harsh) on the body. This notion of *sara*/harshness associated with English medicine was explored in detail in chapter 4.

Sinhala (herbal) medicine

Experience of negative effects deterred people from continuing traditional medical treatment as well, though such effects were often different from what were reported in relation to biomedical treatment. Comparing traditional herbal medicines with the biomedical, some householders felt the former was more "compatible to the body" and "like food". Therefore, the negative experiences that led to the discontinuation of traditional medical treatment were more along the lines of effectiveness and administration of the therapy.

Sarika: I've been having *pinas*[131] for a long time. You know the *devale* (shrine) here? I was asked to come there, that *nanda*[132] said she will cure me for sure. That's why I went for it. I followed [that treatment] for a month or two. She gives *kasaya* herbal potions. My condition became gradually worse. It got so bad that I couldn't bear it at all. Then [we] went to Galle and got medicine from a doctor.

Researcher: So, the treatment from the *devale* didn't work for you?

Sarika: It intensified the condition. The idea is to expel the phlegm [from the body], you know. I suffered a lot from that.

An often-mentioned advantage of traditional herbal therapy was that it leads to a permanent cure as opposed to mere symptomatic relief (attributed to biomedicine). However, it is said that this requires

[131] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

[132] Referring to the priestess at the shrine

long term treatment during which the symptoms could become aggravated. Sarika's suffering while undergoing traditional herbal therapy for *pinas*, as she herself acknowledges, is to be expected: the prescribed *kasaya* (herbal potions) were intended to produce more phlegm in the body in order to expel it all, a process that would first aggravate the condition before curing it. Though she was aware of the professed theory behind the therapy, Sarika—a young mother and a working woman—could not manage the immediate suffering in order to continue with the treatment. On the other hand, Sarika did acknowledge biomedical treatment to be her first choice in any health concern; therefore, it is possible that she had some doubts about the ultimate result of the traditional herbal therapy even if she were to follow it to its completion. This could have also contributed to her abandoning the herbal treatment.

Another significant feature of Sinhala medicine involved its process of preparation and administration. The following interview excerpt, from the household interview with Matara nanda and Matara mama, highlights the differences between the use of biomedical treatment (English medicine) and Sinhala medicine.

Matara nanda: With English medicine, it's a matter of bringing the pill and swallowing it. But Sinhala medicine isn't like that. You have to look for the ingredients…

Matara mama: …boil the *kasaya*..

Researcher: It takes a lot of preparation, doesn't it?

Matara mama: Preparation as well as [lifestyle] adaptation.

Researcher: Do you mean adapting in terms of your food and drink?

Matara nanda: Food, drink, bathing, use of water…

Matara mama: …everything. Even where you go and what you do.

As Matara nanda and Matara mama explained to me, Sinhala medicine requires people to source the necessary ingredients and prepare the infusions at home. Taking a holistic approach that goes beyond treating the immediate illness symptoms, it also prescribes considerable changes to the lifestyle for the duration of the treatment. It is clear that the administration of traditional herbal therapeutics remains largely unchanged through the years. This, perhaps, adds to its popularity among the older generation in the community, though considerably reducing their appeal for others. In the present study, for example, I observed that the older householders were often enthusiastic proponents of Sinhala medicine, whereas the younger people, even in the same households, frequently opted for biomedical treatment; though, of course, there were exceptions.

Weerasinghe and Fernando (2011) note how traditional medicine becomes less accessible to rural Sri Lankans due to time and resource constraints as well as the difficulty of accommodating the demands associated with therapy administration in their lifestyles. Similarly, many householders in the present study declared that traditional medicine was not a viable therapeutic choice for them. They explained that they did not have adequate time nor willingness to undergo the arduous process of sourcing herbal extracts, preparing medications at home and effecting significant changes in their lifestyles over an extended period. While most of them did not even seek Sinhala medicine due to this reason, there were others who reported initially starting Sinhala medical treatment but discontinuing it quickly, having found it impossible to follow the demanding prescription for an extended period of time. The case of Sunimal mama, described below, is one such example.

(Prolonged) use of therapeutics conflicting with ordinary life

> We can't afford to follow treatment for one year or two. If we get ill today, we'd want to be well by tomorrow.

Quoted above is Sunimal mama, explaining why he had discontinued herbal therapy for a severe skin condition. After three months of regular visits to the traditional practitioner and using medications that cost nearly 500 Rupees per week, he had experienced little improvement in his condition. While Sunimal mama has discontinued traditional herbal treatment, it was not due to any lack of faith in the medicine's effectiveness per se: for he understands that herbal medicine entails prolonged treatment. Rather, he finds the treatment—and its requirement of a long-term commitment—to be incompatible with, or even disruptive of, his lifestyle.

Most of the people in Pitawella, like Sunimal mama, lived on daily wages for physical, labour-intensive work. Whereas illness may affect their capacity to work and earn their living as well as to participate effectively in daily activities in the home, the financial and care demands of long-term treatment, and its toll on the household, could be equally debilitating. Accordingly, prolonged and immersive therapeutic treatment could be as much a burden as is an illness. This appeared to induce many householders to seek, whenever possible, therapeutic interventions that guaranteed a quick cure, such as biomedical treatment for acute conditions.

Following long-term therapeutic treatment requires much "invisible work" on the part of the medication users (Huyard et al., 2019), which may become an unwelcome addition to daily life. Therefore, where medications prescribed for long-term use did not appear to be associated with the control/management of any perceivable symptoms or immediate risk, people were likely to discontinue them. To illustrate, several participants had given up long-term pharmacotherapy for hypertension and high blood

cholesterol. This tendency is reflected in previous (biomedically oriented) studies that indicate a low adherence to antihypertensive medications in the country. Nearly 60% of persons diagnosed with hypertension are reported as having uncontrolled blood pressure, while over 50% of those prescribed medications have given up within one year; this low rate of adherence being at least partially attributed to people experiencing few or no symptoms from the condition (Kumanan et al., 2016; M. Perera et al., 2019).

Where comorbidities were involved, some people may selectively follow medications based on a comparative assessment of risk. Sumith ayya, for example, in his expressed desire to limit his medication intake, had temporarily given up treatment for arthritis (as will be discussed later in the chapter); however, he diligently followed the medications for his heart condition. There were other cases, where, on the contrary, discontinuation of medicines appeared to be tied in with unfolding circumstances. Nagama akka had been on pharmacotherapy for arthritis and hypertension, until she had a road accident several months before the research interview and was hospitalised for a few weeks. She had been administered other medications while in hospital, and the antihypertensives had been, as she put it, "left out", probably forgotten amidst the anxiety and general chaos following her accident. The constant pain in her arthritic leg demanded relief, which meant that she continued the relevant pharmacotherapy; though medications for hypertension (a more or less symptomless condition, as mentioned earlier) were never resumed even after returning home from hospital.

Disruption to habits and practices

Discontinuation of medications, particularly biomedical pharmaceuticals, also seemed to be prompted by their incompatibility with life-long habits and practices. Consider the following quote by Dolahe-gedara nanda, who had given up on asthma medication prescribed for her:

> I was given some medication to inhale, from the hospital. While I was using that, I couldn't eat [anything with] chilli, no chilli at all. My throat was sore. It felt *sarayi* (harsh). [So] I stopped using it. … When I used it for a couple of days, I couldn't eat any chilli at all. I was staying at our daughter's place … She would cook *kathurumurunga* leaves [for me]. It's after doing many, many, such things that I got well again. I got rid of [that medication]. Eating k*athurumurunga* leaves will cure sores quickly and you can eat chilli again. I stopped it, that medication. It was bothersome to me.

As she clearly explains, the immediate reason that led her to stop using the medication was its *sara* (harsh) effects that interfered with her food habits: she could not eat any "chilli", meaning hot food. The gravity of this problem can only be made sense of by contextualising it to Dolahe-gedara nanda's everyday life. In Sri Lankan cuisine, chilli is an essential ingredient. Almost any dish that accompanies

rice—the staple food that many people consume two or three times a day—includes chilli in some form (i.e. chilli powder, dried red chilli and/or fresh green chilli), and most of these curries can be considered as hot. This being the case, avoiding chilli would be impossible under normal circumstances, unless meals were specially prepared for her, which in turn would mean extra time and effort on her own part or her daughter's[133]. On the other hand, chilli-free curries would taste bland for someone who enjoyed hot food, rendering their meals less appealing. Faced with such negative prospects, Dolahe-gedara nanda had reasoned that it was too much bother to continue the medication. The excerpt below, where Sujatha akka speaks of her discontinuation of biomedical treatment, sheds further light on the reasoning process involved in a similar situation:

> I was told not to chew betel. Well, I didn't as much as I used to, but I did chew about two or three a day. When I went again [to the doctor], he said, "*Amma*[134], you should decide it yourself, whether to stop chewing betel or to stop the treatment". I did think it over. Well, my teeth will fall out one day, anyway… but chewing betel, on the other hand… So, I didn't go to see the doctor again! I decided it myself, not to go. Then there's that good toothpaste, you know, you see it on TV, too… called X or something … I get that toothpaste and brush teeth with it. *Deyihamuduru pihiten*[135]*,* that worked.

Similar to chilli in the previous example, betel chewing can be identified as a culturally significant practice. Though it has been scientifically linked to various oral diseases including cancer, betel chewing continues to be popular in rural Sri Lanka, as well as in South Asia as a whole (Singh et al., 2020). Sujatha akka, a 48-year-old woman, had enjoyed chewing betel since she was a young girl. When she went to seek treatment for loose teeth, the biomedical practitioner had diagnosed her as having a gum infection and instructed her to stop chewing betel as part of the treatment. Her decision to give up the treatment derives from the popular assumption that losing teeth is a normal part of ageing[136]. Given its perceived inevitability, she reasons that she might as well continue to enjoy chewing betel and risk losing teeth soon, rather than give up the habit and then ultimately lose the teeth anyway.

On having discontinued the medication that conflicted with her food habits, Dolahe-gedara nanda had sought biomedical treatment elsewhere and was, at the time of the interview, using a pill that did not

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[133] In most households, including Dolahe-gedara nanda's, the daily chores and food preparation were generally handled by women. Men would only take them over occasionally, when the women were absent from home or too sick to work.

[134] Mother. This term can be used to address an elderly woman, or a woman who has children, in addition to one's own mother.

[135] With the blessings of gods

[136] This is signalled at in studies on the high prevalence of oral disease and low perceived need for dental treatment among the elderly in Sri Lanka. E.g. Ekanayake & Perera, 2005.

feel *sara* (harsh). As for Sujatha akka, she had found an alternative in the form of a certain toothpaste that is widely advertised on television as a remedy for sensitive teeth. At the time of the interview, she claimed that her teeth were fine due to the new toothpaste, and that she continued to chew betel. Therefore, it appears that they both have succeeded in finding therapeutic alternatives that they felt to be in harmony with their lifestyles, which reflects the theme of compatibility as discussed in the first section of the chapter.

Perceived (non-)need for medications

> It is laziness in a way. [I] don't like taking medicine very much. [I] bring medicine home, and when the pain is too much to bear, I'll take it. [But] when the pain goes down, I'd forget the medicine!

During household interviews, a majority of the adult participants emphasised the dispensability of medications in their lives. To illustrate, when talking of medicine prescribed by a doctor for a minor illness, Ishani (quoted above) says that she would always "forget" or feel lazy to continue them. Punchi nona, quoted at the beginning of this chapter, echoed a similar sense of laziness and a dislike of medicine (in addition to other reasons). Such utterances were, in fact, very common during household interviews with participants who were neither chronically ill nor long-term therapeutic users. These conveyed a sense of medications as being rather superfluous and inconsequential for them, as well as a shared desire to distance themselves from medications.

In the present study, the perceived non-need for medications was the most common reason stated by the participants for discontinuing therapeutic treatment. For Ishani, as mentioned above, medicine becomes irrelevant "when the pain goes down". Sujatha akka seems to discontinue medicine based on a similar rationale:

> [The doctor] gives about eight or nine doses of medicine, but I don't use all of that. I don't know, as soon as I can lift my head, I'd stop the medications. That's it. … I do it intentionally. I'd think, "Now that I'm better, I don't need medications", and stop taking them.

As Sujatha akka explains, once she feels her health is somewhat improved, she does not consider herself to be in need of medicine, which leads to a deliberate withdrawal from medicine. Her words imply a desire to distance her convalescing self from medications as soon as possible. Medicine intake, for her, seems to be associated with a state of physical incapacitation (i.e. inability to "lift [her] head"). Therefore, entwined with Sujatha akka's wish to be restored to health and her normal way of life is a keen desire to get rid of the medicine.

Using medicine as indicative of physical weakness and illness

Indeed, research findings from elsewhere propose that medications, being inexorably linked with illness, could become a symbol of illness for the medication users. Tangibility of medications and the embodied process of using them would come to represent ill-health experiences, which are otherwise often abstract and insubstantial (Whyte et al., 2002). A similar association is voiced by Nita akka, where she conflates her understanding of good health with being rid of medications:

> There are some homes where the *kasaya* pot[137] is [always] on the hearth, even on the New Year's Day. … As for us, well, we hope not to take even a bit of medicine through the year. *Deyiyange pihiten*[138]. Well, that's what I wish for! [My wish is] not to be ill.

Household interviews revealed that medication use for everyday minor illnesses often followed a similar trajectory as that of Sujatha akka and Ishani. That is, people would seek therapeutic treatment where they deemed it was necessary, but stopped the medications once they felt their health to have improved, so that a considerable portion of the prescribed medicine always remained unused. Accordingly, my impression was that they regarded medicine as a kind of a prop or crutch to lean on where there was a dire need for it and desired to be rid of as soon as they could do without it.

Previous research findings outside of Sri Lanka point to narratives of physical strength, stamina and masculinity associated with managing ill-health without resorting to medications. To illustrate, Dew et al. (2015) report that people speak of foregoing medications as "tough[ing] it out" (p. 275). Similar attitudes were expressed by some participants in the present study. For example, Jaya mama declared that

> I don't even take a tablet of Panadol unless I cannot get up from the bed. Ask [my wife] if I do! … [My wife] brings enormous packets of Panadol from the pharmacy, by the lorry-ful. But I don't [take any].

His wife suffered from recurrent episodes of severe headache, which necessitated buying Panadol "by the lorry-ful". In comparison to her alleged excessive use of medicine, Jaya mama constructed himself as a proud non-user. Another example for intentional non-use of medicine can be found later in the chapter, in the case of Sumith ayya. He had decided not to use pain relieving medicine for arthritis, and thereby to live with the pain, as he believed it was better than ingesting more and more pharmaceuticals.

[137] Kasaya herbal infusions are prepared in a pot over the woodfire.
[138] With the blessings of gods

Similar to Sujatha akka (discussed earlier), Jaya mama, too, associates the need for medicine with severe physical incapacitation. This narrow approach to ill-health would make sense once it is contextualised within the everyday lives of the participants. As I have articulated earlier, for the participants in the present study, illness translates into being unable to work and fulfil one's responsibilities, which in turn would mean a loss of daily income and general chaos in the household. This could explain a certain reluctance on their part to admit to ill-health, unless they absolutely cannot "lift [one's] head" or "get up from the bed". Ishani, as mentioned earlier, voiced a similar attitude. She is the young wife in a household that includes a school-aged child and an elderly woman who is chronically ill. When asked about her own therapeutic practices, Ishani put it very simply, "I don't get ill" (chapter 7). In this light, the (non)need for medicine may emerge through a specific approach to ill-health that is situated in their own (and their community's) living circumstances and the fulfilment of their gendered roles therein.

Research literature notes that people are generally averse to prolonged medication use. What is perceived as a dependence on medicine could evoke a sense of powerlessness and lack of control over one's own body and life in general. Studies (mostly based in Western societies) have demonstrated that the inability to lead a normal life without medication may give rise to feelings of disempowerment, regret or self-condemnation (Dew et al., 2015; Haafkens, 1997). Viewed this way, the essentiality of medications—or being dependent on medications—could be perceived as indicative of bodily weakness and illness, as well as a loss of self-autonomy and independence. I would suggest that the participants of the present study, by emphasising (to me) how they did not depend on medications in ordinary life, may have sought to disassociate themselves from such negative connotations of medication use.

It may also be argued that the discontinuation of medicine pointed to a strict delimitation of professional therapeutic expertise, by the householders, to the duration of perceived illness. While people relied on a therapeutic practitioner to prescribe them medicine when they perceived themselves to be ill and followed the prescription as long as they continued to feel ill, they were also eager to be 'free' of such dependence on professional expertise. For, just as their seeking medicine was prompted by sensed and perceived signs of ill-health, their discontinuation of medicine also occurred based on what was sensed, perceived and interpreted as signs of return to health, as opposed to what the practitioner had recommended.

To summarise, in this section I expanded on the widely prevalent practice of discontinuing medications by highlighting the principal reasons which the householders mentioned. One was negative experiences with therapeutics, under which I mainly considered the side-effects of biomedical treatment and the difficulties involving the administration of Sinhala medicine. Disruption to ordinary life was another reason; and in this regard, I looked into how the use of therapeutics could disrupt work and everyday

living, as well as have negative impacts on a person's lifestyle and long-standing habits. The third reason for discontinuation of therapeutics, which was also the most commonly stated by householders, is a perceived non-need for therapeutics. Here, I shed light on the potential association of medications with (physical) incapacitation and loss of autonomy, and how these would be constructed negatively in the lived realities of ordinary life of the participants.

Overall, it appears that discontinuation of therapeutics would occur where they were perceived as either negatively impacting on the body or one's life style, or redundant, so that their discontinuation could be rationalised as restoring the balance and/or harmony of life.

Adapting and calibrating of therapeutic practices

In addition to actively seeking therapeutics that are compatible to oneself, and discontinuing those that were felt to be disruptive or unnecessary, householders also modified therapeutic practices in order to personalise them. In fact, studies on medication usage in everyday life, situated in both Western and non-Western cultures, frequently note how people adapt, modify and experiment with their medication practices (Dew et al., 2014; Haafkens, 1997; Whyte et al., 2002). Such attempts are prompted by a wish to improve therapeutic outcomes based on one's own sense of wellbeing and embodied knowledges of what works for oneself. This way, medication users' attempts at calibrating and modifying therapeutic practices may distort the standardised prescriptions based on therapeutic expertise. Though at the same time, these attempts at 'tinkering' (Mol et al., 2015) may also be necessary to operationalise therapeutic prescriptions by transposing them onto the experienced realities of everyday life.

In this section, I elaborate on three ways in which the participants adapted and calibrated their therapeutic practices: by reducing their intake of pharmaceuticals, altering the composition of herbal remedies, and mobilising the religious/occult in unorthodox though personally meaningful ways.

Reducing the intake of pharmaceuticals

> I get fed up when I see the handful of pills [that I have to take]. … I'd take the pills about once a day, because I can't [do more than that]. … I'd take them either in the morning or at night. It's very difficult for me to take English medicine. Why should I lie? I'll take them three times a day [as prescribed] only if I was very ill.

Earlier in the chapter, Patty nanda, also quoted above, was mentioned as someone who preferred Sinhala herbal medicine over English medicine, due to the latter's *sara* (harsh) effects on the body. Yet,

the process of preparing Sinhala medicine being very strenuous, she usually opted for English medicine for everyday illnesses. While she appreciated the convenience of English medicine, which often involved merely ingesting some pills, Patty nanda continued to dislike English medicine. For her, the way out of this dilemma was to ingest as few pills as possible. For instance, as she explains above, if she was prescribed medicine to be taken three times a day, she would probably take it only once. Consequently, according to her husband, she did not recover quickly from any illness; though on the other hand, as she reasoned, she did not have to undergo the full impact of the *sara* (harsh) medicine.

While Patty nanda ingested only about a third of the prescribed medicine, Sumith ayya (quoted below) had temporarily halted his medicine for arthritis.

> I didn't get the prescription filled this time. Even without it, even without the medications, I'm [pain-free]. Just like that. I thought I'd buy those medications if I got the pain again. Usually, pharmacies don't fill an old prescription, like when it's 6-7 months old. But you can talk to a pharmacist known to you, and get it done. That's what I thought I'd do, so I didn't buy them immediately. Medications are toxic to the body, aren't they, medications are toxic. So, I didn't take them, and that worked.

Though he had been prescribed a course of medicine for an arthritic episode, Sumith ayya had decided against starting on it immediately. As he clarifies, he had retained the prescription to get filled in case the pain did not abate without medicine; though the pain had in fact subsided. His decision to live with the pain was prompted by a conviction that medications were "toxic", so that he feels undergoing some pain at present would be better in the long run than ingesting lots of medicine that may have a harmful impact on the body.

Altering the composition of herbal remedies

Household interviews revealed the popular uptake of herbal remedies in the home for all kinds of minor illnesses. Most often these were not prescribed by a practitioner and were used on the basis of householders' own knowledge and experience of Sinhala medicine (as described in chapter 5). In doing so, people adapted these remedies with much freedom and as they saw fit. Most herbal remedies require preparation at home, which allows a broad space for their adaptation and personalisation through adding, removing or substituting ingredients.

A good example would be the coriander infusion used in all participating households as a remedy for symptoms associated with common cold. This basic herbal infusion is prepared by adding coriander to a pot of water and letting it boil down, so that a dark coloured infusion can be obtained. However, there

were a number of variations on this preparation as reported across the households. While a few households opted for the basic version, many would also put in ginger with the coriander, whereas others may add *banvelgeta* as well. These changes in recipe were done freely, and people spoke knowledgeably of the ingredients and their therapeutic potential, such as how ginger dissipates phlegm and the diverse benefits of *banvelgeta* in terms of relieving body aches, energising the body and 'purifying blood'.

Sometimes the variations on herbal remedies were prompted by specific therapeutic aims, such as when *banvelgeta* was added to the coriander infusion in order to relieve body aches after a hard day of labour. Or, people might make simple adjustments to improve the taste. Gunapala mama recalled how they used to add sugar to make the coriander infusion appealing to their children. In Kasun's household, *banvelgeta* was avoided as it would make the infusion bitter. Such taste enhancement of herbal remedies could in fact be crucial where their administration and even their general uptake is concerned, given that the generally-acknowledged bitterness of herbal remedies was mentioned in household interviews as a reason that discouraged people (especially children) from using them.

Even where a herbal remedy was prescribed by a practitioner for a specific condition, householders may go on to adapt its recipe as they see fit.

> I even drink [the juice of] *kohomba*[139] leaves. [I'd] grind some raw leaves and drink one cup of its juice. … [*Kohomba*] expels the heat from the body and cools the body. You're supposed to drink one quarter of *kohomba* juice mixed with one quarter of cow's milk. But I take only the *kohomba*. … It's good for the body. It cools the body very well. You can feel it. I took it 3-4 times. [But] you can't drink it, it's as bitter as *kaduru*[140]! It's so bitter that you'd have the bitterness in your mouth for about two days.

Sunimal mama, quoted above, had sought Sinhala medical treatment for a skin condition from the traditional medical practitioner at the *devale* (shrine). As his condition was explained as a result of excessive *ushna* (heat) in the body, he was prescribed *kohomba* leaf extract mixed with cow's milk. Both these ingredients are well known as 'cooling' substances based on an Ayurveda-inspired framework (Nichter, 1987). Confident in this knowledge, Sunimal mama has modified the prescription by leaving out the milk and drinks one cup of *kohomba* leaf extract instead of the quarter-cup that was prescribed. The extreme bitterness of *kohomba* and the almost punitive nature of the treatment appear to have

[139] Margosa, neem (*Azadirachta indica)*

[140] *Kaduru* fruit is extremely bitter, as well as potentially toxic.

increased its therapeutic value for Sunimal mama, who expressed a sense of 'toughing it out' by going ahead with the remedy.

Idiosyncratic mobilisations of religious/occult beliefs

As mentioned previously, all participants of the present study self-identified as Buddhists, and many of them explicitly referred to their religious faith during household interviews. In terms of supernatural healing and the occult in general, a few declared themselves to be non-believers, while a majority of householders ranged between strong belief and sceptical ambivalence. While some participants—mostly non-believers—tried to construct the religious and the supernatural as distinct categories, it was observed that the two manifested as hybrid categories in practice. (These were discussed in chapters 4 and 5.) Similar observations have been made in previous studies where the religious and the supernatural were considered as not two but one therapeutic category (Hettige, 1991). In any case, the near-universal acceptance of Buddhism and the gradient of belief in the occult among the householders were expressed as many nuanced 'versions' of faith in the religious/supernatural.

Household interviews revealed that people adapted standard Buddhist religious practices into their personal version(s) of faith when mobilising them for therapeutic purposes. The resultant practices were highly personalised and idiosyncratic, being derivative of personal understandings of illness and health, and shaped by their life's circumstances. For example, consider Nagama akka's account of the ritual-like practice that she enacted every morning and found to be effective:

> Very recently, I found [a method] in a [religious] book. After waking up early [in the] morning, without even rinsing my mouth, I have to get some warm water [into a glass] and recite [the religious verses on] *budu-guna*[141]. Then I have to concentrate on the thought that "this [glass of water] will be a medication for me and lessen my suffering" [and then drink it]. I did that, too. I have to do it for many days more ... But I think it already has an effect on me. I think it is even more effective than [medicinal] oil. It is I myself who do [this treatment], early in the morning. I do it as soon as I get up, and only then do I go to the kitchen to light the fire. I use the water in the [hot water] bottle for it. I have some faith in it, because *budu-guna* is [a part of] our religion.

The whole conversation with Nagama akka revolved around her desperation to find relief from arthritic pain in her leg. She had tried all therapeutic alternatives available to her, though without a satisfactory outcome. It is in this context that she had discovered the method that she described above. Nagama

[141] Supra-human qualities of the Buddha

akka identifies it as a religious method, though arguably it hybridises religious and occult elements. That is to say, the verses that she chants are used regularly in Buddha veneration, and the positive resolution towards becoming free of suffering resonates with the power of personal determination advocated in Buddhist doctrine, yet the ritualistic chanting of verses over water closely resembles supernatural methods such as *mathirili* (charms). Her faith in the religious/supernatural, combined with the ritualistic nature of the practice, its time-regularity of enactment and the intense personal involvement, seems to contribute towards Nagama akka's sense of wellbeing.

> I have a lot of faith in Lord Buddha. When I tell Lord Buddha [of any illness], I will soon be well again. If I am not able to get up [one day], when I tell that to the gods, I will be well by the next day. When you go to the *bodhiya*[142] and light lamps, your wishes will come true. So, I really believe in Lord Buddha. … I took that *nangi*[143] to the temple with me. We lit lamps. I told her that her leg will be healed soon if she lights lamps for three or four days. No need of medicine, it will be cured quickly.

Quoted above is Nita akka, another participant whose personal version of faith underpinned her idiosyncratic practices hybridising orthodox religious practices and the supernatural. As she explained, she would 'tell' the Buddha and the gods of her ill-health, which always led to a quick recovery. She also firmly believed in the power of Buddhist rituals towards fulfilling one's wishes. She even encouraged her neighbour, who was suffering from knee-cap dislocation in both legs, to light lamps at the temple and wish for a speedy recovery.

Nita akka's belief in the curative potential of the religious/supernatural appears to be idiosyncratic since she, unlike most other householders, considers religious rituals as a powerful cure in themselves as opposed to being complementary to or a catalyst for other (herbal, biomedical) treatment. For her, such curative potential is brought about through a close personal relationship with supra-human beings, namely the gods and the Buddha. Appealing to the gods for various gains, including good health, is characteristic of pantheism in contemporary popular Buddhism in the country (Goonasekera, 2013), though the Buddha is not generally included among the divinities thus propitiated. In this regard, Nita akka's sense of the religious/supernatural appears to be uniquely personalised and anchored to her everyday life through its immediate therapeutic relevance to her health and wellbeing.

In this section, I considered ways of adapting, modifying and calibrating therapeutic practices that occurred in households. One was intentionally reducing the ingestion of pharmaceuticals by reducing the dose or through (temporary) non-use, which was often underpinned by beliefs of the harshness and/or

[142] Sacred Bo tree in the temple
[143] Kinship term meaning younger sister. Here, the reference is to her neighbour.

toxicity of English medicine. Another adaptation was observable where participants altered the recipe of traditional herbal remedies that they prepared at home, based on their own experiential and therapeutic knowledges. Finally, I explored how people mobilised their personal version(s) of faith in the religious/supernatural, in seeking a personalised 'good' therapeutic outcome.

Discussion

This chapter explored how therapeutic practices become personalised within the participating households of the present study. On the whole, my findings indicated that people keenly sought therapeutic alternatives that they felt were compatible to themselves, adapted and modified practices to better align with their needs, understanding and their everyday circumstances; and correspondingly, people discontinued practices that they considered as either not needed or not compatible. Accordingly, these personalisation efforts point to two salient drivers: compatibility and need. Compatibility in this regard was examined through the traditional Sinhalese medical notion of *beheth ahanava* ('medicine answering') (Nichter & Nordstrom, 1989). Incompatibility of therapeutics was generally signalled, for the householders, by their perceived inefficacy, negative effects on the body and potential disruptions to lifestyle. The need for therapeutics, as the second driver of personalisation efforts, was explored in the light of participant interpretation of it as (physical) weakness and incapacitation, as contextualised into their work, family responsibilities and ordinary living conditions. These ideas will be further developed in the ensuing discussion.

Previous studies into everyday medication use, many of them situated in Western societies, have observed that people tend to personalise and experiment with medications. Haafkens (1997) writes of how women using benzodiazepine modify their dosage based on perceived need, as does Mol (2008) with regard to people on medication for diabetes. Household medication use is characterised by adaptation and calibration of medication practices, in addition to trying out new medications and giving up others (Dew, 2019; Dew et al., 2014). Similar practices were described in the present study, as identified through household interviews. However, the processes of seeking, adapting and calibrating, and discontinuing therapeutics in the present study are significantly shaped by the diversity of the therapeutic landscape and the inherent tensions between the therapeutic modalities that constitute the everyday realities of the research participants.

To elaborate, the householders' different approaches to various therapeutic modalities, as discussed in chapters 4 and 5, shaped their attempts at personalising therapeutic practices. It was clear that the householders took greater liberties with Sinhala herbal remedies and religious/supernatural methods

than they did with biomedical pharmaceuticals. Any personalisation of pharmaceutical use was guided by a desire to reduce its intake, which can be associated with the discourse of English medicine as risky substances (discussed in chapter 5). Therefore, other than decreasing their use or discontinuing them altogether, people did not appear to experiment with biomedical pharmaceuticals at all.

Sinhala herbal remedies, on the other hand, were actively sought and freely adapted according to context and perceived need for use. Ingredients were added, removed or substituted at will from herbal remedies that were prepared at home, as people were confident in their knowledge of the properties of the ingredients and how the remedies themselves worked on the body. Further, religious faith in Buddhism and varying levels of belief in the supernatural, as expressed by the research participants, could be observed as underlying the more or less idiosyncratic religious/supernatural practices carried out with a health-related purpose. Even in this regard, people freely tried out what they felt might work for them, unhindered by concerns of potential risk.

In making sense of the personalising of therapeutics in Pitawella, the crux is the locally-relevant ideas of therapeutic compatibility that feed the popular view that treatment should be tailor-made to oneself. This is captured well in Nichter and Nordstrom (1989)'s elaboration of *beheth ahanava*, a traditional Sinhalese notion of therapeutic efficacy, which they explain using three factors: a person's general bodily constitution, habituation to therapeutics over time, and exceptional healing capacity of the treating practitioner (*atgunaya*). These ideas, though not always mentioned explicitly, nevertheless were reflected in household interviews as important ordering principles that guided therapeutic practices. To recapitulate, it was generally understood among the participating householders that not all medicines would work for everyone; that one may become habituated to some medicine over time so that nothing else would work for them afterwards; that medicine prescribed by different practitioners would not work equally well for oneself and that the most efficacious treatment can be expected from a practitioner with *atgunaya*.

Beyond these ideas that Nichter and Nordstrom (1989) document under *beheth ahanava*, the participants in the present study extended the notion of therapeutic compatibility to their lifestyle. Accordingly, many householders required that a therapeutic practice fit comfortably into their lifestyle, or at least that it should not conflict with habits and practices that were important to them. In terms of minor or symptomless conditions that did not significantly affect their everyday life, people were unwilling to let the treatment affect their lifestyle either. Rather than modify their lifestyle to align with a therapeutic prescription, they preferred to give up the treatment or seek a therapeutic alternative that could better fit into their life. In this regard, maintenance of ordinary life undisturbed by illness and/or treatment emerged as an important concern that determined the therapeutic uptake in households.

Issues of dependence and deservingness

Given the keen desire to maintain the normalcy of everyday life, it was often when experiencing severe or debilitating illness that the research participants considered themselves in need of therapeutic intervention, and they attempted to discontinue the treatment as soon as they felt they could cope without it. This potentially aligns with previous research findings that highlight people's efforts to distance themselves from medications so as to not be dependent on them: such dependence being constructed as a moral failing and a loss of self-autonomy (Dew et al., 2015; Gabe et al., 2016).

While similar moral concerns were voiced by some participants, it is doubtful whether such reasoning could fully account for the dynamics of treatment seeking-and-discontinuation that was observed in the present study. Most householders were fully inclined to seek therapeutic treatment, and to follow such treatment, based on their perceived need. In addition, a majority of them sought English medicine where, being biomedically illiterate, they had to fully trust the practitioner (as discussed in chapter 5). In fact, giving up their self-autonomy and submitting to biomedical authority was understood by them as a part of the treatment seeking process, especially in the public hospitals where they were subjected to much structural violence as poor and less-educated people. (These issues were explored in chapter 6.) On the other hand, being ill would have already deprived them of the ability to function normally and be autonomous, so that seeking treatment could be viewed as a means of seeking to restore autonomy through the restoration of good health. Indeed, as soon as they perceived signs of returning health, they would discontinue treatment.

Therefore, I would put more emphasis on the perceived need for treatment than on moral or self-autonomy related concerns. Being in need of therapeutics, as expressed by the participants, is similar to the notion of "deservingness" in the study by Gabe et al. (2016) on users of sleep medicine. As they explain, where a person is severely in need of medications to manage their normal functioning, they are looked upon as a "deserving" user; and any use of medicine beyond the strictly essential would be generally condemned as an indulgence (Gabe et al., 2016). In the present study, the participants often affirmed that they did not use medicine unless they felt themselves to be severely ill and in need of treatment. Therefore, my impression was that they wished to construct themselves as "deserving users".

As I suggested earlier in the chapter, the need for therapeutics, or "deservingness", was generally evaluated on the basis of severity of the bodily impact of the illness. In addition, physical strength/weakness and stamina of the person were also factored in, so that ill-health of children and elderly was prioritised over that of adults. Family and work responsibilities, as well as one's normal engagement in everyday life, further complicate the notion of deservingness. Where illness threatens to disturb ordinary life, it was found deserving of therapeutic intervention; where illness causes no such

immediate impact, it remained untreated and more or less ignored. On the other hand, where the use of therapeutics appeared to disrupt one's normal functioning and/or ordinary life, the therapeutics themselves would be discontinued.

Local 'good' outcome(s)

The various means of adapting, modifying or even discontinuing therapeutics, outlined in this chapter, were explored as means of "persistent tinkering" that is characteristic of care practices (Mol et al., 2015). The participants of the present study enacted such ongoing adaptations and 'tweaking' of therapeutic practices with specific intentions. In some cases, people sought and adapted therapeutic practices based on notions of therapeutic efficacy. In others, the compatibility of therapeutics to their body and lifestyle was paramount. There were also instances of people prioritising their personal therapeutic preferences or being guided by a wish to minimise negative experiences that they associated with therapeutics. Accordingly, what they expected to achieve through their "tinkering" efforts was different from one instance to another. These different expectations are linked to what Mol (2008) calls the local and contingent "goods" of care practices.

The personalising of therapeutic practices, as discussed in this chapter, also point to how people try to find and maintain a certain elusive balance between their health seeking and ordinary life, which I would suggest as another local and contingent "good". This essentially involves seeking therapeutic alternatives that agree with them, modifying and calibrating these practices further, and giving up discordant elements that jar against the other (potentially more significant) aspects of life. Personalising therapeutic practices, viewed this way, is aimed at a desired therapeutic outcome as well as maintaining everyday life intact. Indeed, the need for such attentive maintenance reflects the fragility of ordinary life (Das, 2020) in its potential of being disrupted not only through ill-health but also through therapeutic practices that are intended as remedy.

CHAPTER 9: CONCLUSIONS, IMPLICATIONS AND REFLECTIONS

The present study, as an ethnographic exploration of therapeutic practices enacted in the households in a Sri Lankan village, was shaped by the following research questions:

- How do people understand and relate to various therapeutics in their therapeutic landscape?
- How do medications flow in to, within and beyond the household?
- How are therapeutic practices enacted by people in their homes?
- How are therapeutic practices implicated in people's everyday lives and relationships?

The data generated through fieldwork were thematically analysed, and the findings were presented in the preceding five chapters. These chapters focused on the following themes: the enaction of therapeutic practices in participant homes and how their 'therapeutic potential' was configured (chapters 4, 5), treatment seeking from diverse healthcare providers (chapter 6), spatial and temporal organisations of therapeutics in the homes (chapter 7), and the 'personalising' of therapeutics through which a 'good' therapeutic outcome(s) is sought (chapter 8). In each chapter, I situated the research findings in relation to the relevant literature, and also drew out significant themes to be contextualised against therapeutic practices as a whole.

This final chapter of the thesis brings together the findings of the study into a reflective discussion and expands into considerations of their wider implications. In the first section, I present a comprehensive summary of the significant findings of the study as well as a retrospective analysis of the conceptual framework. Then I take up the themes of knowledge and power implications of therapeutic use, and the significance of Buddhist religiosity on therapeutics use as well as on the study as a whole. The next section explores the findings on the healthcare landscape and treatment seeking, through which I identify potential concerns to be addressed through policy development and public health strategies. The conclusion of the chapter sets up household therapeutic practices as entwining the personal, the social and the ethical; and suggests potential avenues for future research.

Understanding therapeutic practices in rural Sri Lankan households

The analytical chapters in the thesis offered ethnographic insights on how therapeutic practices were enacted in the participant households. Taken together, these findings contribute to further the

(academic) understanding on household therapeutic practices as occurring against a backdrop of economic precarity, limited resources and therapeutic diversity. There being a lack of similar studies beyond the Global North, these findings from rural Sri Lanka hopefully shed some light on the distinctive therapeutic realities as experienced by people in postcolonial and/or non-Western societies. In this section, I recapitulate the important findings of the present study as discussed in the preceding chapters, and follow with a retrospective critique of the conceptualisation of therapeutic practices that I have used.

Therapeutic practices as hybrid, situated, relational and fluid

Overall, the therapeutic practices in households were broadly aligned with (one or more of) the four therapeutic modalities of English medicine, Sinhala medicine, supernatural therapeutics and Buddhist religious methods. English medicine is the direct translation of *ingrisi beheth*, the popular colloquial term for biomedicine in Sri Lanka. This points to the colonial legacy of the Western medical tradition in the country, as well as a lingering foreign-ness that people continue to attribute to it. Sinhala medicine (*Sinhala beheth*) refers to the local variant of traditional medicine, constituting of a hybrid of indigenous *deseeya chikitsa* therapeutics with other regional traditional medicines such as Ayurveda, Siddha and Unani. Supernatural therapeutics involve various mobilisations of occult and supernatural elements towards curing certain conditions, most often those that are viewed as being of supernatural origin. Religious practices associated with Buddhism were also popularly enacted with the purpose of improving health. Buddhism is the principal religion in the country, and all the participants in the study self-identified as Buddhists.

In chapter 4, I pointed out that it is not viable to classify household therapeutic practices into discrete categories based on therapeutic modalities. That is to say, therapeutic practices that are seemingly associated with a given modality would often seep into and merge with elements from other modalities, thus blurring the boundaries of the so-called different therapeutic modalities. To give a common example, the household use of English medicine (e.g. pharmaceuticals) was most often arranged in line with popular ideas associated with Sinhala medicine. In this light, I suggested that the Latourian “hybrid”, as productively drawn on by Dew (2016) and Dew et al. (2014), would be more apt in terms of depicting the nature of therapeutic practices in households. The notion of hybrids has been used to explore the blending of diverse knowledges when making healthcare-related decisions in spaces such as the clinic and the home (Dew, 2016; Dew et al., 2014), and I have proposed extending a similar theorisation towards therapeutic practices that transcend and hybridise multiple therapeutic modalities.

Continuing the analysis of therapeutic practices, in chapter 5, I explored how therapeutic practices may become therapeutic (or not) in the home. In this regard, my argument was built on the seminal work by Annemarie Mol (2002). Studying the multiple and situated enaction(s) of the disease atherosclerosis, Mol (2002) conceptualises multiple enactions (of a phenomenon) as creating ontological multiplicity. Drawing on the ambiguous potential to heal/harm implied in the Sinhala term for medication, *beheth*, I approached the 'therapeutic potential' of medications and other therapeutic practices in the home as fluid and relational. I suggested that the volatile therapeutic potential(s) in such cases is inexorably linked, and in fact, arising in relation to, the specific arrangements of materials, knowledges and power in which they are embedded within the households.

Organising therapeutic practices: Cost-effectiveness, risk and responsibility

The present study also highlighted certain critical factors based on which household therapeutic practices were organised. Where treatment seeking from various healthcare providers is concerned (as discussed in chapter 6), cost-effectiveness can be pointed out as potentially the most significant concern. It was clear that a majority of households preferred the (fee levying) private sector in terms of fulfilling primary healthcare needs, as they appreciated the greater degree of flexibility, convenience and patient-oriented services that were offered. However, in cases where the cost of treatment was high in the private sector, such as for in-patient care, the unanimous choice was the fully subsidised services in the public sector. Even among the numerous private practitioners frequented by the participants, the most popular was the one who charged the lowest fee and prescribed *sara* (harsh) medicines that were considered capable of producing an 'instantaneous' cure.

On the contrary, relational needs (such as good communication and positive relationship with the practitioner) did not impact significantly on the treatment decisions nor the perceived efficacy of treatment, for most households. This presents a sharp contrast to mostly Western scholarship that generally associates satisfactory treatment outcome with a good doctor-patient relationship (as reviewed by Ong et al., 1995), yet it aligns with previous findings from low-income communities in Sri Lanka (Sachs, 1989). I have argued that the overriding priority of cost-effectiveness of treatment, as well as the collateral neglect of other concerns, should be contextualised against the economic precarity and resource limitations that characterise the everyday life of the participants. As such, striking a balance between the cost and efficacy of treatment appears to be essential for them to 'make do' within their limited means.

Perceived risk of medications, as discussed in chapter 5 and 7, is another significant factor that shaped therapeutic practices in participant households. English medications (i.e. biomedical pharmaceuticals),

which people considered as potentially toxic and risky objects, were hardly used without a medical prescription, and were often stored away out of easy reach in the home. Assorted herbal medications and oils, perceived as posing very low risk, were widely used in self-medication and commonly found in shared household spaces. Medications of long-term users, which most often turned out to be English medicine, were clearly segregated and appeared only in their personal spaces.

Perceived risk of medications is also relational, as I pointed out through two cases where the norms of risk-based arrangement were upended in the participant homes. One of the cases involved Panadol. Though an English medication, Panadol had effectively become a home remedy in the community through casual everyday use and the resultant familiarity. Consequently, people were more relaxed towards the potential risk of Panadol as was reflected in its emplacement in the home: it was nearly always stored together with the herbal preparations and traditional home remedies, not with other English medications.

The second divergent case involved children. The perception of medication-related risk was clearly amplified in homes with young children. Young ones were generally considered less strong and therefore more vulnerable to ill-health that might follow if they succumbed to the temptation to taste some colourful medication. These concerns manifested as elaborate modifications in the emplacement of medications to prevent children from accessing them. In these cases, all English medications, including Panadol, were perceived as posing a danger and were kept either enclosed and/or out of children's reach. On the other hand, it was also unanimously voiced across these households that children should be given English medicine (prescribed by a biomedical practitioner) whenever they fell ill. Children, in general, are showered with love and care and receive preferential treatment over other householders. In brief, children are given the best, in any situation. As such, the parental preference of English medicine for children brings to light an implicit understanding of English medicine as a superior choice when compared to other modalities, notwithstanding its perceived risks.

In examining the specific emplacement and other arrangements involving medicines in the home, I pointed to notions of responsibility as entangled with therapeutic practices. Many such arrangements aimed at neutralising or at least minimising the perceived risk of medications by preventing the dangers of toxicity or accidental ingestion. In the case of long-term medication users, responsibility was often associated with regular ingestion of medications as per the therapeutic prescription. This involved weaving them into elaborate daily routines as well as planning ahead to make sure the medication regime did not get interrupted. Where medications were not 'properly' handled, those who were held accountable for such lapses were blamed by others, so that the 'proper' and responsible handling of medications appeared to be a social imperative. Accordingly, I have suggested that careful use and

management of medications, aimed at ensuring the wellbeing of oneself and others, was understood as responsible behaviour. In addition, it was demonstrated that older children were being taught how to handle medications as per the established norms of medication use in the home, which would ensure the continuity of these practices.

Delimiters of therapeutic practices: (in)compatibility, perceived (non)need, maintenance of the ordinary

Chapter 8 explored specific organisations of therapeutic practices which I called 'personalising', which were principally aimed at seeking/improving compatibility of medications to oneself. The popular notion of *beheth ahanava* (Nichter & Nordstrom, 1989) indicates the lay understanding of a necessary compatibility of the therapeutics to the bodily constitution of the medication user in order to be effective. Participants in the present study were similarly desirous of seeking therapeutics that were compatible to their bodies, though they extended this requirement to encompass compatibility to their lifestyle as well. I have demonstrated that a sense of compatibility, as a basic principle of medication use, worked in two ways: on the one hand, people actively sought therapeutics that they felt were compatible for them; and on the other, they discontinued any that they felt would be incompatible for them and/or did not fit in with their normal lifestyle.

Much of the therapeutic involvement(s) in households were delimited by a perceived non-need for therapeutics. Some participants went to great lengths to establish the dispensability of medications in their ordinary life, and disclosed that they would try to manage any illness without seeking treatment. There are significant moral dimensions of using medications as reported in (Western) literature: dependence on medications can be deplored while non-dependence and managing without medications are applauded (Dew et al., 2015; Gabe et al., 2016; Murdoch et al., 2013).

I have proposed that, apart from a potential need to maintain self-autonomy with regard to medications, the participants were likely to be guided by an awareness of the limitations of resources available to deal with ill-health (e.g. money for treatment costs, time, care work). As such, seeking treatment and using medications would be reserved for illness events deemed very severe or to be of high priority. Children's illnesses were generally attended to without delay; while for adults, the perceived need for treatment was identified only in relation to illness-induced physical incapacitation. Through their highly delimited definition as to which illness(es) require therapeutic intervention, it appeared to me that the (adult) participants were quite unwilling to admit to being ill. Given their circumstances, being ill and needing to be taken care of would hardly be affordable for them.

It was also demonstrated that the maintenance of everyday life was a major concern in the households, which shaped their (non)use of therapeutics. Treatment was sought when ill-health threatened ordinary life; but treatment itself was frequently discontinued where it was perceived as a disruptor of the ordinary. In their financially precarious homes, it is necessary to ensure that a regular income is generated while also enacting the household chores and caring responsibilities on a daily basis. The (continued) use of medications was often perceived as interfering with such ongoing and incessant work of everyday life. Special adjustment(s) and accommodation(s) are often required in order to integrate therapeutic practices into the already established household routines, besides the potential addition to household expenses in the form of medical costs. As such, the immediate encumbrance of medication use on the whole household may outweigh the personal health benefits to be expected through using medications; in which case the latter would be discontinued or not resorted to at all. In this regard, therapeutic practices in households were shaped by the implicit need to maintain a fragile balance between health concerns and ordinary life.

In this section, I have tried to condense the exploration of household therapeutic practices in the present study into several principal findings. To summarise: therapeutic practices are diverse and they hybridise across therapeutic modalities; their being 'therapeutic' (or not) is not a given, but fluid and relational; they are organised around concerns of cost-effectiveness, as well as locally-relevant notions of risk and responsibility; and they are delimited by popular notions of therapeutic (in)compatibility, perceived (non)need for therapeutic intervention, and efforts to maintain ordinary life undisrupted by neither ill-health nor therapeutic practices.

Next, I retrospectively critique the theoretical framing of therapeutic practices ('tinkering') that was used in the present study. Reflecting on its success and limitations, I also present my suggestions in terms of developing a new complementary metaphor, so as to better capture the lived realities of therapeutic users in resource-poor settings.

Tinkering as metaphor: perseverance, adaptability, making adjustments

In the present study, I have conceptualised household therapeutic practices as care practices that involve tinkering with medications, bodies and technologies. This is based on Annemarie Mol and colleagues' work (Mol, 2008; Mol et al., 2015). According to them, care is a matter of "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2015, p. 14), and involves "a sticky combination of adaptability and perseverance" (Mol, 2008, p. 79). Mol and colleagues take into consideration the complexities and uncertainties of life which impact on (ill)health, the potentially ambiguous outcomes of care practices, as well as the fluidity of the notions of 'health' and 'good care'

across diverse contexts. As such, it is essential that care be understood as always-ongoing and incessant work through which a local and contingent 'good' is sought (Mol, 2008). Care practices also encapsulate, despite all efforts to the contrary, the possibility of failure, which, in different contexts, may involve deterioration of health and even death (Mol, 2008).

The metaphor of 'tinkering' in the above scholarship focuses on the minor but ongoing changes and adjustments through which people deal with their changing circumstances of life and (ill)health. This formulation, I believe, has been useful in the present study to shed light on the trends and nuances in household therapeutic practices in response to minor and/or everyday events of ill-health. Therapeutic practices, as I have described, are often adapted, calibrated, and 'tinkered with'. These changes and modifications point towards what the householders understand as 'good' in terms of care practices and health-related outcomes. For them, 'good' therapeutic practices involve cost-effectiveness, risk-management, compatibility (to one's body and lifestyle), and minimal impact on ordinary life.

On the other hand, the study also brought to light certain aspects of treatment seeking and related decision-making that contested the sense of doing minor adjustments implied through tinkering. I have reported that most households shunned the public hospital and opted for the private sector unless the treatment costs were very high, that cost-effectiveness was often prioritised over relational needs when dealing with a healthcare provider, and that delays in treatment seeking of adults were most often health trade-offs indicative of economic hardship. Such treatment seeking practices were explained as means of dealing with the everyday realities of a resource-poor and underprivileged community. Additionally, these practices involve significant and well-reasoned actions that may carry major impact: the forging of new treatment trajectories, the reworking of notions of 'good' to be sought, and the active reconfiguration(s) of the healthcare landscape. As such, the metaphor of 'tinkering', in its immediate sense of making minor adjustments, may fall short of capturing such trends in treatment seeking. However, the notions of perseverance and adaptability, which are likewise emphasised by Mol and colleagues in their work on care practices (Mol, 2008; Mol et al., 2015), continue to be applicable across the range of therapeutic practices discussed in the present study.

The limited success of the 'tinkering' metaphor when conceptualising treatment seeking activities, as I have noted above, may arguably be situated in the vast differences between the context(s) of its original use and that of the present study. Annemarie Mol and colleagues' work on care practices is largely based in European settings, where the everyday realities of life and healthcare landscape(s) would be worlds apart from those experienced by the householders in Pitawella village. In the former, with their vast resource base, potentially well-structured and methodical healthcare provision, greater accessibility of healthcare services and availability of (some) social security measures for the underprivileged, it is likely

that people's treatment seeking trajectories involve minor adaptations and deviations as implied by tinkering. In Pitawella, on the other hand, people appear to be fending for themselves when navigating the often-inhospitable spaces of their therapeutic landscape, and potentially forging unique treatment pathways in their aim to seek 'good' therapeutic outcomes against all odds.

Through such trends in treatment seeking, I have emphasised the ingenuity and creativity with which people manoeuvre the adverse circumstances by drawing on whatever resources they have. Similar creative adaptations have been recorded in the scholarship of Veena Das, which was also extensively drawn on in relation to the theoretical framing of the present study (Das, 2015a, 2020). Her interlocuters from poor urban neighbourhoods in India are faced with multiple oppressors in their everyday life, among them being severe poverty, social discrimination and events of ill-health. Given their unfavourable circumstances, it requires considerable and ongoing effort from the people to maintain normalcy in everyday life as well as the fragile balance of health. Where such balance is disturbed (e.g. by illness), greater effort is required to restore it to (at least some degree of) normalcy. Veena Das's ethnographies capture well the stupendous efforts directed towards maintenance/restoration of the ordinary (healthy) life, and the ingenuity with which people make do within their limited resources. This I feel closely approximates the treatment seeking practices I have identified above as defying the metaphor of tinkering.

As such, the limited success of the metaphor of 'tinkering' in the present study reinforces the epistemological concerns stated in chapter 2, in terms of the need for reworking conceptualisations from Western scholarship to reflect a more accurate and fair depiction of (therapeutic) realities in non-Western/postcolonial contexts. Given that 'tinkering' was quite productive as a metaphor, as I have demonstrated above, the best way forward may be developing a new metaphor to complement it. If I am to propose such a new metaphor based on the present study, I would draw from a common idiom in Sinhala language, *jeewithaya gatagaha-gannava*. Literally translatable as 'tying up one's own life', this idiom is a general reference to the painstaking efforts of people to make do within limited means in their everyday life. *Gatagaha-gannava* (tying up), therefore, indicates a sense of wrangling. I have explained how, given the deprivations of everyday life in a poor rural community as well as the many challenges of an under-resourced and inhospitable healthcare landscape, health seeking will feature careful deliberations as well as creative manoeuvring where people draw on whatever resources they have access to. The metaphor of *gatagaha-gannava* or 'wrangling' would, therefore, successfully capture these crucial aspects that escape the notion of tinkering.

In the following sections I take up various themes that run across different chapters of the thesis and discuss their significance and broader social implications. I also outline the practical relevance of the study in terms of informing social policy and public health initiatives in the country.

Knowledges, power and politics in/of diverse therapeutic modalities

The enaction of therapeutic practices sheds light on the diverse knowledges in relation to which these practices become therapeutic, such as professional or expert knowledges in the case of English medicine, or 'lay' experiential knowledges where Sinhala medicine is concerned. I also identified potential conflicts where dominant knowledges contest others, such as where the biomedical prescription subjugates traditional medical knowledges, and where a Buddhist doctrine is mobilised to invalidate the claims of supernatural therapeutics. Thus embroiled in diverse knowledges and their tensions of power, the enaction of therapeutic practices as 'being therapeutic' appears to be a political matter, in line with the notion of "ontological politics" (Mol, 1999).

Describing "ontological politics", Mol (1999) notes that "..reality does not precede the mundane practices in which we interact with it, but it is rather shaped within these practices." (p. 75). In the present study, the reality of care practices as therapeutic (or otherwise) varied across their different iterations within specific materially-mediated relationalities in the participant households. For instance, English medicine was therapeutic when prescribed, though it was toxic and risky otherwise; and *kalka* herbal tonics for infants could be either beneficial or harmful in a given household, depending on whether the householders subscribed to traditional medical and/or biomedical discourse. Where there is multiple possible 'versions' of reality, which 'version' of reality would be enacted in a given context is a political matter (Mol, 1999).

On the whole, the politics of household therapeutic practices were particularly notable in relation to the divergent social, historical and political significance of English medicine and Sinhala medicine within the country's therapeutic landscape. While Sinhala medicine has been embedded in Sri Lankan culture for eons, English medicine, too, is well-rooted in the therapeutic landscape and is in fact the most popular therapeutic modality in the country (Arseculeratne, 2002; Liyanage, 2000; Obeyesekere, 1976). Yet, despite the wide-spread use of English medicine in the community, the general approach of research participants towards English medicine was characterised by unfamiliarity and a resultant fear of the unknown. Most participants openly acknowledged their lack of knowledge regarding English medicine and were concerned about its potential effects on the body. Not being English literate, they could not even grasp the names of the pharmaceuticals they were prescribed, much less decipher a biomedical prescription. While they were comfortable with Sinhala medical preparations and tinkered with them as

they saw fit, the participants hardly ever took such liberties with English medicine (as discussed in chapter 8).

Literature demonstrates that biomedicine in the country has always been dominated by elite groups, from Europeans and English educated Sri Lankans during the colonial era (Uragoda, 1987), to those having high socio-economic status in more contemporary times. While biomedicine is vastly popular in the country, its historical legacy of marginalising the underprivileged appears to continue within the biomedicalised healthcare system, as reflected in the lived experiences of the research participants as poor and less-educated persons from a rural community. They were ill-treated at public hospitals; community health workers ridiculed and stigmatised them in public for following traditional therapeutic practices; and a biomedical practitioner rarely spent time to explain matters to them during a consultation, whereas the prescription in English was anyway unintelligible to them. (These issues are taken up again later in the chapter in relation to epistemic injustice.)

The packaging that biomedical pharmaceuticals are dispensed in, such as paper envelopes and plastic bags, provided ample evidence of the epistemic gap as was maintained in the homes. For, in most cases, essential information such as the medication's name and expiry date were omitted from the packaging, which was also a clear violation of the good practices of medication packaging and labelling (Athuraliya et al., 2016). Where such information is not made available to the medication user and no apparent effort is made to alleviate their medication-related concerns by the healthcare provider, as was reflected in the participant narratives, it is not surprising that people regard biomedical pharmaceuticals as unfamiliar and risky substances.

As opposed to the 'foreign-ness' of biomedicine, Sri Lankan popular culture constructs Sinhala medicine, with its traditional knowledge base, as being local and national. This popular construction has been historically mobilised as a rallying point for anti-colonial nationalist groups calling for postcolonial government reforms (Arseculeratne, 2002). Given its political motives, the nationalist discourse on Sinhala medicine however glosses over the predominance of Indian Ayurvedic content in its therapeutic repertoire, which has even led to its being officially termed 'Ayurvedic medicine' in the official healthcare framework regulated by the Ministry of Health. Similarly overlooked are the many convergences between Sinhala and English medicines that are observed in academic literature, in terms of people's usage of therapeutics, practitioners' therapeutic eclecticism that hybridises the two therapeutic traditions, and the 'indigenisation' of the biomedicine in Sri Lanka over the years (Obeyesekere, 1976; Waxler-Morrison, 1988; Waxler, 1984).

Being thus constructed as local and national, and having been practised widely for ages in the community, Sinhala medicine exudes a greater sense of familiarity for the participants of the study.

People comfortably use traditional medical terminology and mobilise traditional therapeutic knowledges to prepare remedies even without the guidance of a practitioner. The popular narratives of naturalness and benevolence of herbal remedies have led to their being perceived as posing very low risk in the household, contrary to the popular perception of English medicine as dangerous. I pointed out previously that this air of benevolence is extended even to commercially manufactured (allegedly) herbal remedies, so that there is a high level of self-medication with all kinds of Sinhala medicine in the household.

As such, the findings of the study indicate that everyday therapeutic practices are enmeshed within the relationalities of diverse knowledges and power in the contemporary therapeutic landscape. They reflect social, cultural and political characteristics that have emerged through and/or been shaped by the country's colonial history, nationalism and hierarchical social structures.

Implications of Buddhist religiosity in/on the study

Buddhist religiosity was a constant undercurrent in the present study and was discussed in relation to the themes of various chapters. To recapitulate, all the participants of the present study self-identified as practising Buddhists. I come from a Buddhist background myself, which enabled me to understand, and at times even engage with, the religiosity that they expressed. The participants evoked Buddhist notions at various points in the research process. In addition, Buddhist teachings were frequently woven into the participants' sense making efforts when discussing matters of health and illness, and these potentially shaped their treatment seeking trajectories as well. Here I bring together the various iterations of a Buddhist perspective throughout the study, to consider its overall relevance.

At the outset, when I approached the people in Pitawella as potential research participants and invited them for household interviews, I presented my request along the ethnographic tradition of learning from the participants (Spradley, 2016). Accordingly, I requested their help for me to learn about their health-related experiences. (The process was elaborated in chapter 3.) This request was situated, by the potential participants, in relation to the Buddhist teachings that encourage helping others. Many of them voiced the idea that helping others was *pin*, i.e. a meritorious deed that can contribute to future betterment of the enactor. Helping becomes a meritorious act through the notion of *dana* or giving, which is one of the most celebrated *pin* in Buddhism. It appeared that the participants approached the research process as an opportunity for *dana*, where they would be giving me the knowledge that I sought, and in return they would gain *pin*. The preoccupation with accumulating *pin* for future wellbeing is noted as a popular trend among contemporary lay Buddhists. It is characteristic of what has been identified as "Kammatic buddhism" (Spiro, 1982), where people focus more on getting a good rebirth

after death, as opposed to the lofty goal of ending the cycle of rebirth to reach *nirvana*, as advocated in the Theravada Buddhist canon.

Pin or merit is accumulated through good *karma* (deeds) and is believed to lead to future wellbeing, both in this life and in the following ones. Conversely, enacting bad *karma* can lead to similarly negative outcomes (Rāhula, 2017). Karmic causality, in fact, is a popular lay rationale that people often resort to in order to make sense of occurrences beyond their control (de Silva, 2006; Levy et al., 2009; Obeyesekere, 1985). As discussed in chapter 5, some participants made sense of their undiagnosed and chronic illness as potentially caused due to bad *karma* from a previous life. Buddhist canon states that karmic consequences (both good and bad) cannot be avoided unless there are specific circumstances that may override the *karma* (Rāhula, 2017). In popular lay reasoning, however, it is the inevitability of bad *karma* that is emphasised. Further, the belief that illness was caused as a consequence of bad *karma* would create a sense of personal accountability for one's misdeeds through illness-induced suffering. Accordingly, it would facilitate acceptance of and resigning oneself to the inevitable. Additionally, I demonstrated how a religious devotee may feel a moral obligation to undergo ill-health as a way of atoning for ones' bad *karma* so that they may be unwilling to alleviate their illness-related suffering, thus potentially rejecting therapeutic practices aimed at improving health (chapter 5).

When discussing events of illness and resultant suffering, participants made frequent references to *duka*. Variously translatable as sadness, misery or suffering, the term *duka* (*dukkha* in Pali language) in Buddhist discourse has specific reference to the recurrent cycle of birth and death. It is said that all beings are trapped in an endless cycle of life where they are born, grow old and die, and are reborn. Every stage in this cycle is imbued with *duka*: meaning continual change and the affect associated with it (Rāhula, 2017). As a popular religious reference, however, *duka* is limited to the suffering and the negative experiences of change, illness and decay. Where illness is considered *duka,* it therefore captures the ongoing element of change in life that brings about ill-health, as well as the physical and psychological suffering that is experienced through illness.

Buddhist religiosity was a key element in certain therapeutic practices undertaken by participants with an aim to seek improved health. Religious methods, in fact, are often included as popular practices in Sri Lanka's therapeutic landscape (De Silva, 2015; Gombrich & Obeyesekere, 1988; Hettige, 1991; Seneviratne & Wickermeratne, 1980). In the present study, *bodhi puja*, the veneration of the sacred Bo tree, was the most frequently reported religious-therapeutic practice, where the blessings of the Buddha and the gods were called upon a sick person. Regular rituals of veneration were also reported as being of therapeutic value to some participants (chapter 4). In addition, some participants mobilised certain idiosyncratic religious beliefs towards seeking a more 'personalised' health outcome (chapter 8).

Religious practices when performed with a therapeutic aim, function at several levels. They, as systematic rituals, are expected to calm one down, while faith in the restorative potential of religious methods may relieve the anxiety associated with illness. As a more direct intervention, the practice of *bodhi puja,* in its contemporary version, involves seeking blessings from the Buddha and the gods towards a speedy recovery. It is most often performed by multiple others on behalf of a sick person, who add their good wishes to the blessings being evoked. On a cosmic level, engagement in religious practices as good *karma* may balance out any illness-inducing bad *karma* and bring about an overall improvement of health. Therefore, the possibility of seeking improved health through religious methods, in fact, attests to the multifaceted nature of (ill)health as conceptualised from a Buddhist worldview, as encompassing physiological, psychological, social, spiritual and cosmic dimensions.

Healthcare landscape and treatment seeking

In exploring the treatment seeking practices of householders, the present study shed light on treatment trajectories, treatment-related decision making, and the healthcare landscape as a whole. The participants' lived experiences pointed to numerous shortcomings affecting the public and private sectors of healthcare provision, which often had considerable impact on their treatment seeking. These findings, which demonstrate how and where the existing systems fail to provide effective and efficient services, would be of immediate practical relevance for health policy development in the country.

In this section, I discuss the following themes: delay in treatment seeking, issues in healthcare provision, and epistemic issues faced by treatment seekers who access (biomedical) healthcare services. Based on these, I offer some recommendations as to changes that I believe would make a positive difference in the healthcare landscape for people such as those who participated in the present study.

Therapeutic engagements, delay and 'active waiting'

The present study contributed to an understanding of therapeutic practices as temporally organised. Time elapsed since initially perceiving illness symptoms and the relative improvement or deterioration of health during the period, were identified as crucial determinants of whether the condition requires therapeutic intervention or not. It was the common practice to 'wait and see'. In most illness events, an initial self-administered remedy is followed by another period of time during which the efficacy of the remedy, and the need for further – potentially professional – healthcare, would be gauged.

Research findings in Sri Lanka point to how these waiting times would vary based on different circumstances. To illustrate, similar symptoms experienced by persons of different socio-economic

backgrounds could be attended to in different ways. High alertness to personal health may prompt treatment seeking without delay, as would the encouragement from one's family and acquaintances (Liyanage, 2000). In the events of children's illnesses in particular, mother-carers are reported as seeking professional healthcare with little delay (de Silva et al., 2001). On the other hand, where financial and social responsibilities take precedence over personal health concerns, the delay in seeking treatment could be prolonged, potentially even exacerbating the health issues (Liyanage, 2000). These findings were corroborated through the present study as well.

Waiting has been noted, in global literature, as a part of the process of accessing healthcare, particularly where the poor and the marginalised are concerned. Such people are made to wait more often and for longer than others when seeking various social and healthcare services, through which they experience helplessness and frustration (Auyero, 2011; Lee et al., 2020). Waiting may be perceived, by those who wait, as a "game" where the rules are not known and often inconsistent, so that there is an oppressive sense of uncertainty (Lee et al., 2020). Similar negative experiences were related by participants in the present study in relation to public hospitals. They spoke of long waiting times to access healthcare services, and of being verbally abused and ill-treated by hospital staff while waiting.

The long wait list for surgeries at the public hospital was also mentioned in the study. I indicated, in chapter 6, that the principal reason that motivated seeking public sector 'free' healthcare was households' concerns about the cost of treatment in the private sector. This was particularly the case with regard to in-patient treatment and complex therapeutic interventions of which the cost would be unaffordable to them, such as surgeries. This, in fact, mirrors the island-wide trend of high utilisation of the public sector services for in-patient care (*Annual Health Bulletin 2017*, 2017; *Annual Health Statistics 2019 Sri Lanka*, 2021). To recapitulate the experience of one participant, she was recommended an urgent surgery of the thyroid gland, though, due to the exceedingly high number of patients awaiting similar surgeries, the earliest available date had been three years away. As described in chapter 6, her household had drawn on their social contacts and secured a date within a few months for the surgery. While there may be persons who can 'wrangle' their way to cut down the wait times, there would be countless others who do not have such means at their disposal. They would therefore be obliged to wait even for years for their medical appointment, regardless of potential deterioration of health brought on by the prolonged wait.

Writing of the events of waiting performed by the poor when accessing healthcare in the USA, Lee et al. (2020) point out how such waiting is necessitated by reasons beyond their control, though people very often would try to manage, negotiate and navigate the wait-times so as to result in as satisfactory an outcome as possible. In view of how persons survive and negotiate wait-times within their limited

capacities, Lee et al. (2020) suggest “active waiting” as a better alternative to the term “delay”. In the present study, instances of “active waiting” can be gleaned from narratives of treatment seeking in the public hospital. Most householders experienced the public hospital as inefficient, paternalistic and as involving long wait-times, yet they made use of whatever means available to circumvent such systemic disadvantages and to obtain health services in as short a time as possible. However, given the limited means available to the poor, the manipulation of wait-times would likely result in numerous trade-offs (Lee et al., 2020). In the study, for example, there were relatively long periods of ‘wait-and-see’ before deciding to seek professional therapeutic treatment for sick adults, whereas treatment was sought much sooner for children. These differential patterns of treatment seeking for adults and for children are indicative of context-dependent trade-offs between costs of treatment and good health.

Issues in the provision of healthcare services

In terms of the public sector, inefficiency of service, overcrowding and resource limitations were among the frequent criticisms voiced by the research participants. In Sri Lanka, much of the challenges faced by the public health services could arguably be traced back to the inadequacy of government investment, which currently stands as low as 1.8% of GNP (*Annual Health Statistics 2019 Sri Lanka*, 2021). The low allocation of funds to peripheral hospitals, such as the one in Neluwa, potentially exacerbates these issues in such contexts. I have shown how the lofty ideal of ‘free healthcare’ is being undermined in a rural hospital through chronic medicine shortages, thereby denying the benefits of the national health policy to the poor and the underprivileged who need it the most.

Participants also reported being subjected to ill-treatment and neglect at public hospitals. The rigid institutional processes discriminated against the poor and the low-literate, whereas those who had the means and/or the know-how would successfully navigate or circumvent the system. Narratives of treatment seeking featured negative experiences such as being ignored, verbally abused and even facing aggression from hospital staff. Patient-care related issues that undermine the public sector services have been identified in previous studies as well (Perera et al., 2018; Russell, 2005). It became apparent through the present study that such issues often dissuaded householders from seeking public health services, unless as a last resort.

The study also identified, in relation to community pharmacists, numerous pharmacy practices that violated government regulations on good pharmacy practices. These included dispensing restricted category medications without a medical prescription, filling expired prescriptions, and inadequate labelling. As such, these have been reported as widely prevalent in the country, and are associated with inadequate enforcement of government regulations (Sakeena et al., 2019; Zawahir et al., 2019).

However, such pharmacy practices often appeared to be closely entangled with the provision, to the community, of increased flexibility and convenience of accessing medications on their own terms, and this *was* evidently the main attraction of community pharmacy services.

Similarly, there were ethical concerns in relation to private medical practices, which were not always remarked upon as problematic by the participants. Many such issues involved practitioners who were employed full-time in the public sector and worked in the private sector in their spare time. There were, for example, practitioners who were careless when working in the public hospital but very attentive to patients in their private practice, and even some who openly encouraged patients to see them at their private practice instead of at the public hospital. While it was understood that such practices of doctors were motivated by self-interest, the participants pragmatically reasoned that it meant the provision of high-quality and/or patient-centred services in the private sector. Where public healthcare was no longer truly 'free' nor comprehensive due to resource shortages, the cost of (fee-levying) private services may be a worthwhile trade-off in view of their (perceived) superiority. In fact, this was a principal reason that induced a majority of the participant households to regularly seek the services of private practitioners.

Epistemic issues affecting treatment seeking experiences

As revealed in the present study, there were significant knowledge deficits in the participant homes in relation to the biomedical pharmaceuticals that the householders used. I have shown that the inadequacy of medication-related information contributes to sustain the community's lack of knowledge about English medicine, reinforcing the heightened sense of risk and fear that householders associate with English medicine.

It appeared that inadequate labelling, meaning the omission of essential details such as the name of a pharmaceutical, its date of expiry and usage instructions, was the norm rather than the exception when dispensing medications. In this regard, it is not the community pharmacies alone that are to blame: most of the private biomedical practitioners also dispense medications and their labelling practices were often similarly faulty. Such labelling inadequacies, or more generally, neglecting to explain the diagnosis and/or the treatment process to the 'patient', point to the enaction of gate keeping by healthcare providers to biomedical knowledge. For, being conscious of their own lack of knowledge, the participants had to rely on doctors' or pharmacists' epistemic authority to navigate the (perceived) toxicity and risks of English medicine. This therefore further solidified the status of biomedical knowledge as expert knowledge unavailable for the public.

Such gate-keeping practices as described above maintain the status quo of power imbalance that characterised the treatment seeking experiences of the participants, thereby feeding into the 'epistemic injustice' in healthcare settings (Carel & Kidd, 2014). Epistemic injustice refers to "a distinctive class of wrongs, namely those in which someone is ingenuously downgraded and/or disadvantaged in respect of their status as an epistemic subject" (Fricker, 2017, p. 53). Much of the experiences of treatment seeking as narrated by the participants of the study, even those that they themselves may consider as normal, involved being patronised and marginalised (by healthcare staff) on the basis of their being less educated and lacking biomedical literacy. This was especially notable in public hospital settings.

There were, for example, many events of misdiagnosis followed by prolonged ill-health and suffering. People lamented that their ill-health complaints were not taken into account by the practitioners and, as a result, they were not sent in for diagnostic procedures nor provided with adequate care. Such experiences recounted in the study resonate with the notion of 'testimonial injustice', which Fricker (2017) identifies as one form of epistemic injustice. In healthcare settings, patients could be dismissed as not credible in their knowledges, their lived experiences of ill-health considered "irrelevant, confused, too emotional, unhelpful, or time-consuming" (Carel & Kidd, 2014, p. 530). Similarly, the people in Pitawella were largely ignored in their health concerns, belittled and generally subjected to ill-treatment at the public hospital. This, I would suggest, reinforced in them a sense of their own inferiority: they were well aware that people who were educated, English literate and otherwise sophisticated as is characteristic of a high socioeconomic status, would never have been dismissed nor ill-treated as they regularly were.

'Hermeneutical injustice', though closely related, is more of a matter of lay articulation of illness/health being incoherent with the established biomedical discourse (Carel & Kidd, 2014). In the present study, for example, the householders very often drew on Ayurveda-inspired ill-health idioms such as *ushna* (hot), *seethala* (cold), *visa* (toxic), *sara* (harsh), as well as traditional medical illness categories such as *sema* (phlegm), *pinas*[144] and so on. It is clear that these articulations are incommensurable with a biomedical point of view, as has been demonstrated in previous research findings in the country (Sachs, 1989). Transcending such a hermeneutical gap, however, is not impossible: it calls for "especially virtuous epistemic and communicative conduct" (Fricker, 2017, p. 55). I have described, in chapter 4, a case where the biomedical practitioner had explained the functionality of arthritis medication deriving from a metaphor of supernatural healing. This had enabled the 'patient' to understand (and later explain to me

[144] A condition characterised by excessive phlegm in the body, which encompasses symptoms of "catarrh, sinus, tonsillitis, hay fever, and asthma" (Obeyesekere, 1976).

during the household interview) very clearly how the treatment worked and also its limitations, thus successfully bridging the hermeneutical divide.

Epistemic injustice is theorised as being unintentionally enacted in a given setting, as opposed to being a deliberate means of enforcing someone's inferiority on the basis of a knowledge differential. Accordingly, such incidents most often point to deep-rooted social and structural prejudices, which are mirrored in interpersonal relations (Fricker, 2017). Sri Lanka, as a country, has a traditionally hierarchical society, where structural inequalities and wealth disparities manifest as social segregation in terms of wealth, ethnicity, religion, level of education, and even English literacy (Gunasekera & Rajapakse, 2005; Wickramasuriya, 2005). As such, the epistemic injustices that the participants face during their treatment seeking trajectories have become, more or less, normalised.

To summarise, the findings of this study on treatment seeking as undertaken by the participants shed light on the structural and epistemic issues, the scarcity of resources and technologies, as well as the inherent tensions between biomedical and traditional therapeutic knowledges in this postcolonial therapeutic landscape in the Global South. Given these manifold complexities and constraints, treatment seeking becomes a matter of 'wrangling': it takes considerable ingenuity and pragmatic manoeuvring in order to seek 'good' health outcome(s) against all odds. (I take up some of these practices again in relation to their ethicality, later in the chapter.)

Issues identified and some recommendations

I have observed, throughout the thesis, that people do their best to seek 'good' health outcomes despite the odds, but that it often requires working around or even against the systems in place. This demonstrates the significant gap between the current nature, scope and organisation(s) of healthcare services and the actual needs of the people. From a health and social policy perspective, the findings of the study point to areas where the existing healthcare system has failed the people. They also signal potential issues that may affect the success of public health initiatives that aim to uplift health and quality of life of (rural) Sri Lankans. Substantial changes in the healthcare landscape would be called for in order to improve on these long-standing concerns, some of which I point out below.

There are numerous issues to be addressed in relation to public sector healthcare provision, as reflected in the participants' experiences. Public hospitals are not equipped with adequate resources to serve the people effectively and efficiently. In addition, rigid procedures in hospitals curtail the possibility of offering patient-oriented services. It is very unfortunate that the poor and the underprivileged, who would have benefitted the most from fully subsidised healthcare, are being driven away from the public

hospitals to the fee-levying private sector in search of more efficient and convenient services. Various scholars have recommended increased state investment, as well as redistributing and streamlining the available resources, in the public sector (Kumar, 2019; S. Perera et al., 2019); and through the findings of the present study, I strongly support such recommendations.

While the private sector appears more popular than the public sector, experiences of treatment seeking highlighted significant issues there as well. Private healthcare provision in Sri Lanka lacks proper regulation, and the present study pointed to complex ethical issues that can arise due to profit-orientation among practitioners. They were reported as catering to the demands of treatment seekers for more flexible services delivery, multi-modal treatment and/or quicker resolution of illness symptoms, which has led to their high popularity among the people. Yet it is questionable whether these practitioners consider potential health repercussions and the long-term quality of life of the treatment seekers when prescribing medicine, and whether some of them even fulfil the qualifications required under the country's existing regulations to work as a therapeutic practitioner. I have also pointed to risky pharmacy practices such as dispensing prescription-only medicine without prescription, inadequacies in labelling and giving medication-related information at community pharmacies. By introducing timely amendments to the existing regulatory framework on private healthcare services, and ensuring that they are properly enforced, many of the issues affecting private healthcare services could potentially be resolved.

A major concern in the biomedical healthcare provision which is not duly identified, is the high degree of paternalism and the massive and unbridgeable knowledge/power differential between the practitioner and the treatment seeker. In the present study, the participants were largely low-educated and poor persons from a rural community. Their treatment seeking experiences vividly depict how they were belittled and spoken down to in biomedical spaces, their health concerns often dismissed, and that they were not offered the information necessary to understand the biomedical diagnosis of their condition(s) nor their medications. Public health workers who visited their homes were dismissive of traditional care practices that the community valued highly, and even humiliated them for following such practices. It appeared that these people were very rarely offered a reasonable explanation of their health concerns by a health professional, and the few such instances reported in the study indicated a strong willingness on their part to grasp new knowledge and ways of making sense of (ill)health matters. It is regrettable, therefore, that most often health professionals seemed to expect blind conformity and compliance from these people, without taking the effort to educate them as to the biomedical and/or public health rationale involved. As demonstrated in the study, some people would simply follow the paternalistic dictates; but there were others who would question them and resist.

If considered from a lens of epistemic injustice (Fricker, 2017), the generally discriminatory approach towards the underprivileged may be due to unconscious prejudices of healthcare professionals. Accordingly, there is a tremendous need for educating health staff across the public and private sectors on providing a more equitable and higher quality service to all patients regardless of social status. People, particularly those from underprivileged communities, should be informed of their rights and entitlements as treatment seekers, and of remedial actions available to them in case those were not upheld. A practical measure in this regard would be to appoint a group of 'health liaison staff' per district, to act as intermediaries between the people and the healthcare system. They can support people in navigating healthcare services as well as advocate on their behalf if/where required. In addition, people need to be encouraged to seek information on their health concerns, and it is up to the health professionals, in their position of power and privilege in the medical setting, to facilitate patient education. These measures would very likely prove challenging, given the normalisation of biomedical paternalism in the country; yet I believe they are essential in order to make a positive and lasting difference in the healthcare landscape.

The next section presents my concluding reflections on household therapeutic practices. I comment on their diverse personal, social and ethical entanglements, drawing on the work of Veena Das (Das, 2012, 2020) in terms of the ethicality of ordinary life. In the final section that follows, I suggest potential directions for future research.

Therapeutic practices as entwining the personal, the social and the ethical

Therapeutic practices are, in essence, attempts at attaining and/or maintaining 'good' health: their 'good' being local and context-specific. They are most often responses to ill-health symptoms that appear in one person's body, and often involve intensely personal actions enacted on/into the body, such as ingestion (of pharmaceuticals or potions), application (of lotions, balm), inhalation (of steam, medicinal vapour) and so on. Further, one needs to accommodate such actions in one's everyday life, by making space and time for them and ensuring that they are not forgotten amidst the ongoing events of ordinary life. As explored in the present study, therapeutic practices are often 'personalised', as it is understood that an efficacious cure should 'agree with' one's body and living circumstances. Further, there is no one universal cure that works for everybody: therapeutic outcomes are local and situationally contingent, as well as geared towards the needs of individual sick bodies (Mol, 2008; Mol et al., 2015).

While their 'personal' element is undeniable, therapeutic practices in the home essentially appear as social activities that are realised through the involvement of multiple householders. Medications, once they reach home, need to be stored and administered/used appropriately, which signal domestic

therapeutic responsibilities. This work, as noted in the present study, is most often taken up by women in the household, and more generally by adults. Children are also encouraged to enact 'responsible' behaviour with regard to medications. Often therapeutic practices were enacted on behalf of a sick householder(s) by others who facilitate the therapeutic process by procuring medications and encouraging them to continue following the therapeutic regime. They may ease the sick person's life by taking over their daily chores. Therapeutic practices may also be enacted by others on behalf of a sick person, without any involvement on the latter's part. Some examples found in the present study include *bodhi puja* (veneration of the Bo tree) being held to invoke divine blessings or getting someone's horoscope read to check for potential maleficence and carrying out the prescribed activities with a therapeutic intention.

Household therapeutic practices, particularly in a close-knit community as in the present study, may often seep out of the home and into the community. I have remarked on how the health and illness of the household was generally a communal matter, being discussed openly and freely with one's neighbours, so that the household interviews at times had to be expanded to include neighbours who were paying a social visit (in chapter 3). The common practice of discussing health issues with the neighbours and sharing each other's experiences had created a rich repository of therapeutic knowledges in the community. Such knowledges were very often made use of when making therapeutic decisions in the home, as was demonstrated in the study.

Love and caring attention from others can be a significant influence towards the enaction of therapeutic practices and their satisfactory outcome(s). As evident through the literature, this is particularly the case for the chronically ill who are expected to carry on medication practices throughout the rest of their lives. The concern of significant others in the family, as well as the responsibilities that one feels obliged to shoulder on their behalf would motivate a person to carry on with therapeutic practices in order to live a good, or at least a useful, life for as long as possible (Wilson, 2007). Where overt approval is absent, even the knowing silence of loved ones in relation to unorthodox and potentially risky medication practices could serve a similar purpose of encouragement (Haafkens, 1997).

On the other hand, the dynamics of therapeutic practices may severely impact the very social fabric of the community, as I demonstrated through relationship conflicts potentially emerging in and across households due to incompatibilities of therapeutics usage across generations. To illustrate, elderly householders were often critical of younger persons who they perceived to be following the fashionable practice of seeking biomedical treatment instead of Sinhala medicine. They could not come to terms with the disinclination of their grown-up children to follow the traditional therapeutics that they themselves value highly. In this regard, therapeutics use becomes intensely politicised when interpreted as declaring

allegiance to a certain way of life. Navigating such conflicts calls for attentive care and consideration, as well as tinkering with one's own practices so as not to hurt the feelings of a loved one who is different-minded.

Ordinary ethics in therapeutic practices

Sensitivity and attentiveness to others' wellbeing, as manifested in instances of navigating and resolving conflicts that emerge around incompatible therapeutic preferences, align with "ordinary ethics" as conceptualised by Veena Das (Das, 2012, 2020). To recapitulate, Das's notion of the ethics in ordinary life, or "ordinary ethics", requires approaching the ethical as situated in and arising through everyday living itself, as opposed to a universal framework of ethics that is applied to evaluate life events (Das, 2012, 2020). In this light, ethicality involves "a descent into [the ordinary] as a way of becoming moral subjects" and "cultivation of sensibilities *within* the everyday" (Das, 2012, p. 134, original emphasis). Accordingly, it follows that ethics of ordinary life are necessarily situated and local, so that the ethical dimension pertaining to a given context needs to be teased out through how an ordinary life event is lived by ordinary people.

I would like to explore how, as practices in everyday life, therapeutic practices mirror the "ordinary ethics" of the rural low-income community of Pitawella. The care, concern and sensitivity towards one another's wellbeing, as discussed above in relation to the household and the community, captures the essence of therapeutic practices presented in the study. On the other hand, there were stories of neighbours inflicting harm and ill-health on a household due to feelings of jealousy or enmity. In such cases, the alleged perpetrators were accused of doing *adurukam* (sorcery) or even unleashing *as-waha kata-waha* ('evil eye, evil mouth') on someone, so that the latter falls ill or faces some serious misfortune. More often than not, such events were followed by retaliations of a similar nature and/or acts of open hostility by the victimised party. Therefore, whether well-founded or not, the suspicion or allegations of such (unethical) acts in the neighbourhood tends to erode cordial relationships and damage the social fabric of the community.

I have argued that the householders constantly 'wrangle' to achieve as satisfactory an outcome within their limited economic means. Their treatment seeking trajectories, too, are underpinned by currents of ethicality. People choose the most cost-effective treatment alternative(s) available in order to minimise the treatment costs. They seek out the quick-and-easy cure, so as to get better soon and not allow ill-health related disruptions in their everyday work and earnings. For them, these actions and choices make perfect sense, and in fact, are often the only possible courses of action to maintain the fragile economic balance in their households. In this light, treatment seeking efforts as painstakingly tinkered with within

a limited budget, are indicative of "..the labor of bringing about an eventual everyday from within the actual everyday" (Das, 2012, p. 134).

It is only through attentiveness to cost-effective treatment that most participants could fit the treatment-related costs into the fragile household economy already burdened with regular expenses of the household, schooling and so on. And where even a minor affordance towards improving health was not possible, there would be a trade-off between health and other - more immediate - concerns. This was voiced by one woman as, "I don't get ill". In this light, the delaying of treatment seeking, which was a common practice among adults, can be seen as at least partially economically motivated. It is also important to note that such trade-offs were not usually done in relation to children's ill-health, where treatment was most often sought promptly and with less concern for cost than for quality of treatment. To illustrate, the healthcare provider popularly sought for children's illnesses charged a relatively high fee, yet parents preferred him because his treatment was said to be mild on the body as well as effective. Therefore, the divergent trajectories of treatment seeking for adults and children reflect the "ordinary ethics" by which a tenuous balance is brought about, in each case, between economic and health concerns.

Householders' frequent practice of discontinuing medications without completing the prescription, as was suggested in the study, could also be situated in their sense of the ethical and the moral. When discussing this practice, I drew on Western literature that demonstrates perceived dependence on medications and the resultant loss of self-autonomy as being significant moral concerns for medication users (Dew et al., 2015; Gabe et al., 2016). I also argued that the primary ethical/moral concerns of treatment seeking for the householders in the present study may potentially deviate from these findings. Given the normalisation of biomedical paternalism in their therapeutic landscape and the epistemic injustices that they regularly faced in healthcare settings, those who sought treatment often appeared to be docile and resigned. As such, the participants did not complain about being dependent on medications nor of losing self-autonomy, yet they were very keen to get rid of the medications as soon as possible, which nonetheless would imply a desire to relinquish the therapeutics' hold over their lives.

A significant moral concern that *was* identified in the study involved the perceived need for therapeutic interventions. Previous research (in Western societies) point out that long-term medication users often tried to construct themselves as 'deserving' of their medications, since 'undeserved' use or over-use was looked upon as an indulgence and as being morally wrong (Gabe et al., 2016; Polak, 2017). A similar approach to therapeutic practices was found in the present study, where many participants associated a need for therapeutic use with severe physical incapacitation that may prevent them from working and getting on with their ordinary life. I also argued that, in this context, the moral concern of being a

deserving user was also entangled with the economic concerns of their resource-poor homes: it was not 'right' to spend money and time on therapeutic treatment unless it was absolutely necessary to do so, since there would always be other, more immediate, matters to spend these scarce resources on.

In addition, navigating within the limited resources available to the householders may also give rise to what may be potentially unethical. As discussed previously, treatment seeking in the public hospital often involved negative experiences of ill-treatment, neglect and depersonalisation. However, there are persons who 'wrangle' their way through the oppressive system in an effort to seek a better outcome. Examples include pestering the hospital staff, jumping queues, or mobilising one's social contacts. If viewed by a person who conforms to the hospital system, such behaviour would be unethical, as it involves usurping the opportunity of another 'patient'. However, it is not as easy to evaluate the ethicality if, for example, someone circumvents the system where the wait-list for an urgent surgery requires a wait of over three years, and the prolonged wait is bound to deteriorate their condition. As Das (2012) put it,

> … it is, thus, not a matter of eliciting opinions about what behavior is considered ethical or unethical, or of cataloguing cultural practices on which we can bring judgment from an objective, distant position but rather of seeing how forms of life grow particular dispositions. (Das, 2012, p. 136)

Therefore, the manifold moral and ethical concerns of therapeutic practices, as discussed so far, are given rise to within the concrete and local relationalities of ordinary life as lived in the rural households in Pitawella, and should be made sense of in that context.

Looking ahead: Future research directions

In conclusion, I would like to note several avenues for research which can be identified through the present study. These hold much promise though I have not been able to do them justice in my thesis, and future studies could potentially explore them further.

Gendered care work in the household

One potential line of inquiry involves the gendering of care practices in the home. The present study pointed to therapeutic practices in the household as potentially gendered work, particularly in relation to the women's responsibility towards the storage and management of medications within the home (chapter 7). The gendering of responsibility was also manifested during fieldwork. In the household

interviews on care practices, it was the women who dominated the discussion, and there were several homes where only women took part; whereas the men tended to avoid participation or remained relatively silent throughout. While it was certainly not the case that men were never involved in therapeutic practices, their engagement was often downplayed during interviews, by both men and women participants. I have suggested that this could be a way of projecting household healthcare work as woman's work, and thus to be in conformation with the gender norms upheld in the community (chapter 3).

Gendering of household care work is, in fact, supported by the findings of studies carried out in other countries (Bird & Rieker, 2008; Hunt et al., 2010; Saltonstall, 1993) as well as of recent studies on women's household work during COVID-19 in Sri Lanka (McLaren et al., 2020; Meegaswatta, 2021). In addition, women often being the main caregivers for children in Sri Lanka, they shoulder the bulk of responsibilities in relation to the health and wellbeing of the young. As such, women's understandings of health-related risks have been reported as significantly shaping the treatment seeking trajectories for children (de Silva et al., 2001). Future studies could further explore the implications of gender-based division of care work on the household. Some possible aspects would be the construction of health and wellbeing practices as women's work, children's gendered engagements in care practices, and the (dis)continuity or evolution of gendered care work across generations.

Community involvement

Another potential area for future research is the involvement of the community in illness and health concerns of the household. Through this study based on a tight-knit village community, I have commented on the intimate involvement of neighbours and friends in health-related matters of the household. To illustrate, participants of the study often discussed their illness and health seeking experiences openly in the presence of non-householders, even inviting the latter to join in research interviews that were meant to be for the householders only. In addition, participant narratives highlighted frequent sharing of health-related information in the community, and seeking help from others to facilitate health seeking efforts. During fieldwork, it was mostly women who enthusiastically participated in the research interviews that I, also a woman, carried out; and I was struck by the warmth and solidarity among the women, which they (at times) generously extended to me as well.

Given the confines of a doctoral study, I was not able to explore in sufficient detail these very promising aspects of community life in their relation to concerns of illness and health seeking. Future research, I hope, would explore their significance. I would particularly recommend studying the mobilisation of informal communal networks as a resource to facilitate 'wrangling' of health in resource-poor settings,

and the (potentially gendered) relations of solidarity among community members that strengthens the communal network.

Health seeking as 'wrangling'

In terms of theoretical development, the present study used a socio-materialist and ethnographic framework with a view to maintain a sustained focus on therapeutic practices as being ongoingly shaped within the ordinary life as it unfolds in participant homes. In particular, I used the notion of 'tinkering' (Mol et al., 2015) to set up care practices as involving perseverance, attentiveness and minor adaptations. However, there were aspects of health seeking discussed in the present study that could not be captured effectively through 'tinkering', due to which I have proposed a complementary metaphor. In this regard, I drew on the popular idiom in Sinhala language, "*jeewithaya gatagaha-gannava*", for which an approximate English term is 'wrangling'.

This new metaphor was an attempt to conceptualise more accurately the health seeking practices in a resource-poor context, where people may have to creatively manipulate whatever means at hand in order to secure a 'good' health outcome. While I have proposed 'wrangling' as a means of making sense of health seeking practices beyond 'tinkering', future research in similar settings could explore its productivity as a metaphor and develop it further. I have noted that wrangling practices could give rise to ethical concerns, which also holds potential for insightful research.

Towards more decolonial research

Finally, the present study advocates a decolonial approach in future research, particularly with regard to studies carried out with local/indigenous/postcolonial communities. In chapter 2, I explained my epistemological concerns as a non-Western researcher working in Western academia whose research is based in my own country. It should be acknowledged that I was inspired by the decolonial trends sweeping through my host university - a Western research institution in the settler colonial state that is Aotearoa New Zealand.

There being hardly any mainstream theoretical work from the Global South that was applicable for my study, I faced the challenge of adapting conceptual framework/s developed in the Western societies to the context of my study. In doing so, I was also informed by decolonial/postcolonial scholarship which critique Western scholarly traditions' tendency to construct the postcolonial/non-Western as the 'other'. Consequently, I opted for an ethnographic approach that would permit an intensive engagement with the lived realities of the participant community. In retrospect, I have identified that the study's

conceptual framework could be further improved to better capture the experiences in the local setting, and have made suggestions accordingly. Through close attentiveness to participant narratives and rigorous 'tinkering' on my part as a researcher, I have tried to give life to the voices of my research participants through my words. This called for flexibility in borrowing and adapting concepts to capture participant experiences as well as creating new ones where the existing ones failed, rather than contorting the lived experiences to fit in within the boundaries of fixed concepts (Das, 2020).

This thesis marks my own initial faltering steps towards more reflexive and decolonial research engagements. I invite researchers, particularly those working in non-Western/indigenous/postcolonial contexts, to explore the potential of decolonial theoretical orientations towards developing more grounded, equitable and collaborative research projects in the future.

In conclusion, the present study took an ethnographic approach towards therapeutic practices as enacted in households in the rural and therapeutically diverse setting of Pitawella village in Sri Lanka. Through my thesis I have described the enaction of health seeking practices in the home, the relational and fluid nature of their therapeutic potential, household arrangements of space and time around the use of medications, and ways in which medications became adapted and 'personalised'. Through these, I extended the discussion to the multi-faceted nature of 'good health', notions of risk and responsibility, moral/ethical dimensions of medication use, and the social and (post)colonial tensions in the contemporary healthcare landscape. What was foregrounded through this broad-based exploration is the significance of health seeking practices, as matters of 'tinkering' and of 'wrangling', which are woven into the ordinary everyday life of a rural Sri Lankan community.

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APPENDIX 1: ETHICS APPROVAL RECEIVED FOR THE STUDY

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Phone 0-4-463 6028
Email judith.loveridge@vuw.ac.nz

MEMORANDUM

TO	Supuni Liyanagunawardena
FROM	Dr Judith Loveridge, Convenor, Human Ethics Committee
DATE	2 August 2018
PAGES	1
SUBJECT	**Ethics Approval: 0000026273** Medications in everyday life: A study on a rural community in Sri Lanka

Thank you for your application for ethical approval, which has now been considered by the Human Ethics Committee.

Your application has been approved from the above date and this approval is valid for three years. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards

Judith Loveridge

Convenor, Victoria University Human Ethics Committee

Ethics Review Committee for Social Sciences and Humanities

Faculty of Arts

University of Colombo, Sri Lanka.

P.O. Box 1490, Colombo.

94, Cumarathunga Munidasa Mawatha, Colombo 03, Sri Lanka.

Chairman
Dr. C. Liyanage
Sociology

Secretary
Dr. Sunethra Perera
Demography

Committee Members

Prof. Amala de Silva
Economics

Dr. J. Jayawardena
History

Dr. M. W. Pasqual
International Relations

Dr. Fareena Ruzaik
Geography

Dr. P.N. Peris
Political Science

Dr. P. Karunananayake
Faculty of Medicine

Prof. D. Mendis
English

Ms. H.K.C.K. Ranaweera
Sinhala

Prof. Athula Ranasinghe
Economics

Prof. M. Ganeshmurthi
Director
Post Graduate Programme

Dr. A.M.A.U. Aththanayaka
DELT

Dr. W. Hewamanage
Buddhist and Pali

27th November 2018

Reference Number: ERCSSH/18/16

Ms. Supuni Liyanagunawardena,
Level 9,
Murphy Building,
School of Social and Cultural Studies,
Victoria University of Wellington,
Wellington,
New Zealand.

Dear, Ms. Liyanagunawardena,

Application for Ethics Review of Research Proposal "Medications in everyday life: A study on a rural community in Sri Lanka"

This letter refers to your application for ethics review of the above titled research proposal dated 15th November 2018, and submitted to the Ethics Review Committee for Social Sciences and Humanities, Faculty of Arts, University of Colombo.

I am pleased to inform you that the committee met on 21st November 2018 to review your application and relevant documents and decided to grant Ethics Clearance to your research.

Dr. Chandani Liyanage
The Chairmen, ERCSSH,
Faculty of Arts,
University of Colombo.

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APPENDIX 2: INFORMATION SHEETS, CONSENT FORMS, TRANSLATOR CONFIDENTIALITY AGREEMENT

Information sheet for participant households (English and Sinhala versions)

Medications in everyday life: A study on a rural community in Sri Lanka
INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is Supuni Liyanagunawardena. I am a Doctoral student in Sociology at Victoria University of Wellington, New Zealand. This research project is work towards my thesis.

What is the aim of the project?

This project will look at how people use medications in their everyday lives. It is based on onerural community in Sri Lanka.

This research has been approved by the Victoria University of Wellington Human Ethics Committee (#0000026273) and Ethics Review Committee of Faculty of Arts, University of Colombo.

How can you help?

Your household has been invited to participate because you live in the community that is selected for this project. I would like to do a group interview with your household. But I can interview you separately, if you prefer that.

If you agree to take part I will interview you at your home, at a time that is convenient for you. I will ask you to take photographs of the place/s where you keep medications at home and give the photographs to me at the interview. I will also ask you to bring the medicationsyou use to the group interview and show them to me. You can decide which of your medications you want to show me.

At the interview, I will ask you questions about the medications you use. The interview will take about two hours. I will audio record the interview with your permission and write it uplater. You can choose to not answer any question or stop the interview at any time, withoutgiving a reason.

You can withdraw from the study by contacting me at any time before 01.02.2019. If you withdraw, the information you provided will be destroyed or returned to you.

What will happen to the information you give?

This research is confidential. This means that the researchers named below will be aware of your identity but your identity will not be revealed in any reports, presentations, or publicdocumentation.

Only my supervisors, the translator (who will be required to sign a confidentiality agreement)and I will read the notes or transcript of the interview. Any information that may identify youwill be kept securely and destroyed on 31.12.2021.

What will the project produce?

The information from my research will be used in my PhD dissertation. Some information willbe presented in academic publications and conferences, as well as in newspaper articles andblogs. They may also be conveyed to the government officials and appear in publications related to public health strategies and policy. However, your name, your identity or your village will not be revealed in any of these.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to.

If you do decide to participate, you have the right to:

- choose not to answer any question
- ask for the recorder to be turned off at any time during the interview
- decide which information you want to share with the researcher. This includes which locations to photograph in your home, and which medications to show the researcher
- withdraw from the study before 01.02.2019
- ask any questions about the study at any time
- review and comment on the information that you have provided
- be informed of the outcomes of this research and about any publications.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact me or mysupervisors:

Name : Supuni Liyanagunawardena

Telephone : 077 22 66068 / 0064 211 500 486

Email : supuni.liyanagunawardena@vuw.ac.nz

Supervisors:

Prof Kevin Dew Victoria University ofWellington New Zealand 0064 4463 5291 kevin.dew@vuw.ac.nz

Prof Antonia Lyons Victoria University ofWellington New Zealand 0064 4463 4758 antonia.lyons@vuw.ac.nz

Dr Dilrukshi Abeysinghe University of Colombo Colombo dilrukshiabeysinghe@yahoo.com

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact

- Victoria University Human Ethics Committee

  Telephone: 0064 4463 6028 / Email: hec@vuw.ac.nz

- Ethics Review Committee of Faculty of Arts, University of Colombo

  Telephone: 011 2500 457 / Email: ercssh@arts.cmb.ac.lk

ශ්‍රී ලංකාවේ ග්‍රාමීය ප්‍රජාවක එදිනෙදා ජීවිතය තුළ ඖෂධ භාවිතා කිරීම පිළිබඳ අධ්‍යයනය

සහභාගීවන්නන් සඳහා තොරතුරු පත්‍රිකාව

මේ අධ්‍යයනයට සහභාගීවීමට ඔබට ආරාධනා කරමි. සහභාගීවීම ගැන තීරණය කිරීමට පෙර කරුණාකර මේ තොරතුරු පත්‍රිකාව කියවන්න. අධ්‍යයනයට සහභාගීවන්නේ නම් ඔබට ස්තූතියි. සහභාගී නොවීමට තීරණය කළ ද මගේ ඉල්ලීම සළකා බැලීම ගැන ඔබට ස්තූතියි.

මා ගැන

සුපුනි ලියනගුණවර්ධන වන මම, නවසීලන්තයේ වික්ටෝරියා විශ්වවිද්‍යාලයේ ආචාර්ය උපාධිය හදාරමි. මේ අධ්‍යයනය මාගේ උපාධි නිබන්ධනය වෙනුවෙනි.

අධ්‍යයන අරමුණ

එදිනෙදා ජීවිතය තුළ බෙහෙත් පාවිච්චි කිරීම පිළිබඳ සොයා බැලීම මගේ අරමුණයි. ශ්‍රී ලංකාවේ ගම්බද ප්‍රදේශයක් මූලික කර ගැනේ.

මෙම අධ්‍යයනය වික්ටෝරියා විශ්වවිද්‍යාලයේ ආචාර ධර්ම සමාලෝචන කමිටුව (යොමු අංක 0000026273), හා කොළඹ විශ්වවිද්‍යාලයීය කලා පීඨ ආචාර ධර්ම කමිටුව මගින් අනුමත කර ඇත.

ඔබේ සහභාගීවීම

මෙම අධ්‍යයනයට ඔබ ජීවත්වන ප්‍රදේශය තෝරාගෙන ඇති නිසා, ඊට සහභාගීවීමට ඔබට ද ආරාධනා කෙරේ. ඔබේ ගෙදර සියලුදෙනා සමග එකට කතාබහ කිරීමට (කණ්ඩායම් සම්මුඛ සාකච්ඡාවක්) මම කැමැත්තෙමි. ඔබේ කැමැත්ත අනුව එකිනෙකා සමග වෙන වෙනම කතාබහ කිරීම වුවත් කළ හැකියි.

ඔබ සහභාගීවීමට කැමති නම්, ඔබ ගෙදරදී ඔබට පහසු වේලාවක ඔබ සමග කතාබහ කරන්නෙමි. ගෙදර බෙහෙත් තබන තැන් ඡායාරූපගත කිරීමටත්, එම ඡායාරූප අපේ කතාබහ අතරතුර මට ලබාදෙන ලෙසත් ඉල්ලා සිටිමි. ඔබ පාවිච්චි කරන බෙහෙත් වර්ග ගෙනැවිත් මට පෙන්වන ලෙස ද ඉල්ලමි. ඔබ පෙන්වීමට අකමැති බෙහෙත් ඇත්නම් ඒවා නොපෙන්වා සිටීමට ද හැක.

ඔබේ බෙහෙත් පාවිච්චිය ගැන මම ඔබෙන් විස්තර අසන්නෙමි. අපේ කතාබහ සඳහා පැය දෙකක් පමණ ගත වේ. ඔබේ කැමැත්ත මත මම අපේ කතාබහ හඬ පටිගත කර පසුව එය ලියා දක්වමි. මාගේ ඕනෑම ප්‍රශ්නයකට උත්තර නොදීමටත්, ඕනෑම විටක අපේ කතාබහ නැවැත්වීමටත් ඔබට හැකියි. ඒ පිළිබඳ හේතු දැක්වීමක් ද අවශ්‍ය නැත.

අධ්‍යයනයෙන් ඉවත්වීමට අවසාන දිනය 2019.02.01 වේ. ඊට පෙර ඕනෑම වේලාවක මට දැනුම්දීමෙන් ඔබට අධ්‍යයනයෙන් ඉවත්විය හැක. ඔබ ඉවත්වන්නේ නම්, ඔබ ලබාදුන් තොරතුරු විනාශ කිරීම හෝ නැවත ඔබට ලබාදීම සිදු කෙරේ.

තොරතුරු

මෙය රහස්‍ය අධ්‍යයනයකි. පහත නම් සඳහන් පර්යේෂකයන් ඔබේ හැඳුනුම දැන සිටිනු ඇත. එහෙත් කිසිදු වාර්තාවක, ඉදිරිපත් කිරීමක හෝ ලේඛනයක ඔබේ පුද්ගලික තොරතුරු හෙළි කරන්නේ නැත.

මාගේ පර්යේෂණ සුපරීක්ෂකවරුන්, භාෂා පරිවර්තක (රහස්‍යභාවය රැකීමට ගිවිසුම් අත්සන් කරයි) සහ මා පමණක් මෙම සම්මුඛ සාකච්ඡාවට අදාළ වාර්තාව හා සටහන් කියවනු ලබයි. ඔබගේ පුද්ගලික තොරතුරු ආරක්ෂාකාරීව පවත්වාගන්නා අතර, ඒවා 2021.12.31 දින විනාශ කර දැමේ.

අධ්‍යයනයේ ප්‍රතිඵල

මෙම අධ්‍යයනයෙන් ලබා ගැනෙන තොරතුරු මාගේ ආචාර්ය උපාධි නිබන්ධනය සඳහා යොදාගැනේ. සමහර තොරතුරු ශාස්ත්‍රීය ප්‍රකාශන හා සම්මන්ත්‍රණ, පුවත්පත් වාර්තා හා අන්තර්ජාලය හරහා ඉදිරිපත් කෙරේ. අධ්‍යයනයේ ප්‍රතිඵල රජයේ නිලධාරීන්ට සැපයීමට අදහස් කරන අතර, ඒවා මහජන සෞඛ්‍යය පිළිබඳ ප්‍රකාශනයන්හි පළවීමට ඉඩ ඇත. එහෙත් ඉහත කිසිම විටක ඔබේ නම, ඔබේ ගම හෝ ඔබ හඳුනාගත හැකි පුද්ගලික තොරතුරු හෙළි කරන්නේ නැත.

අධ්‍යයනයට සහභාගීවන්නේ නම් ඔබේ අයිතීන්

සහභාගී වීමට ඔබ අකමැති නම්, සහභාගී විය යුතු නැත.

ඔබ සහභාගී වීමට තීරණය කරන්නේ නම්, ඔබට පහත අයිතීන් හිමිවේ.

- මා අසන ඕනෑම ප්‍රශ්නයකට ඔබ අකමැති නම් පිළිතුරු නොදී සිටිය හැක.
- සාකච්ඡාව තුළ ඕනෑම වේලාවක හඬ පටිගත කිරීම නවත්වන ලෙස ඉල්ලීමට හැක.
- මට ලබාදෙන තොරතුරු මොනවාදැයි තීරණය කරන්නේ ඔබ විසිනි. එසේම ගෙදර තුළ ඡායාරූපගත කරන තැන් මොනවාද, මට පෙන්වන බෙහෙත් වර්ග මොනවාද යන්න ඔබට තීරණය කළ හැක.
- 2019.02.01 දිනට පෙර අධ්‍යයනයෙන් ඉවත්විය හැක.
- අධ්‍යයනය ගැන ඕනෑම ප්‍රශ්නයක් ඕනෑම වේලාවක ඇසිය හැක.
- ඔබ ලබාදුන් තොරතුරු නැවත බැලීමටත් ඒ ගැන අදහස් ලබාදීමටත් හැක.
- අධ්‍යයනයේ ප්‍රතිඵල හා එහි ප්‍රකාශන ගැන දැනගැනීමට හැක.

ප්‍රශ්න ඇත්නම්

මේ අවස්ථාවේදී හෝ ඉදිරියේදී ඇතිවන ප්‍රශ්න පිළිබඳ කරුණාකර මා හෝ මාගේ සුපරීක්ෂකවරුන්ගෙන් විමසන්න.

නම : සුපුනි ලියනගුණවර්ධන

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සුපරීක්ෂකවරු

මහාචාර්ය කෙවින් ඩිව්
වික්ටෝරියා විශ්වවිද්‍යාලය
වෙලිංටන්

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ලියොන්ස්

වික්ටෝරියා
විශ්වවිද්‍යාලයවෙලිංටන්

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කොළඹ විශ්වවිද්‍යාලය
කොළඹ

dilrukshiabeysinghe@yahoo.com

ආචාර ධර්ම සමාලෝචන කමිටු පිළිබඳ තොරතුරු

මේ අධ්‍යයනය පර්යේෂණ ආචාර ධර්මවලට අනුව සිදුකිරීම පිළිබඳ යම් ගැටළුවක් වේ නම් පහතකමිටුවලට දැන්විය හැක.

- නවසීලන්තයේ වික්ටෝරියා විශ්වවිද්‍යාලයීය මානව ආචාර ධර්ම කමිටුව
  දුරකතන : 0064 4463 6028 / විද්‍යුත් තැපැල් :hec@vuw.ac.nz

- කොළඹ විශ්වවිද්‍යාලයීය කලා පීඨ ආචාර ධර්ම කමිටුව
  දුරකතන: 011 2500 457 / විද්‍යුත් තැපැල් : ercssh@arts.cmb.ac.lk

Consent form for household interview participants (English and Sinhala versions)

Medications in everyday life: A study on a rural community in Sri Lanka

CONSENT TO INTERVIEW

This consent form will be held for 5 years.

Researcher: Supuni Liyanagunawardena

School of Social and Cultural Studies, Victoria University of Wellington, New Zealand.

- I have understood the contents of the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that Ican ask further questions at any time. YES / NO
- I agree to take part in an audio recorded interview. YES / NO
- I agree to take photographs of the place/s where I keep medications in my house and givethem to the researcher OR to allow the researcher to take photographs of the places that I point out. YES / NO
- I agree to show my chosen medications to the researcher. YES / NO

I understand that:

- I will decide which information to share during the interview, which places in my house tophotograph, and which medications to show the researcher;
- I may withdraw from this study at any point before 01.02.2019 and any information that Ihave provided will be returned to me or destroyed;
- The identifiable information I have provided will be destroyed on 31.12.2021;
- Any information I provide will be kept confidential to the researcher, the supervisors andthe translator;

- I understand that the results will be used for a PhD dissertation and academic publications,presented to conferences, conveyed to government officials for policy development, and published in newspapers or blogs;
- My name will not be used in any reports, nor will any information that would identify me.

Name of participant: _____

Contact details: _____

Date: _____

ශ්‍රී ලංකාවේ ග්‍රාමීය ප්‍රජාවක එදිනෙදා ජීවිතය තුළ ඖෂධ භාවිතා කිරීම පිළිබඳ අධ්‍යයනය

සාකච්ඡාවට සහභාගීවීමට කැමැත්ත දැක්වීම

මෙම පත්‍රිකාව වසර 5 ක් දක්වා තබා ගැනේ

පර්යේෂක : සුපුනි ලියනගුණවර්ධන

වික්ටෝරියා විශ්වවිද්‍යාලය, නවසීලන්තය

- තොරතුරු පත්‍රිකාවේ ඇති තොරතුරු මම තේරුම් ගතිමි. පර්යේෂක විසින් මෙම අධ්‍යයනය ගැන මට විස්තරකරන ලදී. මගේ ගැටළුවලට සතුටුදායක පිළිතුරු ලැබිණි. තවත් ඕනෑම ප්‍රශ්නයක් ඕනෑම වේලාවක ඇසිය හැකි බව මම දනිමි. **ඔව් නැත**

- සම්මුඛ සාකච්ඡාවකට සහභාගීවීමටත් එය හඬ පටිගත කිරීමටත් මම කැමැත්තෙමි. **ඔව් නැත**
- නිවසේ බෙහෙත් තබන තැන් ඡායාරූපගත කර එම ඡායාරූප පර්යේෂකට ලබාදීමට <u>හෝ</u> පර්යේෂකට ඡායාරූප ගැනීමට එම තැන් පෙන්වීමට මම කැමැත්තෙමි. **ඔව් නැත**
- මම පාවිච්චි කරන බෙහෙත් අතරින් මම පෙන්වීමට කැමති ඒවා පර්යේෂකට පෙන්වීමට මම කැමැත්තෙමි. **ඔව් නැත**

එසේම,

- සාකච්ඡාවේදී පර්යේෂකට ලබාදෙන තොරතුරු මොනවාද, නිවස තුළ ඡායාරූපගත කරන තැන්මොනවාද, පර්යේෂකට පෙන්වන බෙහෙත් මොනවාද යන්න තීරණය කරන්නේ මා බව මම දනිමි.

- 2019.02.01 දිනට පෙර ඕනෑම වේලාවක මට මෙම අධ්‍යයනයෙන් ඉවත්විය හැක. එවිට මා ලබාදුන් තොරතුරු නැවත මට ලබාදීම හෝ විනාශ කිරීම සිදුකරන බව දනිමි.

- මා හඳුනාගත හැකි තොරතුරු 2021.12.31 දින විනාශ කෙරෙන බව මම දනිමි.
- මා ලබාදෙන තොරතුරු පර්යේෂක, සුපරීක්ෂකවරුන් හා භාෂා පරිවර්තක යන අය අතර රහස්‍ය ලෙස තබාගන්නා බව මම දනිමි.
- අධ්‍යයනයේ ප්‍රතිඵල යොදාගැනීම් ගැන මම දනිමි. එනම්, ආචාර්ය උපාධි නිබන්ධනය සඳහායොදාගැනේ, ශාස්ත්‍රීය ප්‍රකාශන හා සම්මන්ත්‍රණවල ඉදිරිපත් කෙරේ, රජයේ නිලධාරීන්ට ලබා දේ, පුවත්පත් වාර්තා හා අන්තර්ජාලය හරහා ඉදිරිපත් කෙරේ.

- කිසිම වාර්තාවක මගේ නම හෝ මා හඳුනාගතහැකි තොරතුරු හෙළි කරන්නේ නැති බව මම දනිමි.

සහභාගීවන්නාගේ නම :

ලිපිනය :

දිනය :

Consent form for children's participation in the study (English and Sinhala versions)

Medications in everyday life: A study on a rural community in Sri Lanka

CHILDREN'S ASSENT AND PARENTAL CONSENT TO INTERVIEW

This assent/ consent form will be held for 5 years.

Researcher: Supuni Liyanagunawardena
School of Social and Cultural Studies, Victoria University of Wellington, New Zealand.

For the child:

- I understand what the researcher told us. She answered my questions. I know that I can askmore questions at any time. YES / NO

- I am happy to talk to the researcher and have it audio recorded. I know that I don't have totell her anything that I don't want to. YES / NO

- I am happy to take photos of where my medications are and give the photos to the researcher OR to show the places to the researcher to take photographs. I know that I don'thave to show any place that I don't want to. YES / NO

- I am happy to show the researcher the medications I use. I know that I don't have to showany medication that I don't want to. YES / NO

Name of child: _____
Date: _____

For the parent/ guardian:

- I have understood the contents of the Information Sheet and the project has been explained to me. My questions regarding my child's participation have been answered to my satisfaction. I understand that I can ask further questions at any time. YES / NO

- I agree to allow my child to take part in an audio recorded interview. YES / NO

- I agree to take photographs of the place/s where medications are kept (including my child's medications) in my house and give them to the researcher OR to allow the researcher to take photographs of the places that I point out. YES / NO

- I agree to show my child's chosen medications to the researcher. YES / NO

I understand that:

- I will decide which information to share during the interview, which places in my house to photograph, and which medications to show the researcher;

- I may withdraw my child from this study at any point before 01.02.2019, and any information that he/she provided will be returned to me or destroyed;

- The identifiable information my child has provided will be destroyed on 31.12.2021;

- Any information my child provides will be kept confidential to the researcher, the supervisors and the translator;

- I understand that the results will be used for a PhD dissertation and academic publications, presented to conferences, conveyed to government officials for policy development, and published in newspapers or blogs;

- My child's name will not be used in any reports, nor will any information that would identify him/her.

I consent to my child's participation in the group interview with me/ with the other members ofour household.

Name of parent/ guardian: _____ Contact details: _____

Date : _____

ශ්‍රී ලංකාවේ ග්‍රාමීය ප්‍රජාවක එදිනෙදා ජීවිතය තුළ ඖෂධ භාවිතා කිරීම පිළිබඳ අධ්‍යයනය සම්මුඛ සාකච්ඡාවට සහභාගී වීම සඳහා දරුවන්ගේ කැමැත්ත හා දෙමාපිය /භාරකරු අනුමැතිය දැක්වීම

මෙම පත්‍රිකාව වසර 5 ක් දක්වා තබා ගැනේ

පර්යේෂක : සුපුනි ලියනගුණවර්ධන

වික්ටෝරියා විශ්වවිද්‍යාලය, නවසීලන්තය

<u>දරුවා සඳහා</u>

- අපට කියාදුන් විස්තර මට තේරුණා. මාගේ ප්‍රශ්නවලට උත්තර දුන්නා. ඕනෑම වේලාවක තව ප්‍රශ්න අහන්න මට පුළුවන් බව දන්නවා. **ඔව් නැත**
- පර්යේෂක එක්ක කතා බහ කරන්න මම කැමතියි. ඒ කතාබහ හඬ පටිගත කරනවාට මම කැමතියි.මම කියන්න අකමැති කිසි දෙයක් කියන්න ඕනෑ නැති බව මම දන්නවා. **ඔව් නැත**
- මම පාවිච්චි කරන බෙහෙත් තියෙන තැන් ඡායාරූපගත කර ඒ ඡායාරූප පර්යේෂකට දෙනවාට,නැතිනම් ඒ තැන් ඡායාරූප ගැනීමට පර්යේෂකට පෙන්වන්නට මම කැමතියි. මම පෙන්වන්න අකමැති කිසිම තැනක් ඡායාරූපගත කරන්න ඕනෑ නැති බව මම දන්නවා. **ඔව් නැත**
- මම පාවිච්චි කරන බෙහෙත් පර්යේෂකට පෙන්වන්නට මම කැමතියි. මම පෙන්වන්න අකමැතිඒවා පෙන්වන්නට ඕනෑ නැති බව මම දන්නවා. **ඔව් නැත**

දරුවාගේ නම

:දිනය :

<u>මව / පියා / භාරකරු සඳහා</u>

- තොරතුරු පත්‍රිකාවේ ඇති තොරතුරු මම තේරුම් ගතිමි. පර්යේෂක විසින් මෙම අධ්‍යයනය ගැන මට විස්තර කරන ලදී. දරුවාගේ සහභාගිත්වය ගැන මගේ ගැටළුවලට සතුටුදායකපිළිතුරු ලැබිණි. තවත් ඕනෑම ප්‍රශ්නයක් ඕනෑම වේලාවක ඇසිය හැකි බව මම දනිමි.

ඔව් නැත

- සම්මුඛ සාකච්ඡාවකට මගේ දරුවා සහභාගී කරවීමටත් එය හඬ පටිගත කිරීමටත් අවසරදෙමි.

ඔව් නැත

- නිවසේ බෙහෙත් තබන තැන් (මගේ දරුවාගේ බෙහෙත් ද ඇතුළුව) ඡායාරූපගත කර එම ඡායාරූප පර්යේෂකට ලබාදීමට <u>හෝ</u> පර්යේෂකට ඡායාරූප ගැනීමට එම තැන් පෙන්වීමට මම කැමැත්තෙමි.

ඔව් නැත

- මගේ දරුවා පාවිච්චි කරන බෙහෙත් අතරින් පෙන්වීමට කැමති ඒවා පර්යේෂකට පෙන්වීමටමම කැමැත්තෙමි. **ඔව් නැත**

එසේම,

- සාකච්ඡාවේදී පර්යේෂකට ලබාදෙන තොරතුරු මොනවාද, නිවස තුළ ඡායාරූපගත කරන තැන් මොනවාද, පර්යේෂකට පෙන්වන බෙහෙත් මොනවාද යන්න තීරණය කරන්නේ මා බව මම දනිමි.
- 2019.02.01 දිනට පෙර ඕනෑම වේලාවක මගේ දරුවා මෙම අධ්‍යයනයෙන් ඉවත් කරගතහැක. එවිටමගේ දරුවා ලබාදුන් තොරතුරු නැවත මට ලබාදීම හෝ විනාශ කිරීම සිදුකරන බව දනිමි.
- මගේ දරුවා හඳුනාගත හැකි තොරතුරු 2021.12.31 දින විනාශ කෙරෙන බව මම දනිමි.
- මගේ දරුවා ලබාදෙන තොරතුරු පර්යේෂක, සුපරීක්ෂකවරුන් හා භාෂා පරිවර්තක යන අය අතර රහස්‍ය ලෙස තබාගන්නා බව මම දනිමි.
- අධ්‍යයනයේ ප්‍රතිඵල යොදාගැනීම් ගැන මම දනිමි. එනම්, ආචාර්ය උපාධි නිබන්ධනය සඳහා යොදාගැනේ, ශාස්ත්‍රීය ප්‍රකාශන හා සම්මන්ත්‍රණවල ඉදිරිපත් කෙරේ, රජයේ නිලධාරීන්ට ලබා දේ, පුවත්පත් වාර්තා හා අන්තර්ජාලය හරහා ඉදිරිපත් කෙරේ.
- කිසිම වාර්තාවක මගේ දරුවාගේ නම හෝ මගේ දරුවා හඳුනාගතහැකි තොරතුරු හෙළි කරන්නේනැති බව මම දනිමි.

මා සමග / අපේ නිවසේ අනෙකුත් සාමාජිකයන් සමග කණ්ඩායම් සම්මුඛ සාකච්ඡාවකට මාගේ දරුවා සහභාගී වීම සඳහා අනුමැතිය ලබා දෙමි.

මව / පියා / භාරකරුගේ නම :

ලිපිය :

දිනය :

Information sheet for local healers participating in the study (English and Sinhala versions)

Medications in everyday life: A study on a rural community in Sri Lanka

INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is Supuni Liyanagunawardena. I am a Doctoral student in Sociology at Victoria University of Wellington, New Zealand. This research project is work towards my thesis.

What is the aim of the project?

This project will look at how people use medications in their everyday lives. It is based on one rural community in Sri Lanka.

This research has been approved by the Victoria University of Wellington Human Ethics Committee (#0000026273) and Ethics Review Committee of Faculty of Arts, University of Colombo.

How can you help?

You have been invited to participate because you work as a traditional medical practitioner or healer in the community that is selected for this project. I would like to do a brief interview with you.

If you agree to take part, I will interview you at your home or work place, at a time that is convenient for you. At the interview, I will ask you questions about your work as a traditional medical practitioner or healer. The interview will take about 30 minutes. I will audio record the interview with your permission and write it up later. You can choose to not answer any question or stop the interview at any time, without giving a reason.

You can withdraw from the study by contacting me at any time before 10.03.2019. If you withdraw, the information you provided will be destroyed or returned to you.

What will happen to the information you give?

This research is confidential. This means that the researchers named below will be aware of your identity but your identity will not be revealed in any reports, presentations, or public documentation.

Only my supervisors, the translator (who will be required to sign a confidentiality agreement) and I will read the notes or transcript of the interview. Any information that may identify you will be kept securely and destroyed on 31.12.2021.

What will the project produce?

The information from my research will be used in my PhD dissertation. Some information will be presented in academic publications and conferences, as well as in newspaper articles and blogs. They may also be conveyed to the government officials and appear in publications related to public health strategies and policy. However, your name, your identity or your village will not be revealed in any of these.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to.

If you do decide to participate, you have the right to:

- choose not to answer any question
- ask for the recorder to be turned off at any time during the interview
- decide which information you want to share with the researcher
- withdraw from the study before 10.03.2019
- ask any questions about the study at any time
- review and comment on the information that you have provided
- be informed of the outcomes of this research and about any publications.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact me or my supervisors:

Name : Supuni Liyanagunawardena

Telephone : 077 22 66068 / 0064 211 500 486

Email : supuni.liyanagunawardena@vuw.ac.nz

Supervisors:

Prof Kevin Dew
Victoria University of Wellington
New Zealand
0064 4463 5291
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Prof Antonia Lyons
Victoria University of Wellington
New Zealand
0064 4463 4758
antonia.lyons@vuw.ac.nz

Dr Dilrukshi Abeysinghe
University of Colombo
Colombo
dilrukshiabeysinghe@yahoo.com

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact

- Victoria University Human Ethics Committee

  Telephone: 0064 4463 6028 / Email: hec@vuw.ac.nz

- Ethics Review Committee of Faculty of Arts, University of Colombo

  Telephone: 011 2500 457 / Email: ercssh@arts.cmb.ac.lk

ශ්‍රී ලංකාවේ ග්‍රාමීය ප්‍රජාවක එදිනෙදා ජීවිතය තුළ ඖෂධ භාවිතා කිරීම පිළිබඳ අධ්‍යයනය

සහභාගීවන්නන් සඳහා තොරතුරු පත්‍රිකාව

මේ අධ්‍යයනයට සහභාගීවීමට ඔබට ආරාධනා කරමි. සහභාගීවීම ගැන තීරණය කිරීමට පෙර කරුණාකර මේ තොරතුරු පත්‍රිකාව කියවන්න. අධ්‍යයනයට සහභාගීවන්නේ නම් ඔබට ස්තූතියි. සහභාගී නොවීමට තීරණය කළ ද මගේ ඉල්ලීම සළකා බැලීම ගැන ඔබට ස්තූතියි.

මා ගැන

සුපුනි ලියනගුණවර්ධන වන මම, නවසීලන්තයේ වික්ටෝරියා විශ්වවිද්‍යාලයේ ආචාර්ය උපාධිය හදාරමි. මේ අධ්‍යයනය මාගේ උපාධි නිබන්ධනය වෙනුවෙනි.

අධ්‍යයනයේ අරමුණු

එදිනෙදා ජීවිතය තුළ බෙහෙත් පාවිච්චි කිරීම පිළිබඳ සොයා බැලීම මගේ අරමුණයි. ශ්‍රී ලංකාවේ ගම්බද ප්‍රදේශයක් මූලික කර ගැනේ.

මෙම අධ්‍යයනය වික්ටෝරියා විශ්වවිද්‍යාලයේ ආචාර ධර්ම සමාලෝචන කමිටුව (යොමු අංක 0000026273), හා කොළඹ විශ්වවිද්‍යාලයීය කලා පීඨ ආචාර ධර්ම කමිටුව මගින් අනුමත කර ඇත.

ඔබේ සහභාගීත්වය

මෙම අධ්‍යයනයට තෝරාගෙන ඇති ප්‍රදේශයේ ඔබ පාරම්පරික වෛද්‍යවරයෙක් ලෙස හෝ වෙනත් සුවකරන්නෙකු ලෙස සේවය කරන නිසා නිසා, ඊට සහභාගීවීමට ඔබට ආරාධනා කෙරේ.

ඔබ සහභාගීවීමට කැමති නම්, ඔබ ගෙදරදී හෝ රැකියාවෙදී ඔබට පහසු වේලාවක ඔබ සමග කතාබහ කරන්නෙමි.

පාරම්පරික වෛද්‍යවරයෙක් ලෙස හෝ වෙනත් සුවකරන්නෙකු ලෙස ඔබේ සේවය ගැන මම ඔබෙන් විස්තර අසන්නෙමි. අපේ කතාබහ සඳහා පැය භාගයක් පමණ ගත වේ. ඔබේ කැමැත්ත මත මම අපේ කතාබහ හඬ පටිගත කර පසුව එය ලියා දක්වමි. මාගේ ඕනෑම ප්‍රශ්නයකට උත්තර නොදීමටත්, ඕනෑම විටක අපේ කතාබහ නැවැත්වීමටත් ඔබට හැකියි. ඒ පිළිබඳ හේතු දැක්වීමක් ද අවශ්‍ය නැත.

අධ්‍යයනයෙන් ඉවත්වීමට අවසාන දිනය 2019.03.10 වේ. ඊට පෙර ඕනෑම වේලාවක මට දැනුම්දීමෙන් ඔබට අධ්‍යයනයෙන් ඉවත්විය හැක. ඔබ ඉවත්වන්නේ නම්, ඔබ ලබාදුන් තොරතුරු විනාශ කිරීම හෝ නැවත ඔබට ලබාදීම සිදු කෙරේ.

තොරතුරු භාවිතය

මෙය රහස්‍ය අධ්‍යයනයකි. පහත නම් සඳහන් පර්යේෂකයන් ඔබේ හැඳුනුම දැන සිටිනු ඇත. එහෙත් කිසිදු වාර්තාවක, ඉදිරිපත් කිරීමක හෝ ලේඛනයක ඔබේ පුද්ගලික තොරතුරු හෙළි කරන්නේ නැත.

මාගේ පර්යේෂණ සුපරීක්ෂකවරුන්, භාෂා පරිවර්තක (රහස්‍යභාවය රැකීමට ගිවිසුම් අත්සන් කරයි) සහ මා පමණක් මෙම සම්මුඛ සාකච්ඡාවට අදාළ වාර්තාව හා සටහන් කියවනු ලබයි. ඔබගේ පුද්ගලික තොරතුරු ආරක්ෂාකාරීව පවත්වාගන්නා අතර, ඒවා 2021.12.31 දින විනාශ කර දැමේ.

අධ්‍යයනයේ ප්‍රතිඵල

මෙම අධ්‍යයනයෙන් ලබා ගැනෙන තොරතුරු මාගේ ආචාර්ය උපාධි නිබන්ධනය සඳහා යොදාගැනේ. සමහර තොරතුරු ශාස්ත්‍රීය ප්‍රකාශන හා සම්මන්ත්‍රණ, පුවත්පත් වාර්තා හා අන්තර්ජාලය හරහා ඉදිරිපත් කෙරේ. අධ්‍යයනයේ ප්‍රතිඵල රජයේ නිලධාරීන්ට සැපයීමට අදහස් කරන අතර, ඒවා මහජන සෞඛ්‍යය පිළිබඳ ප්‍රකාශනයන්හි පළවීමට ඉඩ ඇත. එහෙත් ඉහත කිසිම විටක ඔබේ නම, ඔබේ ගම හෝ ඔබ හඳුනාගත හැකි පුද්ගලික තොරතුරු හෙළි කරන්නේ නැත.

අධ්‍යයනයට සහභාගීවන්නේ නම් ඔබේ අයිතීන්

සහභාගී වීමට ඔබ අකමැති නම්, සහභාගී විය යුතු නැත.

ඔබ සහභාගී වීමට තීරණය කරන්නේ නම්, ඔබට පහත අයිතීන් හිමිවේ.

- මා අසන ඕනෑම ප්‍රශ්නයකට ඔබ අකමැති නම් පිළිතුරු නොදී සිටිය හැක.
- සාකච්ඡාව තුළ ඕනෑම වේලාවක හඬ පටිගත කිරීම නවත්වන ලෙස ඉල්ලීමට හැක.
- මට ලබාදෙන තොරතුරු මොනවාදැයි තීරණය කරන්නේ ඔබ විසිනි.
- 2019.03.10 දිනට පෙර අධ්‍යයනයෙන් ඉවත්විය හැක.
- අධ්‍යයනය ගැන ඕනෑම ප්‍රශ්නයක් ඕනෑම වේලාවක ඇසිය හැක.
- ඔබ ලබාදුන් තොරතුරු නැවත බැලීමටත් ඒ ගැන අදහස් ලබාදීමටත් හැක.
- අධ්‍යයනයේ ප්‍රතිඵල හා එහි ප්‍රකාශන ගැන දැනගැනීමට හැක.

ප්‍රශ්න ඇත්නම්

මේ අවස්ථාවේදී හෝ ඉදිරියේදී ඇතිවන ප්‍රශ්න පිළිබඳ කරුණාකර මා හෝ මාගේ සුපරීක්ෂකවරුන්ගෙන් විමසන්න.

නම : සුපුනි ලියනගුණවර්ධන

දුරකතන : 077 22 66068 / 0064 2115 00486

විද්‍යුත් තැපැල්: supuni.liyanagunawardena@vuw.ac.nz

සුපරීක්ෂකවරු

මහාචාර්ය කෙවින් ඩිව්
වික්ටෝරියා විශ්වවිද්‍යාලය
වෙලිංටන්

නවසීලන්තය
0064 4463 5291

kevin.dew@vuw.ac.nz

මහාචාර්ය ඇන්ටෝනියා ලියොන්ස්

වික්ටෝරියා විශ්වවිද්‍යාලය

වෙලිංටන්

නවසීලන්තය

0064 4463 4758

antonia.lyons@vuw.ac.nz

ආචාර්ය දිල්රුක්ෂි අබේසිංහ
කොළඹ විශ්වවිද්‍යාලය
කොළඹ

dilrukshiabeysinghe@yahoo.com

ආචාර ධර්ම සමාලෝචන කමිටු පිළිබඳ තොරතුරු

මේ අධ්‍යයනය පර්යේෂණ ආචාර ධර්මවලට අනුව සිදුකිරීම පිළිබඳ යම් ගැටළුවක් වේ නම් පහතකමිටුවලට දැන්විය හැක.

- නවසීලන්තයේ වික්ටෝරියා විශ්වවිද්‍යාලයීය මානව ආචාර ධර්ම කමිටුව
  දුරකතන : 0064 4463 6028 / විද්‍යුත් තැපැල් :hec@vuw.ac.nz

- කොළඹ විශ්වවිද්‍යාලයීය කලා පීඨ ආචාර ධර්ම කමිටුව
  දුරකතන : 011 2500 457 / විද්‍යුත් තැපැල්
  ercssh@arts.cmb.ac.lk

Consent form for local healers participating in the study (English and Sinhala versions)

Medications in everyday life: A study on a rural community in Sri Lanka

CONSENT TO INTERVIEW

This consent form will be held for 5 years.

Researcher: Supuni Liyanagunawardena

School of Social and Cultural Studies, Victoria University of Wellington, New Zealand.

- I have understood the contents of the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time. YES / NO

- I agree to take part in an audio recorded interview. YES / NO

I understand that:

- I will decide which information to share during the interview;
- I may withdraw from this study at any point before 10.03.2019 and any information that I have provided will be returned to me or destroyed;
- The identifiable information I have provided will be destroyed on 31.12.2021;
- Any information I provide will be kept confidential to the researcher, the supervisors and the translator;

- I understand that the results will be used for a PhD dissertation and academic publications, presented to conferences, conveyed to government officials for policy development, and published in newspapers or blogs;
- My name will not be used in any reports, nor will any information that would identify me.

Name of participant: _____

Contact details: _____

Date: _____

ශ්‍රී ලංකාවේ ග්‍රාමීය ප්‍රජාවක එදිනෙදා ජීවිතය තුළ ඖෂධ භාවිතා කිරීම පිළිබඳ අධ්‍යයනය

සාකච්ඡාවට සහභාගීවීමට කැමැත්ත දැක්වීම

මෙම පත්‍රිකාව වසර 5 ක් දක්වා තබා ගැනේ

පර්යේෂක : සුපුනි ලියනගුණවර්ධන
වික්ටෝරියා විශ්වවිද්‍යාලය, නවසීලන්තය

- තොරතුරු පත්‍රිකාවේ ඇති තොරතුරු මම තේරුම් ගතිමි. පර්යේෂක විසින් මෙම අධ්‍යයනය ගැන මට විස්තර කරන ලදී. මගේ ගැටළුවලට සතුටුදායක පිළිතුරු ලැබිණි. තවත් ඕනෑම ප්‍රශ්නයක් ඕනෑම වේලාවක ඇසිය හැකි බව මම දනිමි. **ඔව් නැත**
- සම්මුඛ සාකච්ඡාවකට සහභාගීවීමටත් එය හඬ පටිගත කිරීමටත් මම කැමැත්තෙමි. **ඔව් නැත**

එසේම,

- සාකච්ඡාවේදී පර්යේෂකට ලබාදෙන තොරතුරු මොනවාද යන්න තීරණය කරන්නේ මා බව මම දනිමි.
- 2019.03.10 දිනට පෙර ඕනෑම වේලාවක මට මෙම අධ්‍යයනයෙන් ඉවත්විය හැක. එවිට මා ලබාදුන් තොරතුරු නැවත මට ලබාදීම හෝ විනාශ කිරීම සිදුකරන බව දනිමි.
- මා හඳුනාගත හැකි තොරතුරු 2021.12.31 දින විනාශ කෙරෙන බව මම දනිමි.
- මා ලබාදෙන තොරතුරු පර්යේෂක, සුපරීක්ෂකවරුන් හා භාෂා පරිවර්තක යන අය අතර රහස්‍ය ලෙස තබාගන්නා බව මම දනිමි.
- අධ්‍යයනයේ ප්‍රතිඵල යොදාගැනීම් ගැන මම දනිමි. එනම්, ආචාර්ය උපාධි නිබන්ධනය සඳහා යොදාගැනේ, ශාස්ත්‍රීය ප්‍රකාශන හා සම්මන්ත්‍රණවල ඉදිරිපත් කෙරේ, රජයේ නිලධාරීන්ට ලබා දේ, පුවත්පත් වාර්තා හා අන්තර්ජාලය හරහා ඉදිරිපත් කෙරේ.
- කිසිම වාර්තාවක මගේ නම හෝ මා හඳුනාගතහැකි තොරතුරු හෙළි කරන්නේ නැති බව මම දනිමි.

සහභාගීවන්නාගේ නම :

ලිපිනය :

දිනය:

Confidentiality Agreement with the Sinhala – English Translator

VICTORIA
UNIVERSITY OF WELLINGTON

Translating Confidentiality Agreement

Project Title: Medications in everyday life: A study on a rural community in Sri Lanka

Principal Investigator: Supuni Liyanagunawardena

I, Bianca Jayasinghe, agree to ensure that any documents and interview transcriptions I translate (from English to Sinhalese or vice versa) will remain confidential to Supuni Liyanagunawardena and myself.

I agree to take the following precautions:

1. I will ensure that no person other than Supuni Liyanagunawardena sees the relevant documents, interview transcripts and translations.
2. I will ensure that no other person has access to my computer/device.
3. I will delete the files from my computer/device once the translation has been completed.
4. I will not discuss any aspect of the interview transcriptions or documents that I translate, with anyone except Supuni Liyanagunawardena.

Signature: B. JAYASINGHE

Date: 15.05.2017

APPENDIX 3: TOPICS FOR DISCUSSION WITH HOUSEHOLDS

Adapted from the interview schedule used for initial discussions in Dew et al. (2014)

Personal medication use in the household

- What medications are used*
- Used by who and why
- Frequency/ dosage/ patterns of use

Different types of medications

- Reasons for using the particular type/s of medications that is used in the household (i.e. western/allopathic, ayurvedic, home remedy)
- Effects of medication/s, how they work on the body
- Any experience with other types of medications

Managing medications in the household

- Storage**
- Taking / administering medications
- Responsibility for medications
- Relationships involving medications

Flow of medications to and from the household

- Sources of information about medications
- Medications obtained from who/ where
- Whether any medications leave the household. If so, how/ where/ when
- Disposal of medications

Decision making regarding medications

- Deciding when to seek medications, and why (ref. most recent events of accessing medication)
- Deciding which type of medications, and why
- Self medication: when; why; and how the medication is obtained
- Adhering to medication regimes, when to stop medication

Medications in society

- Price, availability
- Promotion over media
- Wide spread use of medications

---

*participants bring in the medications they use to show the researcher and discuss

**discussion prompted by photographs

නිවැසියන් සමග සාකච්ඡා කෙරෙන මාතෘකා

ගෙදර අයගේ බෙහෙත් පාවිච්චිය

- බෙහෙත් ගෙනවිත් පෙන්වීම.
- පාවිච්චි කරන්නේ කවුද, ඒ ඇයි?
- බෙහෙත් පාවිච්චි කරන පිළිවෙල / දිනකට වාර / ප්‍රමාණය

විවිධ වර්ගවල බෙහෙත්

- ගෙදර පාවිච්චි කරන ඒ ඒ වර්ගවල බෙහෙත් (ඉංග්‍රීසි බෙහෙත්, ආයුර්වේද, අත් බෙහෙත් ආදී) පාවිච්චි කිරීමට හේතු
- බෙහෙත්වල ප්‍රතිඵල / බලපෑම, බෙහෙත් වැඩකරන ආකාරය
- වෙනත් වර්ගවල බෙහෙත් පාවිච්චි කර අත්දැකීම් ඇත්නම්

ගෙදර තුළ බෙහෙත් කළමණාකරණය

- ගබඩා කර තැබීම (ඡායාරූප ඇසුරින්)
- එදිනෙදා බෙහෙත් පාවිච්චි කිරීම / බෙහෙත් දීම
- බෙහෙත් පිළිබඳ වගකීම් දැරීම
- බෙහෙත් පාවිච්චිය හා බැඳුණු සම්බන්ධතා

බෙහෙත් නිවසට ඒම් හා ඉන් පිටතට යාම්

- බෙහෙත් පිළිබඳ තොරතුරු ලබා ගන්නේ කාගෙන්ද/ කොහෙන්ද?
- බෙහෙත් ලබාගන්නේ කාගෙන්ද? / කොහෙන්ද?
- ගෙදරින් පිටතට බෙහෙත් ගෙනයාම / ලබාදීම සිදුකරයි නම් ඒ කෙසේද?, කොහේද? කවදාද?
- බෙහෙත් ඉවත දැමීම

බෙහෙත් පිළිබඳ තීරණ ගැනීම්

- බෙහෙත් ගතයුතු බවට තීරණය කරන අවස්ථාව හා හේතු (ළඟදීම බෙහෙත් ගත් සිදුවීමක් ඇසුරින්)
- කුමන වර්ගයේ බෙහෙත් ලබාගතයුතුද, ඒ ඇයි?
- වෛද්‍ය උපදෙස් නොගෙන බෙහෙත් පාවිච්චි, කුමන අවස්ථාවේද, ඒ ඇයි?, බෙහෙත් සපයාගන්නේ කෙසේද?
- බෙහෙත් පාවිච්චි කළ යුතු රටාව පිළිපැදීම, බෙහෙත් නැවැත්වීම.

සමාජය තුළ බෙහෙත් පාවිච්චිය

- බෙහෙත්වල මිල, පහසුවෙන් ලබාගත හැකි බව
- මාධ්‍ය හරහා ප්‍රචාරණය
- සමාජයේ පැතිරීගිය බෙහෙත් භාවිතය