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Anfal Yesmien Nyhan

Trinity College, ainyhan@gmail.com

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Anfal Yesmien Nyhan '14
Anthropology & Neuroscience

Trinity College
Hartford, CT
Advisor: Rebecca Beebe & James A. Trostle

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Gods' Diseases
Conceptualizing the Phenomenon of Hybridity in Sri Lanka

Introduction

Establishing an understanding of the ways in which health and disease are understood and categorized in different settings enables outsiders to better comprehend the context of disease. In this case, such an understanding allows us to recognize the ways that the Sinhalese categorize and experience their diseases. The aim of this project is to study the phenomenon of hybridity embedded in Sri Lankan culture via an exploration of *Gods' Diseases*. The influence of colonization in Sri Lanka has led to this phenomenon of hybridization. Hybridity occurs when existing cultural practices are transformed into new ones via outside intervention. This allows for the transformation of or generation of new cultural practices (Hermans and Kempen 1998). Such processes of hybridization are evident in the ways in which the Sinhalese deal with *Gods' Diseases*. The Sinhalese incorporate varying sets of knowledge when treating these diseases. Patients incorporate both home remedies as well as outside interventions during the recovery process. People also act as agents in their healing process—they incorporate and modify local knowledge, biomedicine and religious healing practices according to their own desires. Such practices in turn have an affect on the ways that patients relate to their health care providers and cultivate trust with medical practitioners.

Theories of disease causation vary across cultures. Anthropological literature and research in the field of ethnomedicine has provided us a foundation to understand and categorize health and disease. Ethnomedicine is the study of different cultures' ideas concerning medical systems or healing practices, including how people perceive health and illness and the ways in which people utilize different health systems (i.e. Ayurvedic medicine, Traditional Chinese medicine [TCM], Greek medicine) (Erickson 2008). In their underlying theories, most ethnomedical systems emphasize the individual body and the natural world, which provides a

more naturalistic explanation of disease and illness, or the social and supernatural world, which provides a more personalistic explanation (Erickson 2008). The treatment for illnesses varies according to the understood cause of the illness. Naturalistic illnesses, for instance, are the result of exposure to threats from the outside world (i.e. malnutrition, infection, trauma, etc.) (Quinlan 2011). Treatment for naturalistic illnesses is sought within biomedicine and the humoral medical systems (i.e. Ayurvedic medicine and TCM) (Erickson 2008). Personalistic illnesses, on the other hand, are the result of supernatural interventions either by a human (i.e. witch or sorcerer) or non-human (i.e. spirit, God, ghost, etc.) (Quinlan 2011).

Inspired by the Mumps

This project was inspired in the fall of 2012. Following the end of my first semester of junior year, after five-years away, my mother and I took a trip back to Sri Lanka to visit family. I spent my winter break there and upon our return I went right back to school. By the end of the first week of school, however, I remember feeling extremely tired; the right side of my neck was sore and I was feeling sluggish. I came back to my dorm and called my mother. She thought that the pain was the result of the sudden change in climate; so, she advised me to bundle up the next time I went out. That night, I remember lying on my bed and being so tired that I was not even able to lift my head. Every time I touched my neck it felt like the side was getting bigger and bigger. By morning, my jaw had grown to the size of a cantaloupe and I was in a lot of pain. I called Campus Safety and asked if they would be able to drive me to the hospital but they refused; they said that I would have to call an ambulance. Not wanting to make a huge deal of the situation I woke up one of my roommates and asked her to drive me to the emergency room.

Once at the hospital, a PA visited me and asked me a routine set of questions. I had nothing out of the ordinary to tell her. I did tell her about my trip, and she asked if anyone had

been sick while I was abroad. That question made me think of my little cousin and his family who had all gotten one of *Gods' Diseases* while I was there. I did not know what that was, but I told her the story anyway. She then left and came back with another physician. They did an ultrasound on my jaw and saw that it was completely filled with fluid. They suspected that it could be a blockage caused by a salivary stone or a rare case of the mumps. We were not sure, but I was advised to go home and rest for three to four days. My dad picked me up and we went home. Out of fear, we visited the dentist and the oral surgeon to figure out what was wrong with me. They, however, could not figure out the problem either. So, I went home and tried to rest.

All of this chaos happened in the morning while my mother was at work. When she got back she was surprised to find me at home. With one look, however, she was certain of what it was. She immediately called her mother for advice. Then she became worried that she did not have any herbal treatments for me. All she could do was advise me to not shower. My mother feared that if I bathed then the swelling on the side of my face would solidify. Each day my jaw got bigger and the pain got worse every morning. I was given no medicine; all I took was generic pain medication and cough drops (sucking on cough drops apparently is supposed to loosen any lodged salivary stone—that is, if we were still entertaining the possibility of a blocked gland). By the third night, the school nurse paid me a visit to draw my blood. It had to be sent to the lab, which two days later confirmed the fact that I did indeed have mumps. The school, and the state were uneasy; they were concerned that I would be the cause of a mumps outbreak. Luckily, it all ended with me.

Aside from my horrible experience and the mini scare that it spread on campus it was not too bad. Things simmered down eventually and thankfully no one else got sick. This experience did however inspire me to ask my mother about *Gods' Diseases*. She was not able to tell me

much though. She did give me their names in Sinhalese, but I was not sure of how they translated into English. She did mention that they were contagious and that there was no treatment for them. While I was recovering though I did note that there were certain rituals associated with these diseases. I, for instance, was kept in my own room, separate from my grandmother. My dad feared that she might get sick. Also, I was not treated with any sort of oral or topical medication specific to mumps. I was, however, given pain medication. Another unique component of this disease seemed to deal with water. First off, I was not allowed to bathe for fear of solidifying my jaw. Secondly, my mother asked me to sprinkle yellow (*kaha*) water into the rooms of my roommates to kill any lingering germs. Via these ritualistic behaviors I realized that there was more to dealing with these diseases than just resting at home. Upon further inspection, however, I found that research on the topic was severely lacking. So, my personal experience with one of *Gods' Diseases* resulted in the making of this senior thesis project.

Unlocking Gods' Diseases

Gods' Diseases is a categorization of infectious diseases found in Sri Lanka. The diseases that people mainly identify as *Gods' Diseases* include: chicken pox, measles, and mumps. Other diseases (i.e. eye infection, yellow fever, diarrhea, small pox, cholera) are at times mentioned alongside the predominant three. References to these diseases, however, are rare and few. Self-treatment is the primary mode of treating the three main diseases. Still, informants also mix local cultural knowledge with biomedicine. Additionally, Sinhalese village folk look towards religion as a form of treatment as well. Many reach to the Goddess Pattini—a goddess responsible for women, children, and the sick. While sick, families ask the goddess for help and promise to return the favor once the sick return to good health. And following recovery, villagers carry out either one of two or at times both religious rituals in her honor. Further analysis of *Gods'*

Diseases reveals the presence of processes of hybridity in varying aspects of Sri Lankan life. First introduced during the time of colonialism, such a phenomenon of cultural transformation or regeneration is still prevalent today. Such processes of hybridity are clearly visible in the ways in which the Sinhalese understand and treat *Gods' Diseases*. So, as a means of understanding the concept of cultural hybridity more closely, I will explore this phenomenon through a focus on the diseases categorization of *Gods' Diseases*.

An Introduction to Sri Lanka

Sri Lanka, formerly known as Ceylon, is an island country off the southern coast of India in the northern Indian Ocean. Sri Lanka's history spans over 3,000 years. The start of early civilizations in the great cities of Anuradhapura and Polonnaruwa were the result of Buddhism's introduction to the country in the mid-third century B.C. (Central Intelligence Agency). By the 14th century, a new Tamil kingdom was established in northern Sri Lanka. The colonial period of Sri Lanka was marked by the arrival of the Portuguese (16th century) and the Dutch (17th century). The island was surrendered to the British in 1726, eventually becoming a colony in 1802, and was formally united under British rule in 1815 (BBC Asia 2013). So, Sri Lanka has a long history of outside influence.

In 1948, the country proclaimed its independence from the British. The country is the oldest democracy in South Asia. Today, Sri Lanka is a democratic republic and a unitary state, meaning that the state is governed as a unit where the central government is the main player and any other administrative divisions only exercise powers delegated to them by the central government (Central Intelligence Agency). The country is governed by a semi-presidential system, which incorporates both a presidential system and a parliamentary system. Sri Lanka is one of few republics with such a political system.

The first two decades of the 20th century were marked by peace between the Sinhalese and the Tamil political leadership. Ethnic tensions, however, began to rise in early 1983. The Liberation Tigers of Tamil Eelam (LTTE) began an on-and-off insurgency against the Sri Lankan government. The Sinhalese majority then became engaged in a twenty-six year war with the Tamil separatists (BBC Asia 2013). The government finally defeated the LTTE in 2009 and re-established its control of the entire country (Central Intelligence Agency). Following the end of the civil war, the Sri Lankan government has been involved in a rigorous plan of economic development projects.

The government continues to pursue reconstruction projects in order to spur growth, develop enterprises, and increase agricultural productivity. The country has incurred high budget deficits due to its high debt payments and civil services. Recent improvements in GDP and fiscal consolidation efforts, however, have helped bring down the fiscal deficit. Currently, the country has an annual GDP of \$134.5 billion with agriculture, industry, and services making up 10.6%, 32.4%, and 57% of the total, respectively. Along the same lines, 31.8%, 25.8%, and 42.4% of the labor force falls into agriculture, industry, and services, respectively. The unemployment rate in the country is 5.1% with 8.9% of the population being below the poverty line (Central Intelligence Agency).

The population has a growth rate of 0.86% with 16.24 births and 6.06 deaths per 1,000 people. The country has an infant mortality rate of 9.02 deaths per 1,000 live births and a life expectancy (at birth) of 76.35 years. 3.4% of the GDP is targeted towards health expenditures (Central Intelligence Agency). Despite its economic standing, Sri Lanka is one of the few developing nations in the world that offers free universal health care, free education, gender equality, and better opportunity to social mobility than other developing nations. As a result, Sri

Lanka maintains one of the most effective health systems. Gender equality—with high levels of female autonomy—and free education have allowed Sri Lankan citizens the opportunity to have an active voice in national priorities (Sirisena 2014). 1.7% of the national GDP is targeted towards education expenditures. The total population has a literacy rate of 91.2% (male: 92.6% and female: 90%) with an average of 14 years of schooling (Central Intelligence Agency).

In terms of demographics, Sri Lanka is home to many ethnicities, religions, and languages. Sinhalese is the official and national language of Sri Lanka and it is spoken by 74% of the population. Tamil, also a national language, is spoken by 18% of the population. English is also spoken by 10% of the population. It is constituted by 73.8% Sinhalese, 7.2% Sri Lankan Moors, 4.6% Indian Tamil, and 3.9% Sri Lankan Tamil. Other smaller ethnic groups (i.e. Burghers and Austronesian peoples) constitute 10.5% of the population. Buddhism, practiced by 69.1% of the population, is the official religion of the country. Islam (7.6%), Hinduism (7.1%), and Christianity (6.2%) are also practiced by Sri Lankans (Central Intelligence Agency). Since the time of colonialism to present day, Sri Lanka has a rich history of mixing cultural practices. The practice of co-existing is prevalent throughout Sri Lankan history.

History of Medical Systems

Healthcare in Sri Lanka is available under varying sectors (i.e. public [government], private, or non-profit sectors). Public sector healthcare is freely accessible to all and is usually free of charge. Sri Lanka employs a highly pluralistic medical system with an array of treatment options available to its users. Such options include Ayurveda (formally trained and informal ['Sinhala medicine'] practitioners), Western (biomedicine), Unani, Siddha, homeopathy, religious healing rituals, and indigenous herbal traditions (Amarasiri de Silva et al. 2001). Sri Lanka actually established a Ministry of Indigenous Medicine in 1980s. There are currently 62

Ayurvedic hospitals and 208 dispensaries in the public system. There are approximately 16,800 Ayurvedic medical officers; still only a little more than 5,000 are academically and institutionally qualified to serve the country (Institute of Indigenous Medicine).

While the practice of Ayurveda has a long history and great prominence in Sri Lanka, the British introduced Western treatment to Sri Lanka in the early 1900s. Following independence a broad welfare package, which included: free education, food subsidy and free English medical treatment in public hospitals and dispensaries, was offered to Sri Lankans (Amarasiri de Silva et al. 2001). Still, Ayurvedic understanding and treatments continue to have prominence in the lives of the Sinhalese. Although Western medicine is gaining prominence in the country, Ayurveda still continues to be an important aspect of the health care system.

In contrast to biomedicine, Ayurveda is a form of ‘comprehensive medicine’ that focuses on interrelating bodily conditions to humors, environmental and climatic factors, psychological dispositions, and moral and spiritual states. Unlike biomedicine, Ayurveda aims to treat a patient as a whole individual. It takes into account a person’s social situation and their moral position in life (Khare 1996). Biomedicine, on the other hand, is solely concerned about the cause and effect relationship of illnesses. It links a specific agent (i.e. virus or bacterium) to a certain outcome (i.e. disease). While Ayurveda provides a holistic representation of the body, biomedicine works to ignore social factors and its effects on the individual and only gives focus to the physical state of an individual’s body.

In Ayurveda diseases are considered to be the result of humoral imbalances. Perceptions of illness are based upon binary divisions of “illnesses of heat” (i.e. boils, mouth ulcers) and “illnesses of cold” (i.e. colds, respiratory infections, fever) (Russell 2005). Thus, the idea of medical treatment is to balance the system, which includes the body humors, the bile, wind and

phlegm (Waxler-Morrison 1988). Sri Lankan mothers, for instance, believe that acute respiratory illnesses are the result of humoral imbalances, the result of external forces such as exposure to wind or hot sun, and/or the result of particular behaviors, such as bathing at bad times, change in (source, quality, or amount) water, getting wet, going out in dew, etc. (Amarasiri de Silva et al. 2001). Such imbalances in the system are the result of both social and environmental contexts as well as of the body. Further examples of such imbalances include: attacks on the senses (i.e. eating too much ‘hot’ [*rasne*] food or seeing a demon), excessive or immoral behavior (i.e. drinking too much or increased sexual activity), supernatural forces (i.e. possession), etc. (Waxler-Morrison 1988).

In terms of treating such imbalances, Ayurveda offers more logical and accessible options for its patients. Biomedicine treats its patients via medications that are most likely foreign and unfamiliar to them. Ayurvedic treatments, however, consists of remedies that are easily comprehensible to its patients. These treatments consist of alterations in one’s diet, conduct, and regimen of life (i.e. bathing, exercise, sleep, morality, etc.) along with natural medicines aimed at re-balancing the system (Amarasiri de Silva et al. 2001). Sri Lankans, however, have their own perceptions of the treatment options available via biomedicine and Ayurveda. For instance, Western medicines such as antibiotics are considered to be ‘heating’ and in order to negate the heating effects they need to be counterbalanced with cooling foods (i.e. milk) (Russell 2005). Ayurvedic medicine, on the other hand, even when misused, is not seen in the same light as Western medicine. Ayurvedic medicine is seen as being ‘much less harmful’ or ‘harmless’ than modern drugs, which are often considered by many to be ‘too strong’, ‘hot and ‘full of long-term harmful side effects’ (Khare 1996).

Interestingly enough such knowledge of Ayurveda is a part of the local culture. Individual understanding of bodily experiences greatly stems from their knowledge of Ayurveda and this knowledge affects how *Gods' Diseases* are understood and treated. Having access to this cultural knowledge not only influences people's perceptions of their diseases, but it also gives them the opportunity to become agents of their own bodies. Some Ayurvedic herbal remedies can be easily made at home; therefore, people can actively take care of their own bodies. This agency, however, is further strengthened by free and easy access to Ayurvedic remedies. While certain remedies cannot be obtained without consultation with either a private Ayurvedic practitioners or a college-trained Ayurvedic doctors, Sri Lankans do have access to certain Ayurvedic medicines from their local dispensaries. In terms of *Gods' Diseases*, for instance, all herbal remedies needed for the three major illnesses can be obtained over the counter or made at home. In this manner, Sri Lankan patients eliminate the need for medical practitioners. They make use of local cultural knowledge and available remedies to cure their own diseases. Such behavior allows Sri Lankans to become agents in their own healing processes for certain diseases.

Sri Lankan's perception of disease and healing, however, is not restricted to Ayurveda. As biomedicine has gained rapid acceptance in Sri Lanka, people have come to accept Western understanding of illnesses. This increasing acceptance of Western medicine indicates growing public confidence in its effectiveness as a form of treatment (Russell 2005). It has been suggested that care seeking patterns have transitioned from traditional to western treatments over time; research suggests that population ideals have shifted from a time where western medicine was viewed as 'another form of magic' and a 'simple substitution for another form of treatment' to a time where traditional treatment is almost neglected (Amarasiri de Silva et al. 2001). In

terms of *Gods' Diseases*, however, Sri Lankans do not seem to favor Western medicine above all. Instead, they seem to either prefer self-treatment (using Ayurvedic knowledge alone) to Western medicine or a combination of both forms of treatment (a mix of Ayurvedic and Western knowledge). Such a mixing of practices makes it interesting to see how these choices are navigated.

Self-Treatment

Despite the availability of varying treatment options, Sri Lankans prefer self-treatment to other medical systems when dealing with *Gods' Diseases*. Self-treatment is growing as a means of care-seeking behavior and studies have provided evidence of the use of home-based Ayurvedic treatments in Sri Lanka. Usually, self-treatment at home is a first response to illnesses that are identified as mild or self-limiting. Such forms of treatment consist of traditional herbal remedies (i.e. boiled coriander for coughs and colds) or Western medicine (i.e. paracetamol) already in homes or easily purchased from local shops (Russell 2005). Even though the use of Western practitioners is rising self-treatment at home is still greatly preferred. If, however, conditions are deemed to be serious people seek out professional medical care. Case study household respondents, for instance, preferred to use a private doctor or pharmacy rather than visit the Municipal Dispensary or a public hospital in severe cases (Russell 2005). Such behavior suggests that people recognize the extent of their control. In the early stages of disease people believe in their capacities to care for the sick, but in cases that are deemed to be too severe people seek help from professional practitioners.

Such practices of self-treatment, however, are not limited to Sri Lanka. Such behavior, for instance, has even been observed among primary school children in western Kenya. Similar to Sri Lankan patients, these children have become autonomous agents in their health care by

integrating Western medicines with local herbal treatments. The kids expressed having easy access to painkillers (i.e. aspirin and paracetamol) and anti-malarials (Geissler et al. 2000). Moreover, these children also had access to herbal medicines. Easy access to medication allows these children to engage in their own processes of healing. Illness along with treatment is a part of everyday life. So, these children understand that learning how to cope with these ailments as a necessary aspect of their lives. Since medical knowledge is not reserved to adults or specialists, children learn these skills early on (Geissler et al. 2000). The same can be said of Sri Lankans. Medical knowledge does not belong to practitioners alone; it is in fact part of local cultural knowledge. Before the expansion of allopathic medicine, traditional means were the only way of coping with common illnesses. So, people had to make do with what they knew and to take care of their ailments by themselves. These skills were never lost; they were preserved in local knowledge. They have proved to be resilient to the effects of both colonization and globalization.

In addition to common knowledge, people have learned about diagnosis and treatment of common diseases via their exposure and use of universal drugs. Pharmaceuticals that are used daily within the community are acknowledged for their effectiveness; thus, they are added to people's existing understanding of herbal medicines. The presence of easily accessible pills and simple preparations of treatments allows the opportunity for people to become free agents in maintaining their own health. It is important, however, to understand the three characteristics of the local medical context that allow for such behavior: 1) no clear boundaries between biomedical and herbal medicines, 2) incorporation of new medicines into existing practices, and 3) shared common knowledge (Geissler et al. 2000).

The lack of boundaries between medical systems allows people to easily move from one to the other. In Sri Lanka, while self-treatment is the primary mode of care for *Gods' Diseases*,

the Sinhalese also actively engage with biomedicine. They do not segregate between different systems of health care. Instead, they move freely from one to the other, seeking out what they need from each sector. Patients also self-treat by incorporating traditional medicine with easily accessible modern medicines. In moving from one sector to the next, Sri Lankans learn about the best possible treatments. They then only do what they believe to be the best course of action for them. They actively mix knowledge from both traditional and modern domains. Finally, knowledge of medicine and care is not an expert domain (few exceptions); all community members share it. Understanding of the body and the illness experience is common knowledge in Sri Lanka; everyone shares it. What happens differently in Sri Lanka is that knowledge from biomedicine is reinterpreted in terms of Ayurveda. Then, according to each individual's necessities they pick and choose the systems of knowledge that they prefer to follow.

Moreover, another study, also in Kenya, explored their treatment behavior of malaria patients in a rural southwestern community. People chose from varying treatments based on their perceived effectiveness. Still, self-treatment was the first option of care-seeking behavior. Treatment included home-remedies or remedies from pharmacies. Use of herbal treatments preceded the use of over-the-counter drugs; once again, easy access to drugs allow people agency to take care of their own bodies when other sources of health care is limited (Nyamongo 2002). Not only that, high rates of self-treatment allow people to develop a working knowledge of drugs for treating fever and malaria.

These informants only sought outside help if conditions continued to persist. Patients start off with the most cost-effective means—self-treatment. If the illness progresses, treatment is moved outside the home. Once outside the home, patients expect to get better because the health care providers are well trained and the clinics have strong medications (money in exchange of

better treatment and recovery). Patients want to minimize the expenditure incurred as a result of the sickness by going to a facility that offers better treatment. If this fails, however, patients move on to another cost saving strategy (Nyamongo 2002). Patients are always calculating for the best plan; their course of action depends on factors such as cost and time to heal.

When is self-treatment alone enough?

It is important to note, however, that self-treatment has its drawbacks. It does not always result in fast recover. It takes a great deal of time and effort. Most importantly, it proves to be problematic if situations get too serious. Self-treatment is not always successful and it is especially during times like these that people look towards biomedicine. Looking at the example provided above it is clear that Kenyan informants reached towards different sectors of care as illnesses progressed and other home-based systems of care failed to provide a cure.

Another study from a Kenyan community looked at the management of childhood malaria at home. Mothers treated the majority of childhood illnesses at home; the explanatory models employed by mothers categorize illnesses into three categories: serious, mild, and mundane. Mothers in this community identified malaria by its symptomology (i.e. fever) and categorized and treated accordingly. Illnesses identified as mild and natural were seen as treatable with modern treatments. In treating their children most mothers utilized over-the-counter drugs, often mixing combinations of drugs (i.e. combination of analgesics and/or mixture of analgesics and anti-malarial drugs). Various factors indicate a mother's decision about doing nothing or seeking treatment for malaria; they include a mother's experience with the illness (i.e. perceived aetiology, prognosis, seriousness), its definition, and the social structure of the household. Mothers understand what they can treat themselves and what needs outside intervention.

The same criteria are used in Sri Lanka when deciding on what treatment to use. The Sinhalese constantly monitor the diseases and move between varying forms of treatment as the diseases progress. If a disease is still in its early stages, then the most likely course of treatment will be home-based remedies. On the other hand, if a disease begins to worsen, then people start to reach out to medical practitioners. A 2001 study, for instance, explored care-seeking behavior in Sri Lanka. Results showed that mother caretakers sought greater care for illnesses with acute high-risk symptoms and signs. Similar to the actions of mothers discussed above, Sri Lankan mothers placed great importance on perceived symptoms and severity; such ideals in turn determine care seeking behavior. The symptomology of episodes seems to serve as an index to choosing early treatment (Amarasiri de Silva et al. 2001). Such behavior may serve as a plausible explanation for the low level of childhood mortality present in Sri Lanka despite the prevalence of a high rate of malnutrition. Since mothers are constantly monitoring their children, they are able to quickly seek help for their children when they feel necessary.

Having such a keen eye for monitoring the sick means that Sri Lankans place great emphasis on symptomology. Sri Lankans seek biomedicine when they perceive the symptomology to be severe. They acquire the advice of physicians, but still continue to follow what they believe to be the best for them, which often includes an incorporation of both Western and traditional means. Sri Lankans may be stressing the importance of symptomology because of its linkages to traditional medicine. Ayurvedic texts, for instance, stress the importance of patient signs, reported symptoms and personal history (Waxler-Morrison 1988). So for centuries Ayurvedic practitioners have been utilizing patient's summaries of their illnesses, rather than physical examinations, to treat and diagnose. This may be a reason for the increased attention

paid towards symptomology. Such an emphasis on symptomology allows Sri Lankans the opportunity of early detection and treatment.

Hybridity

Nowadays, globalization plays a large role in allowing for processes of mixing cultural ideals and knowledge. There is no longer a culture that is independent, coherent, and stable. Such processes of blending or hybridity, however, are not reserved to processes of globalization. They can be traced back to the time of colonization and as post-colonial subjects, Sri Lankans have continued to experience a double heritage, having roots in two or more cultures (Hermans & Kempen 1998; Kuortti & Nyman 2007). Cultural hybridity is a means of describing the cultural contacts of the European explorers and those explored (Raetzsch 2003). Its influence on trade and transformation of empires can be seen as precursors of contemporary global change (Hermans & Kempen 1998). Hybridity is understood as a site of transformation and change “where fixed identities based on essentialisms are called into question.” It addresses processes of intercultural transfer and the identities that such processes of blending generates (Kuortti & Nyman 2007).

Cultural connections have led to this phenomenon of hybridization and this is what we continue to see in Sri Lanka today. The concept of hybridity questions the notion of cultures as being internally homogeneous and externally distinctive (Hermans & Kepen 1998). Everything is connected. Hybridity arises when existing cultural practices are transformed into new ones via external influences. Such processes of hybridization allow for a new repertoire of knowledge about culture. It provides new ways for practices to become fused together and allows for new identities to develop. Greater connection ensures a greater fusion; thus, resulting in a complex mix of cultural ideals and identities. The concept of hybridization allows us to understand the

world as something that is interconnected rather than cultural dichotomies where the world is presented as separate and static (Hermans & Kempen 1998). The presence of heterogeneity, however, does not mean “cultural meanings and practices are so diverse that it is impossible to characterize them in terms of meaningful thematic tendencies” (Hermans & Kempen 1998). They can still be understood in its own terms.

There exists this belief that cultural differences can be understood in terms of cultural dichotomies; such dichotomies, however, do not and cannot meet the challenges raised by globalization (Hermans & Kempen 1998). Dichotomies present a static view of the world; hybridity on the other hand emphasizes the mutual intermingling between varying sets of knowledge (Raetzch 2003). The anthropologist Wolf dismissed the concept of cultural dichotomies; his central belief was that the world is made up of a totality of interconnected processes (Hermans & Kempen 1998). Hybridity acknowledges the formation of identity as something that is constructed via a negotiation of differences (Kuortti & Nyman 2007). And such recognition can be seen in Sri Lanka. It is clear that Sri Lanka is engaged in processes of hybridity, especially in terms of their medicality. Such processes of hybridity, however, can be seen in other domains in Sri Lanka as well. The following sections provide some more examples of this phenomenon.

Care Seeking Behavior

Such a process of mixing ideals is visible in Sri Lankan people’s practice of care seeking. In seeking care, Sri Lankans seem to prefer sampling varying health care sectors. Instead of securing care from one type of physician or practice, Sri Lankans like to mix varying forms of treatments. For example, the work of Amarasiri de Silva et al. looking at care seeking behavior in Kurunegala, Sri Lanka observed that caretakers often sought treatment from both private and

public practitioners, which includes college-trained Ayurvedic physicians (2001). Such displays of multi-system usage have been studied extensively in Sri Lanka. Nancy Waxler-Morrison's work in Sri Lanka in 1988 explored patients' paths to treatment for psychiatric illness and tuberculosis. She worked under the assumption that patients select varying practitioners based on certain symptomology criteria as well as their own knowledge about the therapeutic methods or expertise of the physician. Results, however, showed that patients visit both Ayurvedic and Western biomedical doctors at the same rate and that almost all families use both types of treatment for both common and more serious symptoms. Waxler-Morrison also concluded that patients do not base their choice of physicians on their training or theoretical base of their field. Instead what consists as important is the reputation of the place, cost, and convenience (i.e. distance to physician) (Waxler-Morrison 1988). Moreover, the Sinhalese also want to make use of all possible options so that they may have a choice in terms of what best course of action to take. In this manner people have greater agency in terms of their overall health.

Health Care

Processes of hybridity are not limited to patients alone. Practitioners are also starting to engage in such practices; thus, suggesting that this phenomenon is apparent across varying cultural groupings. Due to changing circumstances in the field of healthcare, patients' expectations have caused traditional practitioners to alter their method of working. Such expectations have resulted in the practice of mixing varying techniques and treatments by traditional healers. Due to the rising value of Western medicine Ayurvedic practitioners continue to adapt to changing times and patient demands (Waxler-Morrison 1988). Thus, about fifty percent of the traditional practitioners interviewed by Wolfers (1989) were working in cosmopolitan style even though not all utilized cosmopolitan medicines to the same extent. Such

indigenous practitioners of modern medicine play a great role in the health care market. They work in the same manner as cosmopolitan doctors, but they differ from each other in their style of working, knowledge of drugs, and their beliefs about cosmopolitan versus Ayurvedic treatment (Wolffers 1989).

Via such means indigenous practitioners may create a space for themselves in an ever changing health care industry and rising patient demands. In addition to changing patient needs, use of Western medicine prevails in Ayurvedic practice due to its position as a powerful institution. The Western institution of medicine has defined the terms of medical practice. It plays a role in delineating what types of medications are available and what is considered to be 'good' and worthwhile (Wolffers 1989). Here, the expansion of Western medicine and the evolving expectations of Sri Lankans are resulting in changes in the traditional health care market. Traditional practitioners are now starting to adapt to changing times in order to make a place for themselves. Practitioners are reacting to patient demands and thus engaging in processes of hybridity to stay competitive in the health market.

Modernization plays a large role in the practices of Sri Lankan health care practitioners. Its affects can also be seen in medical practices in India. In India, modern medicine is also influenced by and continues to influence the traditions of Ayurveda, Unani and Homeopathic medical systems (Khare 1996). According to the work of Wolffers (1989) the incorporation of Western medicine has resulted in the changes in the work ethic of traditional practitioners. The ways in which traditional practitioners can then compete with modernization is either to distance themselves from modern practices or embrace newer ideals.

Indigenous practitioners can cater to patient demands that are not well catered for by modern physicians. Cosmopolitan medicine lacks interest in indigenous taxonomy and modern

practitioners are at time inaccessible due to certain factors such as distance or cost (Wolffers 1989). Such drawbacks work in the favor of indigenous practitioners. Indigenous practitioners can also improve their image by emphasizing the differences between traditional and cosmopolitan medicine. For instance, indigenous medicine is seen as old, 'good' and traditional while cosmopolitan medicine is seen as new, 'bad' and alien (Wolffers 1989). As a last resort, indigenous practitioners can chose to adopt therapeutic techniques from cosmopolitan medicine. Cosmopolitan medicine offers fast cures, which is something that is in constant demand. Moreover, cosmopolitan medicine is often unavailable in rural areas. So, by offering fast treatment and filling the gaps in certain environments traditional practitioners can still make a place for themselves (Wolffers 1989).

Values

Such processes of mixing are not only restricted to process of health and health care; it can be also seen in the values held by individuals. Sri Lanka continues to display an unusual combination of both modern and traditional forces in all aspects of life. For example, such behavior is quite clear when looking at the timing of marriage of Sri Lankan women. Modernization theory attests that socioeconomic development of women results in changes of norms and ideas. That may delay women's entry into marriages. In trying to understand the influence of modernization on marriage systems in Asian societies studies have linked the process of self-selection as being associated with later rather than earlier marriages for women. In Sri Lanka, however, women who choose their own husbands tend to marry earlier than women whose marriages are arranged by their parents. Such findings raise questions concerning the influence of or lack thereof on modernizing forces in enforcing social change (Malhotra & Tsui 1996). This brings to light ways that Sri Lankans are responding differently to processes of

globalization and modernization. Cultural factors are important in determining marriage timing for Sri Lankan women, but the role of modern forces on such decisions are considerably muddled. Such peculiar combinations of both historical and developmental forces are not only present in marriage timings of Sri Lankan women, but are also reflective of its culture in general. Such competing forces between the modern and the traditional exist together; there is no linear relationship between the two. Such varying measures of modernity within a culture shed light on the fact that the younger generation is “engaged in balancing the demands of rapid social change, poor economic prospects, in addition to the needs and functions of the historical family system” (Malhotra & Tsui 1996).

Religion

Gods' Diseases has obvious ties to religion. With Theravada Buddhism being the main religion of the country it is surprising that people seek the help of gods and goddesses because there are no central deities in Buddhism. This incorporation of deities occurred following influences from external sources. Theravada Buddhists became accustomed to the worship of gods because of varying reasons (Ahangama Dhammarama 2005).

Belief in gods and goddesses is separate from belief in Buddhism. Gods and goddesses come from folk-religions and are believed to be subordinates to the Buddha. Buddhism does not give prominence to the worldly side; Buddhism acts as a guide in moral conduct and it deals with “matters causing man’s final destruction and the after-life” (Ahangama Dhammarama 2005). Gods and goddesses, on the other hand, take part in people’s lives and help them “gain material benefits and check natural calamities” (Ahangama Dhammarama 2005). The author Ahangama Dhammarama attests that only the less educated follow worldly practices of other religions (i.e.

making vows to gods and other ceremonies to worship gods). Such beliefs are still common today.

Since Buddhist monks do not partake in the principle events of people's lives this gave way to folk-religious belief. Folk-religion "thrives on belief in beings and matrix of prayer and ritual," but even though the "teaching of the Buddha disregards animism people sought solace through an alternative path for the ills of everyday life" (Ahangama Dhammarama 2005). So, the influence of Hindu customs and beliefs is greatly visible in Sri Lanka practices today. The influence of worshipping gods has prevailed since the beginning. Even after the spread of Buddhism, people continued to adopt folk customs. In society today, gods perform many functions. These gods even became protectors of Buddhism. Gods like *Vishnu* and *Pattini* have even been classed as Bodhisattvas or future Buddhas. So, since the beginning the Sinhalese have sought the refuge of Buddha and gods (Ahangama Dhammarama 2005).

The Role of Religion

In order to understand people's experiences of *Gods' Diseases* we need to outline the key aspects of religion that relate to this category of illnesses. People's experiences of *Gods' Diseases* are colored by ideas of Theravada Buddhism and the Goddess Pattini.

Ideals of Theravada Buddhism

Theravada Buddhism is the oldest surviving branch of Buddhism and it is the religion of approximately seventy percent of the population in Sri Lanka. Theravada places great emphasis on insight gained through critical analysis and personal experience. Theravada emphasizes individual enlightenment (O'Brien 2014). The supreme model is to become the *arhat*, meaning the "worthy one." Someone who has attained arhat has achieved enlightenment. They have freed themselves from the cycle of birth and death. Theravada Buddhists believe that every individual

is responsible for their own self-awakening and liberation; individuals are solely responsible for their own actions and consequences. Theravada places great emphasis on the self; enlightenment is believed to be only possible through one's own efforts (O'Brient 2014).

Goddess Pattini

Goddess Pattini is recognized as a guardian deity of Buddhism. She is identified as the Goddess responsible for helping women, children, and the sick. Ahangama Dhammarama asserts that Sri Lankans regard measles and chickenpox as diseases of Goddess Pattini (2005). When affected by one of *Gods' Diseases* many reach to Pattini for help. Following recovery, either a milk-mother's alms giving (*kiriamma daneyak*) or an offering to a temple is given in honor of her. It is said that there are seven forms of the goddess: 1) Aluth (new) Pattini, 2) Gini (fire) Pattini, 3) Parasidu Pattini, 4) Theda Pattini, 5) Rila Pattini, 6) Kashanu Pattini, and 7) Gala Pattini. She is a goddess waiting for reincarnation, hoping to be born as a man in her next life so that she may attain enlightenment. So, in hopes of achieving this goal she works to collect the good deeds (*pinn*) that people give her. The stories surrounding her life vary from one account to the next. Varying interpretations of her life are provided below.

Sinhala Pattini's Narrative

Verses sung in her honor inform listeners that Pattini was the daughter of a minister in charge of administration of a particular locality. One of the girl's attractions was her hair, which had grown to the length of seven and a half 'fathoms'. Because of incredible beauty her parents made great efforts to look after her. Bathing her was strictly her mother's responsibility. Taking care of her beautiful hair was, however, a tedious task. So, her mother maintained a special comb to do her daughter's hair. One day, however, the mother forgot to bring the special comb. So, she advised her daughter to stay put while she went home to retrieve the comb. Upon return though

her daughter was not there. The mother searched everywhere, but her efforts proved futile. Eventually though the mother got word that her daughter was seen sitting on the branches of a *daminna* tree. Upon arrival at the tree the mother only found her daughter's headband and outer garments. The mother was heartbroken, but one night her daughter appeared to her in her dreams. She consoled her mother that she was no longer a human being. She was now a deity. She said that she received permission from Pattini Devi to "attend to welfare work for the good of human beings." She then disappeared after dropping her seven-stringed necklace and golden bracelets to a pond. She is now dedicated to curing the sick. She never makes others suffer (Aryasinghe 2000). Such references to the number seven have great links to the religious ceremonies associated with *Gods' Diseases*.

Rajavaliya: Historical Ceylonese Chronicle of Sinhalese Kings

Both Sri Lanka and South India has worshipped Pattini since the 2nd century. The Rajavaliya reveals that King Gajaba invaded Chola in order to seek revenge. The Chola King had taken twelve thousand Sinhalese as his prisoners. As punishment, they were brought back with sixteen thousand Cholas. In addition to the prisoners, it is said that King Gajaba also brought back the ornaments of Goddess Pattni's anklet (*salamba*). Another verse from the story says that both the bowl of the Lord Buddha and the ornaments of Pattini were brought across the ocean to Sri Lanka. Such merit is a means of attaining supreme Bliss (Aryasinghe 2000).

Silappadikaram: One of the Five Great Tamil Epics

This story gives a different perspective of Goddess Pattini. Here, it asserts that King Gajaba went to Chola to take part in a ceremony organized to worship Goddess Pattini. In the Chola Kingdom, there was a trader called Puhar, also known as Kowalan. There was also a trader's daughter called Kannaki. Both Kowalan and Kannaki married according to Hindu

customs and they live happily. Some time later though Kowalan met a prostitute named Madavi. Forgetting his wife, he fell in love with her and spent his whole wealth on her. Later on, however, she chased him away. With a sad heart he went searching for his wife, who took him back happily. Without any means of making a living the couple moved to Pandiya, with Kannaki's anklets in tow. At Madura, Kowalan went to sell one of Kannaki's anklets. There, the goldsmith framed Kowalan as the thief of the Queen's royal anklets. The King without any investigation executed Kowalan. Kannaki, having heard this, was furious and cursed the King and the country, which then was destroyed. The Goddess in charge of the city appeared to Kannaki and said that Kowalan had to face such a death due to his past and that four days later Kannaki would join Kowalan in heaven. After that the people of that country started worshipping Goddess Pattini, who is believed to have seven forms: 1. Aluth Pattini, 2. Gini Pattini, 3. Parasidu Pattini, 4. Theda Pattini, 5. Rila Pattini, 6. Kashanu Pattini, and 7. Gala Pattini. And Goddess Pattini is credited with creating seven first to stop another deity from landing in a particular village in Sri Lanka (Aryasinghe 2000).

The Story I was Told

This story is quite similar to the one recounted above. Goddess Pattini had a mate that was unfaithful. He went off with another woman, but eventually came back to Pattini, who wholeheartedly accepted him. Since the couple was poor the Goddess gave her husband one of her anklets to sell. At the same time one of the anklets of the wife of a local king went missing. The Goddess's husband was found, accused of stealing the queen's anklet, and killed. When Pattini found this out she was full of rage. She went to the king and proved her husband's innocence. While Pattini's anklet had diamonds inside, the queen's had pearls. So, Pattini broke her anklet and showed the king that he was wrong. The king and queen then died due to shame.

In her anger Pattini tore off one of her breasts and threw it, which erupted a fire in the region. The children and the women then came to her for help. Her compassion then took over her and she went and took cow's milk and put the fire out. Because of this compassion then is why people now seek help from her. The narrative of this story as well as the one recounted above are incorporated into the religious rituals associated with *Gods' Diseases*. The references to the number seven relate to ways that certain entities (i.e. food and female participants) are organized. Also, the account of Pattini's breast and milk references the participants (i.e. milk-mothers) who are invited to join the ceremony. So, the varying accounts of her life play intricate roles the ceremonies that the Sinhalese carry out in her honor.

The Value of Religion

Religion plays a vital role in people's understanding of their illnesses. It often serves as a coping mechanism. Religion allows the sick to experience psychological growth from their negative health experiences rather than to be defeated or overcome by them (Koenig et al. 2001). It is a means of making sense of one's illness experience. One of the main reasons of performing religious rituals is for the cure or the recovery of the illness. Buddhist and Hindu traditions, for instance, recognize religious care as a part of the healing process. Many believe in its capacity to aid in the process of recovery (Pelzang 2010). Religious beliefs and rituals help patients and families deal with ill health in varying ways. They help 1) enhance well-being and relieve stress, 2) retain a sense of control and 3) maintain hope and sense of meaning and purpose in life (Koenig et al. 2001; Pelzang 2010).

In looking at a religion such as Islam, prayer plays a large role in the process of curing. Prayer is acknowledged as a means of enhancing therapeutic efficacy of medicines and medical treatment. In Islam, however, illness plays a spiritual function. Illnesses, beyond bodily

suffering, convey God's purpose. It is seen as a means of receiving punishment as well as a means of achieving perfection (Khare 1996). Thus, treatment is only sought when the illness is unbearable, until then prayer is used as a means of treatment.

Buddhism, on the other hand, is a nontheistic religion. It identifies illness as a physical and philosophical "suffering" caused by the "impermanent nature of our existence" and not due to external or internal causations (Khare 1996). During the time of the Ming dynasty, Buddhist medicine placed greater emphasis on the mental and the karmic origins of illness. This in turn allowed for the possibility of cultivating an unwavering trust in the Buddhas and Bodhisattvas and engaging in religious practices (i.e. keeping a vegetarian diet or sutra-chanting) to purify the mind (Chen 2008). It is believed that doing so ensures that it cures the illness or at least makes the suffering more bearable. Such beliefs are also shared among the Sinhalese. Sri Lankans believe that promising to take part in a religious ritual after recovery makes the illness bearable for the sick and ensures that no one else gets sick. Such a view of illness offers a viable explanation for their illness and works to alleviate distress. In the Ming dynasty, such beliefs offered women the opportunity to actively engage in their own self-treatment by participating in religious practices of various kinds (Chen 2008).

Methodology

For this project I interviewed a total of 62 informants, all from varying backgrounds (i.e. professions, socioeconomic status, religion, age, etc.) and towns/cities (i.e. Kiriwathuduwa, Kanthekatiye, Colombo, etc.). I interviewed 43 women (12 young women [< 35] and 31 older women [> 35]) and 19 men (3 young men [< 35] and older men [> 35]). The majority of my informants were Buddhist (54), but I also had the opportunity to interview some Tamil (3), Muslim (3), and Christian (2) individuals. I had the greatest access to Buddhist informants

because of my location within the country and the networks of my research aid and informants. Despite the lack of religiously diverse informants, I did have a diverse sample population in terms of professions. I interviewed 14 informants from varying medical professions (i.e. physicians, nurses, midwives, pharmacists, attendants). I also interviewed 4 teachers and 8 religious leaders (i.e. temple leaders, astrologers, monks). The remaining 36 informants were not specified into any particular professional category; individuals in this category include folks with varying job titles or no specific jobs.

Informants		Total		
Grouping	Religious Sect	Buddhist	54	
		Tamil	3	
		Muslim	3	
		Christian	2	
	Religious Leaders	Temple Leaders	3	
		Monk	3	
		Astrologer	2	
	Medical Professionals	Physician	Western	4
			Ayurvedic	1
			Both	1
		Nurse	2	
		Midwife	2	
		Pharmacist	1	
		Attendant	3	
	Education	School Teacher	4	
	Miscellaneous		36	
Total		62		

Table 1. Categorization of informants by profession

Informants belonged to varying socioeconomic levels, with the majority being from middle to lower class. Those belonging to the upper crust were very few. All interviews were conducted at locations most suitable for my informants (i.e. homes, hospitals, stores, etc.). Interviews that I was able to conduct in homes gave me great insight into the lives of my informants. Many of the homes had shrines to Buddha, a customary aspect of Sri Lanka homes. Most were single story brick or cement homes, some finished and some still under construction.

The simplest home that I visited was that of an older grandmother. It was a single bedroom with an attached kitchen; the other section of the house had been leased out to another family. Her house was not swept and it was cluttered with things; I sat on her broken bed and my aunt sat in a lone chair. I conducted the interview with her from the kitchen as she prepared her dinner in a makeshift brick/stick stove. Contrastingly, middle class homes were equipped with nice cushioned wooden couch sets, tiled flooring, ceiling fans, etc. Several were gated with well kept inner gardens. Several middle class homes also had one or more vehicle (i.e. motorbike, rickshaw, car, van, etc.).

I assume that the physicians lived upper class lifestyle. They were all well dressed and the two that worked in the neighboring village drove their own cars. The physicians often worked at the public hospitals during the daytime and in the afternoon and on weekends worked at their own private practices. One physician, for instance, worked at the National Cancer Institute of Maharagama and had his own private practice in *Kandekatiye*. The practice would be open from five to nine, but people would start getting lining up from three onwards. Villagers would often call in to the adjacent store and ask the owner to take ticket stubs for them. The pharmacist would come at four and open the garage door that closed the dispensary/practice. Patients sat and waited on the right side of the space where there was one row of plastic chairs set up. The pharmacy and the physician's office are located on the left side. The pharmacy cubicle is a large square enclosure. You can see into it from the front of the space. Attached onto that on the back is the physician's room. The patient enters through the green curtains and visits his small room, where he has his own computer and medical equipment. He even had his own entrance into the room.

Other interesting settings include an interview at a hospital. During the early phase of my project my cousin had to suddenly get his appendix removed. On the third day of our visit I interviewed a man in my cousin's ward. There were approximately 24 to 32 beds in that ward. Each section (either 3 or 4) housed around eight beds. Each section was separated by genders. There were two bathrooms available, a common sitting area with a TV, and a doctor's station with two-three nurses and three-four residents. Patients had their own bed, nothing too fancy. They had their own mini cabinet for their belongings and the capacity to some privacy with a curtain that encircled the bed. I interviewed the man at his bed. There were only two other people in that section of the ward that day. So, we were able to do a somewhat private interview.

Another interesting interview was conducted at a monastery. I wanted to interview the head monk of the local temple, but I was unable to secure an interview several times. I visited him two or three times before I was finally able to get an interview. He lived in a two-story house adjacent to the temple. It was a house for not only him but also other older and younger monks. During those earlier visits I remember seeing a young monk sleeping on the couch with a radio show blasting loudly. Upon further questioning we found out that the head monk was not around; so, we promised to come back another day. My aunt then called the monk another day and secured an interview. On the day of the interview, my aunt told me to wear light colors. You have to wear light colors, preferably white, when you visit the temple. Also, as a woman you are not permitted to wear short sleeves or short skirts as it is not seen as being decent or respectful of the monks. When we visited we had to kneel and bow down to the monks feet—a customary act. My aunt and I sat on the ground as we interviewed the monk. I had to be respectful when addressing him; I was asked not to use casual terms (i.e. you) when speaking with him.

Following the interview I was not allowed to directly give him the gift that I had brought; I was advised to just place it on the seat and leave.

A Learning Process

For the entirety of my project my aunt was my research aid; she always accompanied me to interviews because it is not culturally acceptable for me to travel to the homes of non-relatives alone. During the interviews, I asked my informants a series of questions concerning “Gods’ Diseases” (see attached questionnaire). I wanted to learn about the identity of these illnesses and people’s health seeking behaviors. I took written notes for all of my interviews and if permitted I recorded the interviews as well. Before participating, my informants were asked to read and sign an informed consent form (see attached consent form). In cases when informants were not able to read the consent form by themselves, either my aunt or a relative of theirs read the form out loud. After the interview I compensated my informants for their participation; I gave each of them a small gift (i.e. milk packets, biscuits, etc.) thanking them for their time and effort. I also gave them my information in case they had any concerns about the interview.

Before the start of the interviewing process, my cousin helped me translate my consent forms and questions to Sinhalese. As I was not yet comfortable asking the questions in Sinhalese it was my aunt who carried out the first interview. So, she read the questions to my informant and I interjected whenever I needed something to be clarified. The problem, however, was that rather than just asking the questions my aunt would also provide her own answers to the questions. At times she would speak for the informant or alter their answers with her responses. For instance, she would ask a question about how to treat *Gods’ Diseases* and then she would give her own answer of how she had learned to treat the illnesses and ask the informant if they

agreed. The informant would then add a line or two of their thoughts and then usually agree. So, I soon realized that I had to do the interviews by myself.

With the following interviews I realized another problem of having my aunt present during the interview processes. For instance, if the informants did not know an answer to a question they would automatically ask my aunt to answer for them. They would say something like, “Well, this is what I know, wouldn’t you agree?” or “I don’t know. Why don’t you say something?” I then had to tell the informants that I was interested in what they had to say and over time I conditioned my aunt to say that she was not allowed to contribute. The informants were uncomfortable with this, but eventually they would give some sort of answer. But at times it was not even my aunt from whom informants would seek answers. At times I had to conduct interviews in the presence of the informant’s relatives or friends, who would also contribute their answers to my questions. During those instances I felt too uncomfortable to ask the other not to interject; so, I would try to either direct my question to my informant or only ask them to elaborate more.

Certain informants did hesitate when they did not know answers to my questions. I had one informant who after every one of her answers would say, “That may be it. Don’t you think?” She was very much uncertain about her answers. On the other hand, I did have informants who were extremely confident about their answers and their stances. One religious leader, for instance was adamant about the power of religion and belief to cure these illnesses. He had a lot of conviction in himself to help others get better and in himself to have never gotten sick from other people’s illnesses.

Dealing with the physicians, however, was a different matter. It seemed like most were unaware of the local beliefs and the actions of the villagers in terms of *Gods’ Diseases*. Even the

nurse that I had interviewed in the previous section was unaware of certain cultural rules and actions. On the day that I interviewed the physicians at the hospital I encountered a lot of uncertainty in terms of local cultural knowledge. I interviewed the physician who took me to the hospital first. He did tell me about the history of these illnesses in terms of the vaccinations that have been available. In general though he was unaware of a lot of the practices that people engaged in when affected by *Gods' Diseases*. He kept asking the young attendants about what people do; they also seemed to not know a lot about the rituals. (I am not sure, however, if the attendants were being truthful. I had the sense that they may be faking how much they knew in order to maybe maintain some sort of status, but I am really not sure).

After the first physician, I spoke to an older attendant who in my company told me about his beliefs about *Gods' Diseases*, which in fact matched what I had already been hearing from my informants in town. It was really surprising to see such varying sets of knowledge all in one setting. Following this, I spoke with two female doctors; one was not too knowledgeable about the village rituals while the other was. The latter doctor spoke about her experience with the illness during her time in medical school. She also addressed the rituals her mother performed and the restrictions her mother insisted upon. The doctor, however, spoke of how she did not listen to her mother's concerns about bathing or restricting certain foods. She admitted to bathing every day and eating foods such as eggs, which are often restricted. The difference between this doctor and the previous two was that this physician had actually had one of *Gods' Diseases*. The first physician had not and the second female physician had taken an antibiotic at the sign of certain symptoms; thus, preventing her from experiencing *Gods' Diseases*.

Another physician I spoke with in town addressed some of the rituals that villagers perform; he confessed that his wife had traditional beliefs and treated him with some homemade

remedies when he was sick with one of *Gods' Diseases*. But he did say that he did not approve and that he himself did not believe in the rituals. One last physician, who practiced both Ayurvedic and western medicine admitted to believing in both traditions. He was aware of the villagers' acts and he admitted that he would participate in those traditions if he or his children were inflicted with one of *Gods' Diseases*. Now, what I found most surprising in interviewing these physicians is their knowledge or lack thereof in terms of local cultural beliefs and traditions. I could not understand how they could be so removed from what these villagers believed. It was not just physicians, even nurses and attendants admitted to not knowing. This lack of knowledge may be exacerbated by the fact that they may not have experienced *Gods' Diseases*, but still I could not understand how they could be so unaware when they are amidst such knowledge.

Now moving away from my uncertainties with the physicians I worked with I would like to address the uncertainties I felt in myself as an interviewer. I remember interviewing one older informant, who along with his wife was incredibly religious. As I continued questioning them I guess I was referring to one particular Goddess too casually. The wife then told me, sternly but still kindly, to show respect to the Goddess. She said that it was not right that I addressed the Goddess and simple "her." I was never warned about my language before so I was really scared. My Sinhalese is starting to deteriorate and I am becoming less and less aware of certain rules; so, my speech is usually broken and incorrect. So, I was truly unaware of my mistake. This experience made me nervous about speaking to other informants. Moreover, it made me scared of offending anyone else. I am not a religious person, but in interviewing all of my informants I have come to recognize how important religion plays into the way you communicate with someone. Also, my having no belief in God was surprising to people. Sometimes my informants

would ask me what religion I was and I would say that I did not have a religion, that to them was surprising. Even my aunt would bring it up to my informants that I had no belief in God. Still, my informants did not get mad at this fact; they would still answer my questions and tell me about their beliefs and rituals.

Another fear, this time not expressed by me, but by my research aids—both my aunt and my cousin, who assisted us on the day we went to visit the Muslim community—was fear of the unknown. Something that I have come to realize about myself is that I do not fear from moving between groups or communities. I have traveled and lived in different communities; therefore, I feel comfortable around different people. When we visited this Muslim community, however, my aunt, cousin, and our hired driver for the day expressed fear for being in this neighborhood. This may be due to growing prejudice in the country, but there does seem to be a lack of interaction between communities of different religious backgrounds.

A further problem I encountered here was a problem with communicating. The primary language of the Muslim informants I interviewed was Tamil. So, it was hard for me, on top of my broken Sinhalese, to ask them certain questions. So, our designated guy that day did have to translate certain questions. He did also interfere at times with his own answers. Another example of miscommunication was when I spoke with several of the physicians. It was not a problem of miscommunication but a concern of how to communicate. A couple of the physicians would try to speak with me in English and then switch back to Sinhalese. In these situations I was not sure of what language to stick with and use. I felt awkward switching back and forth so at times I would stick to one language, but they would speak to me in the other. This error in communication was stressful at times, at least to me.

Securing Informants

In addition to the interviewing process there was a lot of time allotted to securing informants. Informants were selected through personal connections and recommendations from other informants. Some informants were particularly interested in helping me find informants or recommending other people that I could speak with. One informant invited me back to her house to travel to speak with someone else we knew, but unfortunately were not able to make it. Several other informants did, however, take my aunt and me to other people's homes following my interviews with them. All informants that were approached agreed to participate; there was only two or three individuals who out rightly refused.

One particular refusal stands out in my mind. I remember going to the clinic on the day designated for women over the age of 35. My aunt was going in for her checkup, but at the same time were wanted to meet interview the head nurse and some nurse/midwives. As my aunt went through her procedures I waited in the designated waiting area. Around lunchtime I got the opportunity to interview one nurse. They agreed to participate if their title was not taken into account. They feared that participation in my study, as workers in the medical field, would violate certain rules or guidelines. The interview was done in the presence of two other nurses, but the other nurses agreed not to interfere. Regardless of their promise, the other nurses did interject at times. As I was interviewing my informant I realized that I should have interviewed one of the other nurses present in the room, whose knowledge about vaccinations and policies were a bit more developed than the nurse I was speaking with. Still, the information she provided did reveal something else to me (discussed in next section).

Now, I did get the opportunity to interview the head nurse later on in the day. She answered two to three questions before going to see another patient. Later on, however, she got upset and refused to participate. She said that she cannot participate and that I should not be

coming to interview someone such as her without permission. So, that interview faltered. My aunt was afraid that the nurse who participated would get in trouble if the head nurse found out; so, she asked her and the others not to disclose her involvement with the project. And instead of speaking with another nurse at the clinic, like we had planned, we visited her at her home another day to get her insight.

Most villagers were easily accessible. The informants who required the most time and effort was physicians and non-Buddhist informants. One particular physician stood me up three times before I was able to meet with him. He, however, was incredibly accommodating. He took me to work with him allowed me to interview two other physicians and an attendant. Waiting for other physicians in our town was also time consuming. We would either have to wait until their shifts were over at night or interview them between patients. In terms of non-Buddhist informants, we were able to find some Tamil and Christian informants within our town by asking around. As for Muslim participants we had to travel far to a Muslim community to find informants.

Results

Category

Gods' Diseases is a category of infectious diseases found in Sri Lanka. The diseases that the Sinhalese commonly identify as *Gods' Diseases* include: chicken pox, measles, and mumps. Other diseases (i.e. eye infection, yellow fever, diarrhea, small pox, cholera) are infrequently included. References to these extra diseases, however, are rare and few. All informants identify similar diseases, symptoms, and treatments for *Gods' Diseases*. Individuals pay attention to key symptoms. All identify fever as a primary symptom of all three diseases. Chicken pox is identified by large, watery bumps on the body, while measles, on the other hand, is identified by

small, red bumps (similar to a heat rash) on the body. Swelling of the face, either on one- or two-sided, signifies mumps. Informants mention that these diseases are the result of the body's hotness (*usne*) or germs (*visebije*). They, however, do not seem to know exactly why these diseases are called *Gods' Diseases*. Most acknowledge that this name has carried itself throughout the years and people continue to use it. Some have stated these illnesses are contagious and spread quickly. They say that people in the past had no way of explaining these illnesses; there was no indication of its source or reasons as to why it would spread so rapidly. So, it is assumed that Sri Lankans in the past believed that it had to be the result of gods' fury or anger. The title of *Gods' Diseases* is just a name that the Sinhalese have attached to these illnesses; it is just common belief. Some even say that the gods' do not give or make illnesses; so, these diseases are not generally seen as the result of gods' doing.

Treatment

A majority of informants reported that nowadays, Western medication is available for these illnesses. Even though many were uncertain about the new forms of treatments, they were aware of it. Very few informants were completely unaware of Western treatment options. While some informants said that they do not reach for modern medicine, others mentioned that they do seek the help of Western physicians at times, especially in extreme cases. The majority described using herbal remedies for the treatment of these illnesses. The first course of action is to take care of the external symptoms. For chicken pox, the sick are often left to sleep on layers of *kohomba* leaves, which are considered to be cooling to the body. Certain cooling leaves are also boiled and applied onto the sores to help them heal. For mumps, either an elephant's tusk (*ali hacke*) or a blue (*nill*) powder laundry detergent is crushed and mixed with lemon and applied onto the swelling. The application of these substances is meant to be cooling to the

inflammation. Thus, working to reduce the swelling. For measles, no specific topical treatment is recognized for the body rash.

The diets of the sick are also controlled according to strict instructions. The sick are generally given “cool” foods (i.e. rice, certain vegetables and fruits) and Sinhalese herbs (i.e. *kothamalli*, *pathpadagan*, etc). With the exception of the physicians and a few local informants, it was acknowledged by many that *pilli* foods, which include meats, fish, and eggs, should not be given to the sick. Informants agreed that these foods are not clean and that the gods do not prefer them. Therefore, such foods should be restricted from the diets of the sick. Those who disagree, however, believe otherwise. In contrast to the majority of the informants, for instance, the physicians and a select few locals held that meats, fish, and eggs should be eaten while sick. They attest that such foods are necessary means of strengthening a weakened body. This group of informants holds such views because they are educated, to varying extents, about modern medicine. But the majority of the Sinhalese consider these illnesses to be the result of the body’s hotness (*usne*). So, despite the differences in knowledge locals and physicians, the majority of the Sinhalese treats these diseases via cooling therapies, both topical treatment and diet regimen.

Behavior is also an important component of *Gods’ Diseases*. Restrictions are placed upon the behaviors of the sick and of those taking care of the sick. The sick and their belongings (i.e. plates, utensils, clothing, etc.) are often kept separate from the rest of the family. The patient is often constrained to his or her own room. The room is cleaned and the patient is placed on white bedding. White symbolizes purity and cleanliness. Despite this separation of the patient, they are not isolated. Some mentioned that the sick are not left alone in order to protect them from demons or ghosts that may bother them in their sleep. One person is designated to take care of the sick. The sick are taken care of by someone who has already had one of the illnesses.

Buddhist informants reported that if someone in one family were affected by one of *Gods' Diseases*, then everyone except for one person in the household would get sick. That one person is excused so that they may take care of the others who are sick.

Cleanliness is an increasingly important aspect of *Gods' Diseases*. So, the Sinhalese place great emphasis on certain bathing rituals for the sick. Informants mention that the sick are not allowed to bathe for a period of seven, fourteen, or twenty-one days. One Tamil informant, however, identified a modified bathing ritual. He said that the sick are bathed with yellow water and *kohomba* leaves. The sick are then dressed in white and separated. Then, on the seventh day they are bathed again with seven pots of water; three days later the sick are washed again. The belief is that if you are not clean while you are sick, then the disease can worsen. Despite similarities in informants' stories, the bathing periods and the timing of these rituals did vary among individuals. All informants, however, practice rituals surrounding bathing. Still, it is unclear as to why the days vary so much, but the period of days clearly increases by a factor of seven.

Interestingly, not bathing is also a protective measure. Such restrictions are placed upon the sick in order to isolate the germs. Informants said that if the sick are bathed before the allotted time, then the disease could spread to someone else. The germs can wash off and affect another person. Therefore, not bathing is a means of preserving the germs in one body. Then, after that period the sick are bathed separately in a place with flowing water. Such a place is chosen so that the germs that were in the sick person's body get washed away. Informants said that if the sick bathes in a place with stagnant water then there is the possibility that the germs will remain in one place and affect someone else. It is believed that these illnesses can spread by water and wind. Therefore, bathing in a place with stagnant water allows for the possibility of

spreading the illnesses. Such measures are a means of protecting others and managing contamination.

Managing risk of contamination is also exhibited through restrictions on travel and socializing. As mentioned earlier, the sick are not allowed to leave their room or their house. Household members and/or outside visitors are not permitted to go to certain locations and return to the house of the sick. Such places include: (1) funerals, which in Sri Lanka last multiple days—the body of the dead is kept at home and mourned for long periods (i.e. 2+ days); (2) homes celebrating “Big Girl” parties (*magul geval*)—a celebration of a girl becoming a woman (celebrated after a period of isolation); and (3) homes with recent births (up until three months after birth). Informants do not go to and/or come from these places if they are dealing with someone with *Gods’ Diseases*. These places are not seen as clean. They are *pilli* or dirty. So, as a means of warning people about coming from these places Buddhist informants put the flowers from a coconut tree (*gockran*) on the top frame of their main entryway. This serves as an indication to others that there is someone with *Gods’ Diseases* at this house. The sign serves double duty: (1) to protect the sick from the germs that someone may potentially bring into the home and (2) to protect the outsider from the germs that may be at home. Muslim and Tamil informants, on the other hand, place *kohomba* leaves or both mango and *kohomba* leaves outside their homes, respectively. Regardless of the etiology of *Gods’ Diseases* it is clear that the Sinhalese understand that these practices all reflect an understanding of the increasing contagious nature of *Gods’ Diseases*.

Religious Rituals

In addition to herbal treatments and behavioral modifications, religious ritual plays an important part in *Gods Diseases*. This aspect, however, becomes important after recovery. With

the exception of the physicians, the majority of informants said that they seek gods' help when affected by one of *Gods' Diseases*. All Buddhist informants ask the gods for help. In exchange for good health, informants promise to carry out certain religious ceremonies in favor of the gods (*deviyante bare venewa*). The majority of Buddhist informants said they asked the Goddess Pattini for help; this goddess is believed to be responsible for helping women, children, and the sick. When Buddhist informants first learn that they have one of *Gods' Diseases* they immediately tie a coin (*pandurak*) to the Goddess Pattini as a promise. The coin, washed in yellow (*kaha*) water and wrapped in either a white or yellow cloth, is then placed in a place of worship, either at home or at a temple dedicated to the gods (*dewaleyak*). The coin is tied with certain hopes in mind. Informants ask the goddess to help the sick with the disease, to help the patients heal and to prevent the disease from spreading to others. This dedication to the gods is another means of managing risk of contamination. Informants then promise to return the favor once the sick have recovered. In this manner, people assume responsibility to fulfill their promises to the gods. Such a course of action exhibits a reciprocative relationship between the Sinhalese and their deities.

Once the sick have recovered, Buddhist informants aim to complete their promise to Pattini. Within three months or a year informants either take a prayer plate (*puja vattiyak*) to a temple dedicated to Pattini or hold a milk-mother's alms giving ceremony (*kiriamma dane*) at home. The way in which informants choose to complete their promise does not matter. They can complete either one or both ceremonies. They just have to complete whatever ritual they promised to do when they dedicated their coin to the gods. The first type of ritual involves providing the goddess with a direct offering. Informants go to a temple dedicated to the gods or Pattini in particular. There they buy a prayer plate from the vendors stationed outside the temple.

A plate is chosen according to the materials on it, which include certain fruits, sweets, and incense. The individual can choose seven fruits of their choice for the plate; often though the fruits chosen include: bananas, apples, oranges, pineapple, pears, grapes, and mangoes. The mango is actually quite important to Pattini for it is believed that she was born out of a mango. Other items included in the plate are a king coconut, a flower or plastic wreath, two betel (*paan*) leaves, incense, and a coin (*pandurak*)—nowadays though instead of a coin people make larger monetary donations. The prepared plate is then given to a temple leader (*kappu mahatheya*) who offers it to the gods or goddess. He then chants certain prayers and releases the family of the promise that they had made. In the end, the prayer plate is returned back to the family. While some fruits have been kept for the goddess as an offering, the majority of the plate is returned.

The secondary ritual is much more elaborate; it requires more time and money. This particular service (*kiriamma dane*) is dedicated to the Goddess Pattini alone. The ceremony, however, is not particular to *Gods' Diseases*. It can be held for a variety of reasons—as a celebration of the season's first crops, a commemoration of the three months following a child's birth, an appeal for children, etc. For this service, seven women are chosen from the village. One of these women is an established milk-mother. She is the one who leads the others in the ceremony. Informants identified that the best milk-mothers or *kiriammalas* were married women who had one or two young children and is currently nursing one child. Nursing mothers are preferred because they are considered to be pure. They are nursing a child; so, such women are ideals of goodness. Some informants have also mentioned that mothers may be invited because Pattini is often referred to as a mother (*Pattini amma*). Nowadays, however, informants say that it is hard to get nursing mothers. This may be due to the fact that women are now more involved in the work force or that for the same reason they stop nursing earlier. So, women who are

chosen nowadays are often older women from the village. The women are still married and have had children, but they are not considered to be the ideal candidate for the ceremony. They do not embody the purity that the young nursing mothers are believed to possess. Some informants even believe that the ceremony is not successful if the participants are not the ideal candidates.

Purity is an important aspect of this ceremony. Once selected, these mothers come to the place of the ceremony at dawn. This ceremony needs to be completed before dawn, before any animals are awake. This is a means of maintaining the food that is prepared for the ceremony. The dishes cannot be tasted or eaten by anyone before the ceremony. So, the ceremony needs to be completed before anyone unwanted can touch the food. The milk-mothers themselves are also expected to embody this purity. In order to ensure that they are “clean” the women are expected to have slept alone the previous night. As a symbolism of this cleanliness they are expected to come to the ceremony dressed in all white. The women then come into the house at dawn and sit on white sheets laid out on the floor. A table with Buddha’s portrait, a statue of Goddess Pattini, and lit candles is placed somewhere in the room. After all the women have seated themselves, the family, also dressed in white, sits down on the floor to begin the ceremony.

Communal prayer is then enacted as a means of completing the service. The women initially pray to Buddha. Then, a prayer plate is offered to the goddess; following that, poems about the goddess’s life are chanted. As poems are being dedicated to the goddess, the family offers the women food. Onto a banana leaf is placed: seven pieces of milk rice (*kiribath*), seven pieces of *kiriya* and *handi kawun* (both sweets), seven bananas (*ambul kessel*), seven jaggery (*hakuru*) pieces, one betel (paan) bundle (*bulath vittak*), and one king coconut (*thambili gedyak*). The women are also offered something in return for their time. Before it used to be a coin, but now people offer larger sums of money (i.e. 100 – 500 rupees) and/or additional gifts.

After they have sampled a bit of food, the women then bless the once sick individual and their family. Then the promise that was made is released and completed. The women pack up their food to leave. Before leaving the women can symbolize the completion of the family's promise in one of two ways. They can all light a miniature candle and extinguish the flame in water or they can turn over a pot of water outside the house when they leave. Both are signs that the promise has been completed and that the service is over.

A significant aspect of this ceremony is its simplicity. Even though the event itself is elaborate, it is not a large-scale event. The ceremony is elaborate because it requires a lot of work and support, but once the family has figured out the financial aspect of the service it can be carried out right away. Other people are not invited to celebrate the event. The service is an intimate gathering. It is service honoring the goddess; the family is venerating Pattini for her help. So, this celebration is a means of the family to connect with the goddess via the seven milk-mothers. It is a means of not only strengthening their beliefs in the goddess and her power, but also a means of helping the goddess on her journey to enlightenment. The general belief among Sri Lankan Buddhists is that all gods are striving for enlightenment. This enlightenment, however, is only possible for males. So, Goddess Pattini collects the offerings (*pinn*) that Sinhalese give her so that one day she may be reincarnated as a man and reach enlightenment. The Sinhalese perform these ceremonies to venerate these deities so that they may attain their goals. Once again here we see a reciprocative relationship between Sri Lankans and the deities they worship. The Sinhalese worship gods and goddesses so that they may deal with the worldly side of existence. So, the gods and goddesses are believed to grant these wishes. At the same time the Sinhalese also give back to these deities. Through their worship and offerings, Sri Lankans give the gods and goddesses what they may need to attain their own personal goals.

In looking at people's attempts to please these deities, it is interesting to see how the Sinhalese incorporate the narratives of these gods and goddesses into the ceremonies they engage in. From the descriptions provided above it is clear that seven is an important number in all of these ceremonies associated with *Gods Diseases*. Seven types of fruits are used for the prayer plates, seven women are called in for the milk-mother's alms giving ceremony, and food is distributed to them in factors of seven. The majority of informants do not seem to know why seven is such an important number. Others, however, have stated that it may be due to the fact that the Goddess Pattini had seven lives. It is also believed that Pattini had seven servers; so, the seven women who take part in the mil-mothers' alms giving ceremony may be a representation of Pattini's aids. Readings, however, provide different suggestions for the term milk-mother or *kiriamma*. *Kiriamma* is hypothesized to be a goddess also known as *Giri Umma* or Kali. One author recognizes that giving alms to *kiriammas* is a popular practice in Sri Lanka and that Sri Lankan villagers recognize seven *kiriammas*: (1) *Polomahi Kanthawa*, (2) *Mani Mekhala* of the sea, (3) *Saraswathie*, (4) *Sita Parameshwari*, (5) *Umayangana*, (6) *Valli Amma*, and (7) *Pattini Amma*. Interestingly, here Goddess Pattini is included as one of the *kiriammas*. Pattini's narrative is craftily incorporated into the traditional courses of action for these ceremonies.

These services, though elaborate and extensive in their rules and rituals, are practiced religiously. All of my informants give importance to these cultural beliefs, rituals, and ceremonies. And not only that, these services are completed according to tradition. Otherwise, it is believed that something bad might happen when promises are not completed. The chief leader of the main temple for the Goddess Pattini, however, said that while people do hold these particular services faithfully one does not have to anything in return for the gods. Apparently,

you can see these diseases as a prank by the gods and laugh it off. The practices and beliefs of local villagers, however, suggest otherwise.

Aside from the Majority

Unlike the Buddhist informants, Christian, Muslim, and Tamil informants participate in simple religious rituals for these diseases. Christian informants said that most people pray at home. If they do reach out to God, then they promise to either light candles or donate something to the church. Muslim informants wash a coin in yellow (*kaha*) water and tie it to the arm of the sick by a piece of yellow cloth. This is a means of protecting the sick from evil and of hopes that the coin extracts the disease from the patient. Then once the sick recover the coin is given to the poor or to the mosque. Muslim informants also mentioned engaging in another practice not brought up by other groups. They said that when a household has one of *Gods' Diseases* they spray water around the house in order to scare away gods/demons. They would spray yellow water inside the house and water that had washed beef outside the house.

There were varying responses among Tamil informants about religious practices. One Buddhist informant acknowledged cleaning as an important component of *Gods' Diseases* for Tamils. He noted that Tamils believe that the gods have come to their home when someone is affected by one of *Gods' Diseases*. As a response to this, he acknowledged that the Tamil clean their homes. Another Tamil informant had also stressed the importance of cleanliness. As mentioned earlier, he identified an elaborate bathing ritual for the sick. He noted that if one is not clean while sick, then the disease could worsen. Another Tamil individual stated that these diseases happen if people are not doing anything for the gods; he also said that these diseases might be the love of the gods. So, the only way to get better is by reaching out to deities, especially Goddess Pattini. Following recovery, you go to a temple and offer a prayer plate and

complete your obligations to her. Another informant mentioned that when you are sick with one of *Gods' Diseases* you pray to the Goddess Kali or Kaliasman. However, there is nothing special that you have to do for her. You can simply pray at home or ask for her blessing.

The Mother Goddess

Conversations with varying religious groups have also brought to light the importance of the concept of the mother. Clearly, Buddhist rituals surrounding milk-mothers and the Goddess Pattini pay homage to concept of the mother. Still, this component of *Gods Diseases* was not clear to me until my conversations with Muslim and Tamil informants. Muslim informants identify this set of diseases as both *Gods' Diseases* and *Mothers' Diseases* (*amma* or *ammavarunge lede*). When asked why they use the title *Gods' Diseases* they said that this is a common title used for this category of diseases and that the title references the gods of Sinhalese and Tamil folks. When asked whether Allah has anything to do with these illnesses many said no. Most replied that even though Allah gave people everything these diseases are not Allah's diseases. Even though the Muslim informants recognize the title of *Gods' Diseases* most refer to these illnesses as *Mothers' Diseases*. Such a title for these diseases is suitable for Muslim informants for there is not belief in gods in the Muslim faith. Still, what remains unclear is why then the title of the mother gains prominence. I am not sure if there is a local belief that these diseases come from women or mothers. On the other hand, the title may be a reference to mothers, who often are the primary caretakers in the household.

References to the mother are predominant in the Tamil language for these diseases. In Tamil the name for chicken pox (*ammaphathi*) and mumps (*managathiamma*), both have the root word mother (*amma*). Not only that, Tamil informants also reference reaching out to certain mother goddesses for help with these diseases. Tamil informants, like Buddhists, also seem to

ask Pattini Amma (Mother Pattini) for help. However, they also reach to the Goddess Kali (Kaliyamman) for help. Kali is another mother goddess worshipped by Tamil individuals. These two goddesses (Pattini and Kali), however, are completely different from each other. Goddess Kali is a dark protective force in comparison to the gentle guardian Pattini. Despite their varying personalities, their devotees accept both as their mother goddesses. Interestingly though both goddesses were not mothers themselves. Such a reference to them as mothers is a metaphorical representation of their devotees and worshippers as their children. The question still lies, why reach out to a mother goddess for help. One particular Buddhist informant, however, provided a quick and succinct response to this. Often when you are sick the first person you call out to is your mother. So, the goddess you reach out to when you are gravely ill is someone who will care for you—someone like a mother. So, appeals to such deities by worshippers make sense when you work with this understanding.

Discussion

Best of Both Worlds

In Sri Lanka, old ideals continue to survive even amidst a progressive culture. Sri Lanka is a nation with a multitude of influences. The culture there is continually changing and adapting. It has encountered the effects of both colonization and globalization, which have brought over with it influences from varying sources. Sri Lankans, however, are adept at responding to such changes. The Sinhalese deal with conflicting ideals—both traditional and modern—via processes of hybridity. Their response to these forces are based on negotiating varying sets of knowledge and incorporating them into already existing systems of information. This aspect of mixing cultural practices is clearly evident in the ways that people deal with the category of diseases identified as *Gods' Diseases*.

Treatment measures and understanding of these diseases stem from both Ayurvedic and biomedical systems. The Sinhalese take aspects of each entity and then gauge what course of action is best suited for them. In this manner, Sri Lankans are able to take conflicting ideas and build their own understanding of competing systems. Generally, the medical systems of Ayurveda and biomedicine are not in agreement. Their understanding of disease and prospective treatment vary greatly. Sri Lankan patients, however, have made it possible so that they can find some commonality between the two and use both systems mutually. What is important about such cultural practices of mixing is that people are able to make sense of the world that they live in in their own manner. They can generate their own system of cultural knowledge.

There exists this notion that things need to be understood separately—that we need to pay attention to the dichotomies that exist. Such dichotomies, however, do not exist. We are continually living in and engaging with a world that is constantly changing and adapting. So, it is important to understand systems of knowledge as being homogenous. Nothing exists in its purest form anymore. Everything is the result of hybridity. It is all around us continually influencing us. As a result of our immersion into such processes, people are starting to actively seek mixed forms. The Sinhalese, for example have been able to influence the health care system by asking for more hybridity in the practice. Processes of hybridity are valued. So, people are seeking it in all aspects of their lives.

Personal Power

It is interesting to note the growing desire for people to engage in processes of hybridity. Such processes, however, enable the Sinhalese to fulfill certain personal goals. The cultural phenomenon of hybridity allows people to engage in processes of self-treatment. Engaging in processes of self-treatment allow the Sinhalese to become active agents of their lives. They are

able to construct their own systems of rules and follow processes that are best suited for their needs. Such processes of blending cultural practices to ensure agency exemplifies the values of Sri Lankan culture. Sri Lankans, especially those who are Buddhist, value individualism. Self-power is an important component of Buddhism itself. Enlightenment can only be achieved by oneself. Such values of individualism and self are clearly highlighted by the behaviorisms of the Sinhalese as they deal with *Gods' Diseases*. People greatly value processes of self-treatment because it lets them live up to Buddhist principles.

In Sri Lanka, conceptions of the self are also rooted within the community. In Western systems of thought the self is understood in terms of the individual. Non-Western ideas about the concept of the self, however, are rooted in the concept of holism. The Sinhalese have a sociocentric understanding of the self. Such an understanding explains the values placed upon processes of self-treatment. Moreover, the response of health care system to changing public demands brings to light the value place upon the desires of the general population. It also highlights the influence that the community has on bringing forth change.

Sri Lankans have an active say in varying aspects of their lives. This culture is vocal about its needs. Such consensus is clearly apparent in their engagement with the health care system. Practitioner and patient relationships are often unequal. In relationships between a medical practitioner and a patient, often it is the latter who seems to be the weaker party in the relationship. Patients depend on the insight of their practitioners and have to trust that their advice will work in their favor. Patients, however, do possess the power of choice. Due to the varying therapeutic options available in pluralistic medical systems they give patients greater opportunities to seek services elsewhere (Waxler-Morrison 1988). Patients select their practitioners based on certain criteria (i.e. beliefs, reputation, availability of other facilities,

adoption of cosmopolitan techniques, healer's special skills, competition in sectors); thus, practitioners adjust accordingly to patient demands (Waxler-Morrison 1988; Wolffers 1989). When patients' requirements and attitudes change and when they demand greater choices practitioners have to act accordingly if they want to continue attracting patients (Waxler-Morrison 1988).

Such alterations in Sri Lankan medical systems are due to a vocal population that is actively engaged in social priorities. Improvements in different aspects of Sri Lankan life are due to varying cultural, social, and historical factors. Free education, for instance, has been readily available to the Sri Lankan population since 1947. High levels of women's autonomy, gender equality, and high levels of female literacy have had its impacts on cultural attitudes and knowledge. The country is also home to a democratic system based on universal franchise and a high level of consensus. The public has a lot of say in national priorities as it relates to the government's provision of social services (cite). Such factors are of great importance to Sri Lankan citizens. These priorities and systems of knowledge have not faltered. They have prevailed periods of civil war and economic decline; thus, demonstrating the resiliency of the Sinhalese. This culture is vocal about its necessities. It seeks change and if ever things fail to go accordingly they simply switch their own behaviors. In the end, systems have no choice but to respond to people's demands.

Resulting changes in the health care system are efforts to respond to patient needs. Practitioners in turn work to provide good care to patients. They also serve as examples of the interaction between modern and traditional understandings. Such varying adaptations of indigenous practitioners to modernization reflect the ongoing changes in practices as well as the changing demands of patients. And with the existence of such varying forms of treatment,

medical systems cannot discourage patients from seeking out effective combinations of treatment. As a response, medical systems work to incorporate all of patients' demands so as to provide better quality care (Khare 1996).

Despite the fact that patients demand changes in the health care system, they still prefer self-treatment to other care options. The reasons for this are two-fold. Historically, external forces have influenced Sri Lanka. Such outside involvement have influence people's everyday practices. In this manner, Sri Lankans have become engaged in processes of blending cultural ideas and practices. They prefer to take care of these illnesses at home and blend their traditional knowledge with that of Western medications and understanding of illnesses. There are no borders between biomedical and herbal medicines; patients extract varying aspects of each practice and only use what they believe to be the best for them. Such processes of blending, however, are not reserved to the home. They are also extended out into the system of health care, as more and more patients are demanding that physicians cater to both traditional and Western understanding of illnesses.

Another aspect of self-treatment, however, is that of individuality. The concept of the self is very important to Sri Lankans, especially for Sri Lankan Buddhists. The majority of Sri Lankans practice Theravada Buddhism. This branch of Buddhism places great emphasis on individualism. The ideal is to become an *arhat* or the "worthy one." Such a person has realized enlightenment through their own self-power and freed himself from the cycle of birth and death. Enlightenment is only possible through one's own efforts, without the help of gods or outside forces. No salvation is expected by worshipping gods. The importance of the individual effort points to the values in self-treating these illnesses. Still, what is ironic is that though values are

placed upon the self, Buddhist Sri Lankans still reach to the gods for help. Such behavior, however, is another example of mixing varying cultural practices.

Clashing Beliefs

Both home treatments and religious practices were common knowledge among many informants. Religion, age, and gender did not affect awareness. However, physicians and a select few locals mentioned that the villagers engage in certain practices that they themselves do not adhere to. One physician even classified these local beliefs and rituals as “ill practices.” Physicians believe cultural knowledge to be part of lower-class villagers. Most of my informants did belong to a middle- or lower-class and many of them held the views that I have outlined above. Physicians do not hold onto such beliefs because they and their families seem to follow Western practices. Informants of lower classes, however, generally only have access to local cultural knowledge. These practices and beliefs reveal important cultural differences between informants. These differences may arise from class, education, socioeconomic status, etc.

Interestingly, however, a few informants defy these sets of cultural rules. One particular physician, for instance, practiced both Ayurvedic and Western medicine. He held onto both traditional and modern sets of beliefs. He told me that in the case that his children would one day be affected by one of *Gods' Diseases*, then they would utilize both traditional (i.e. herbal home remedies and religious rituals) and Western (i.e. modern medicine) route. Two young mothers, also trained in the field of medicine, held similar views. These women—one a pharmacist and the other a nurse—held blended opinions. Even after being educated about antibiotics and treatments, both said that they would follow both the paths. Both said that when they had these diseases they had taken antibiotics, eaten the restricted *pilli* foods, and engaged in religious rituals. They even said that they would take care of their children in the same manner. So, despite

these three individuals having higher education in the field of medicine, they still incorporate both forms of practices into their lives. This suggests that some individuals tightly hold on to the practices for *Gods' Diseases*, while others are exercising the practice of blending two forms of cultural knowledge.

The larger population, however, also practices blending cultural ideas in their own manner. Informants continued to engage in elaborate home treatment and religious rituals in addition to using modern medicines during times of need. Even during times of self-treatment people utilize herbal remedies and over the counter pills (i.e. aspirin and paracetamol). Still, the consensus about these diseases does not match up with their eventual behavior. Many informants state that it is important to let these diseases come out of the body, for the hotness to be released. They acknowledge that modern medicines in fact suppress these diseases in the body. Informants believe that Western medicines can worsen the diseases by raising the body's heat. So, the only means of taking care of these illnesses is to let them be. The Sinhalese admit that these illnesses get better on their own. Still, informants admit to engaging in both traditional and modern practices.

Such conflicting beliefs and actions may highlight an underlying issue of people's lives. Even though Ayurveda is widely accepted among the Sinhalese recovery with Ayurvedic medicine takes time. In order to keep up with a competitive and growing economy it is necessary that people take advantage of the easiest measures. Modern medicine offers that possibility. Even though harm is seldom done with Ayurvedic prescriptions healing with Ayurveda takes time. While modern medicine is seen as being both helpful and harmful, it attracts a large audience. Modern medicines offer quick relief without needing to commit time to recovery. Therefore, Western medicine is more attractive than Ayurveda.

Still, the problem lies that modern treatments are harmful as much as it is helpful. These treatments act fast on the body; therefore, they are appealing to patients. For that same reason, however, they are harmful as well. The perception is that if something as simple as a pill can cure a disease right away, then it must be incredibly powerful. Such a quick acting agent may not be good for the body. Moreover, participating in modern medicine means that there is no power attributed to the self. An external agent is facilitating the recovery. Ayurveda, however, offers people the opportunity to heal by themselves over time. It gives power to the self and upholds the values of traditional Buddhism. So, in this manner Ayurveda continues to ensure its place. Still, amidst a changing economic system these two systems oppose each other. So, in order to achieve the best of both worlds the most sensible possibility for people is to engage in the cultural processes of blending.

Disagreements

Despite this existence of this hybrid phenomenon, there is varying consensus among people about the right and wrong ways to behave when afflicted with certain diseases. Studies indicate that Western-style physicians in Sri Lanka realize that there are medical beliefs imbedded in the culture and Waxler-Morrison argues that biomedical physicians explain diagnosis and drugs in terms of Ayurvedic theory. Researchers assert that the practice of all types of medicine reflect the common culture. “Diagnosticians of all kinds follow the common cultural themes by providing explanations of illness that stress impersonal rather than personal causation and that are based on the ideas of excess and imbalances” (Waxler-Morrison 1988).

In my work, however, Western medicine seems to be removed from Ayurvedic understanding. Even though Ayurvedic understanding is so embedded in local culture physicians do not recognize its importance to their patients. The Western physicians who spoke with me did

not believe that local knowledge was valid. The majority of Western-style physicians cast the traditional practices of local villagers as “ill-practices.” They did not give credibility to their beliefs. Such stark denomination of local beliefs greatly separates physicians from their patients. This in turn affects the relationships that physicians may eventually develop with those they treat. If physicians are keen on building strong relationships, then they must build good trusting relationships with their patients. If they want their patients to trust them, then they also have to trust their patients. Such behavior will promote strong relationships between both parties. More importantly, it will also secure physicians positions for it is the people who have the true power. If they demand change, then the system has to change. So, if Western-style physicians want to maintain their standing, then they have to start listening to their patients.

Building Trust

Trust and type of care offered are integral aspects of the ways Sri Lankans seek care outside the home, either within the public or the private sector. Patients’ trust in health care providers is based on the quality of care provided. Initially, patients assess the clinical or technical competency of providers. Then, they pay attention to the inter-personal quality of care (i.e. listening, politeness, concern for the patients and not just the disease). Essentially, developing trust in providers is based on (1) personal trust, which is built through face-to-face encounters and (2) abstract institutional-level trust, which is based on “faceless” or institutional factors as much as personal encounters. Building good relationships between users and providers is an integral part of the health care system for it encourages greater usage of medical services. Patients need to trust their health care providers because they need to have confidence in the physicians’ motives and decisions (Russell 2005).

Patients' trust within the public and private sectors, however, differed in terms of types of illnesses. In general, people preferred to use public providers for serious illnesses due to their free services and trust in their technical competency at both a personal and institutional level. Still the public sector was lacking in inter-personal quality of care (Russell 2005). Thus, a large percent of the population sought care from private doctors. Despite the additional costs, private services were sought after because of their availability, less waiting time, more consultation time, dignity and respect shown to mothers, doctors listened and patients could build better relationships with the physicians (Amarasiri de Silva et al. 2001; Russell 2005).

Trust builds with greater experience and more time; thus, explaining the desire for greater consultations with private services. And for such a relationship to continue the health system must perform its expected delivery functions. If it fails to do so, then there lies the risk of losing patients to other providers. Moreover, poor relationships in the public sector may encourage patients to seek care from private services, which may in turn affect the financial protection that public health services aim to achieve. The public health system has great strengths in terms of providing high levels of coverage, equitable access and a pro-poor benefit incidence. Such benefits are being undermined by poor inter-personal quality. So, if policy makers are not wary of sustaining trust in public hospitals they may lose out on patients as well as sustaining good coverage and financial protection (Russell 2005).

Building such trust is valuable to those belonging to lower socioeconomic classes. Concepts of trust become less important as you move higher up in social standing. Many of those belonging to upper classes have greater freedom to access good medical care. So, trusting their physicians is not a priority. Trust, however, is an important component of health seeking for those belonging to lower classes. Such folks do not have the freedom to access varying treatment

options. So, if the health care infrastructure is keen on providing good and accessible health care to its patients then it has to work on its ways to build trust with their patients. People need to know that they are cared for and if these systems are not fostering good relationships they lose out on helping its patients.

Still Prevalent?

This research project has provided the answers to the questions what are *Gods' Diseases* and how do Sri Lankans treat this category of diseases. The question that is left unanswered, however, is why are these diseases still prevalent? If the country has an excellent health care system and strong immunization programs, then why do these preventable diseases persist? When I first asked my mother about these diseases she suggested that their prominence might be due to the fact that the vaccines are not effective; they may be watered down. If people are suspecting such a thing, then how can Sri Lankans have trust in their health care system? In such cases efforts of self-treatment are the best course of action. If people realize that the system is failing them, then how can they build trust with their own health care institution?

The state is accountable for universal health-care provision that is free at the point of delivery; thus, trust in public health services is an integral part of the conversation. Due to the actions of the population the state has greatly invested in an extensive network of health services since the 1930s. Such arrangements arise from a strong public action stemming from a literate and politically active population. Resulting public action and government responses have ensured public trust in the state as a provider of essential services (Russell 2005). Thus, such results and outcomes are the result of the Sri Lankan population and are based on the foundations of a trusting relationship between the people and the government.

Furthermore, the Expanded Program on Immunization (EPI) is another important aspect of the public health system in Sri Lanka. It aims to reduce morbidity and mortality associated with vaccine preventable diseases. The program is regarded as one of the strongest performers; it has an excellent record, with high coverage of EPI vaccines and low incidence of EPI diseases. The country has had great successes in combating the major communicable diseases. Still, communicable diseases like *Gods' Diseases* are prevalent in the country. So, if Sri Lanka wants to completely eliminate the presence of preventable diseases, then there is a necessity for greater trust between patients and providers. If people cannot trust the system then there is no point to establishing a wide system of health care services.

Year	Introduction of Immunization Campaigns
1886	Vaccination against smallpox (Vaccination Ordinance)
1949	BCG vaccination against tuberculosis for adults
1961	“Triple” vaccination against diphtheria, whooping cough, and tetanus
1962	Oral polio vaccination
1963	BCG vaccination for newborns
1969	Tetanus Toxoid administration to pregnant mothers
1978	Launch of the Expanded Program on Immunization (EPI)
1984	Measles vaccination
1991	Revision of Tetanus Toxoid (TT5) dose schedule for pregnant mothers
1995	First National Immunization Days to eradicate polio conducted
1996	Rubella vaccine for women of child bearing age
2001	Revised National Immunization Schedule with MR and aTd
2003	Hepatitis B vaccine (phase basis)
2008	Haemophilus influenza & Hib containing Pentavalent Vaccine
2009	Japanese Encephalitis (JE) vaccine
2011	MMR vaccine

Table 2. History of Immunization in Sri Lanka

Future

Understanding of *Gods' Diseases* is still incomplete. There is a lot more to be explored. While the information that I collected during my time in Sri Lanka provides a basis for our understanding of this category of diseases it is still not enough. There is a lot more to be explored in terms of varying sets of knowledge that exist. While I did gather a lot of information about

Gods' Diseases from Buddhist informants, information about this category of diseases is severely lacking from other groups. So, a larger sampling of informants from varying groups may improve the overall quality of my data. Moreover, there is a lot to be explored in terms of the themes addressed here. My understanding of varying systems of knowledge (i.e. Buddhism, health care infrastructure, hybridity, etc.) is only now developing. So, there remains a lot of work to be done to understand the whole nature of this category of diseases.

Conclusion

Gods' Diseases is a categorization of communicable diseases found in Sri Lanka. Chicken pox, measles, and mumps are among the main three diseases identified as *Gods' Diseases*. While self-treatment is the primary mode of treating these diseases, informants also engage in practices of mixing local Ayurvedic knowledge with biomedicine. Moreover, the Sinhalese also seek advice from deities to manage these diseases. Many informants reach to the Goddess Pattini—a goddess responsible for women, children, and the sick. While sick, families ask the goddess for help and promise to return the favor once the sick return to good health. Following recovery, informants carry out either one of two or at times both religious rituals in her honor. Analyzing the category of *Gods' Diseases* reveals the presence of processes of hybridity. Introduced during the time of colonialism, such a phenomenon of cultural transformation or regeneration is still prevalent in varying aspects of Sri Lankan life today. Such processes of hybridity are clearly visible in the ways in which the Sinhalese understand and treat *Gods' Diseases*. Such a phenomenon of blending allows people greater agency in their lives; it allows them to dictate the ways they choose to take care of themselves and the types of care that they deem to be the best for them. So, even despite conflicting beliefs systems, local people have authority to dictate their desires to their health care system. If the health care infrastructure is

interested in maintaining good relationships with its patients, then they need to give prominence to their patient beliefs.

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