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Historical Pathway of Medical Pluralism in Sri Lanka

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Abstract

A medical system is a collection of ideas, beliefs, and actions in a community with regard to health and ill health. And since health and ill health have been confronted by humans since the beginning of humanity, ideas, attitudes, and actions surrounding these two states possess a history as old as man. Every society has developed systems in accordance with its beliefs and attitudes and has resources to respond to diseases. The systems of medicine developed by different societies are responses to prevailing diseases. The systems of medicine and customs related to health are a product of a country's history, birthed and improved within a certain environmental and cultural framework. Hence, social scientists consider these medical systems to be cultural systems, as they have been born out of culture. Globally, there are systems of medicine delineated according to geographical zones, which have been defined by their inimitable socio-cultural characteristics. Sri Lanka is home to a successful system of pluralistic medicine. However, the situation can be identified as a result of the gradual development of medical systems over different time periods. Within this background, the paper aims to discuss the historical development of Sri Lanka's pluralistic system of medicine under several stages: pre-colonial, colonial, and post-colonial periods. By using existing secondary data, a literature survey has been done to identify the elements and other characteristics of particular medical systems at different stages. Accordingly, biomedicine and homeopathy were born in Western Europe, while Ayurveda is the predominant system in Sri Lanka. In addition, Deshiya Chikithsa and other home-grown medical systems have been used for people's various treatment purposes since the pre-colonial period. In the context of today's globalization, medical pluralism retains its analytical importance, especially in the examination of people's search for alternative cures locally and transnationally, the growing consumer market of 'holistic', 'traditional', and 'natural' treatments, and the attempts to incorporate alternative treatments into national healthcare.

Key words: *Culture, Development, Health, Medical pluralism*

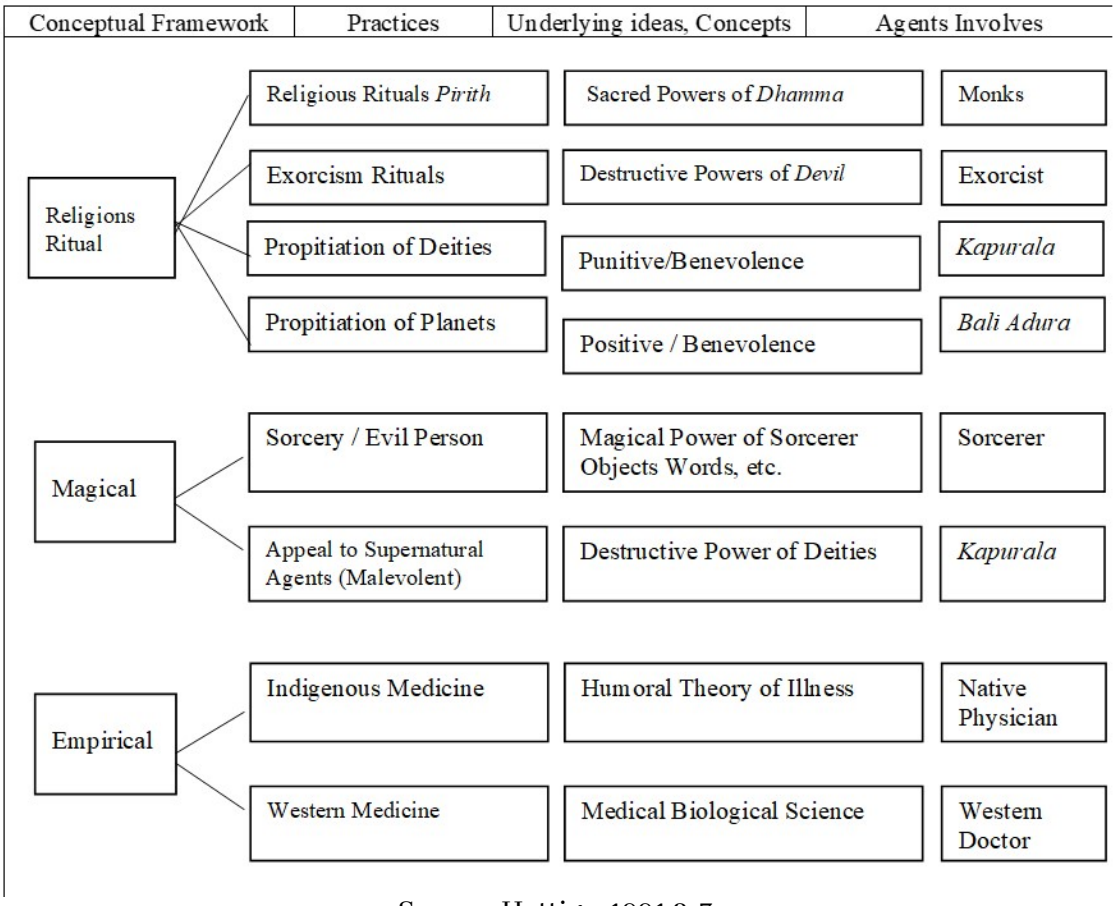
Introduction

Medical pluralism describes the availability of different approaches, treatments, and institutions that people use to maintain health or treat illness. Most commonly, medical pluralism entails the use of Western medicine (or 'biomedicine') and what is variously termed 'traditional medicine' and 'alternative medicine'. Scholars of medical pluralism have used different terms such as traditional, indigenous, folk, local, or alternative medicine, but since they all imply distinction from biomedicine, this entry will refer to them as 'nonbiomedical' practices. As a theoretical framework, medical pluralism was developed in the second half of the twentieth century to examine local medical traditions in their diversity, co-existence, and competition, especially with biomedicine (Khalikova, 2021).

Medical pluralism in Sri Lanka has been extensively discussed in medical sociology and anthropology (Wolffers, 1988a, 1988b, 1989; Nordstrom, 1988; Waxler, 1984, 1988; Silva, 1994; Liyanage, 2000). Sri Lanka's pluralistic system of medicine is an admixture of biomedicine, Ayurveda, Sinhala treatment (Desiya Chikithsa) methods that are in isolation or mixed with Ayurveda, homeopathy, Chinese and Korean acupuncture, Bodi puja, home remedies, and occult treatments. Western biomedicine and Ayurveda are constitutionally endorsed and function under state patronage.

Many writings in medical sociology and anthropology have extensively discussed Sri Lanka's pluralistic medical system (Waxler, 1984, 1988; Nordstrom, 1988; Wolffers, 1989; Liyanage, 2000). All treatment systems accessible in Sri Lanka can be divided into traditional and modern systems. Western medicine is considered modern. Traditional treatment systems can be divided again into empirical and supernatural categories. Ayurveda, considered the indigenous system of medicine in Sri Lanka, together with native methods of treatment are considered empirical, while Siddha and Unani also belong to the empirical model. These two systems of treatment are used in different parts of the country (especially by people living in the North and the East of Sri Lanka). Homeopathy and Chinese medicine, which are moderately accessed by Sri Lankans, also belong to the empirical system. Offerings and sacred puja, as supernatural systems, do play an important role in the treatment procedures of the local populace. Hettige (1991) explains the treatment system used in Sinhala society within the following conceptual framework:

Figure 1: Sinhalese System of Healing and Medicine



Source: Hettige, 1991:2-3

According to the above conceptual framework, Sri Lankans have several treatment options for diseases. The service providers in this pluralistic system can be identified as follows:

1. Practitioners of Western medicine
2. Ayurvedic practitioners (according to the Ayurvedic Act of 1961, it includes government-employed Ayurvedic practitioners trained at a government Ayurveda university and practicing at a government Ayurveda hospital, Diploma holders in Ayurveda, and traditional practitioners)

The above classification provides a reasonable idea of the types of service providers in the health sector of Sri Lanka. While it is not difficult to identify practitioners of Western medicine in this classification, as Waxler (1988) pointed out, it is not the same with practitioners of alternative systems of treatment; their interconnectedness distorts identification. It is clear that the complexity of the Sinhalese system of healing and medicine makes it important to explore how these medical systems gradually developed in Sri Lankan

society. Within this background, the main objective of this study is to examine the historical development of Sri Lanka's pluralistic system of medicine.

Materials and methods

By using existing secondary data, a literature survey has been done to examine the evolution of the different medical systems in Sri Lanka. When collecting secondary data, it was mainly divided into three time periods: the pre-colonial period, the colonial period, the colonial period, and the post-colonial period. Accordingly, the pre-colonial period was considered to be the period prior to 1505 CE, which was before the country was colonised by Europeans. The colonial period was categorised from 1505 to 1948, covering the colonies of three foreign countries. Thirdly, the post-colonial period started in 1948, which marked the country's independence from British rule. Lastly, the gathered qualitative data was analysed under these three main themes accordingly.

Results and discussion

Development of Medical Pluralism in Sri Lanka

The development of medical pluralism could be discussed in several stages. Sri Lanka has gone through tremendous social, economic, political, and cultural changes owing to centuries of foreign rule. It was during colonial rule that the health sector of the country experienced far-reaching changes. These changes could be best analysed and understood by discussing them according to their stages of development. Accordingly, Sri Lanka's medical system could be discussed under the pre-colonial, colonial, and post-colonial periods.

Pre-colonial Period

This refers to the period prior to 1505 CE, which was before the country was colonised by Europeans. It is believed that Sri Lanka's written history can be traced back to 6 BCE with the advent of Vijaya from India. As such, any discussion on the medical system of Sri Lanka based on evidence will have to focus on the period after 6 BCE. This, however, does not mean that the indigenous population of the country prior to the advent of Vijaya did not follow certain practices in relation to treating diseases. Historians and archaeologists deduce that human existence in Sri Lanka could be dated way beyond 125,000 years. The trail of the Balangoda human, the skeletal evidence of anatomically modern Homosapiens, was traced

to have lived 30,000 years ago in Sri Lanka. According to writers, these ancient humans must have followed some system to preserve their status of health, which they presume is the history of Sri Lanka's indigenous medical system (Ranwala, 2009; Ranasinghe, 1995; Chandrasekera, 1995). It is a historical fact that the advent of Wijaya was followed by the arrival of Buddhism and Ayurveda in the country. According to Uragoda (1987), whatever system of medicine was in practice at the time was eventually taken over by Ayurveda. Systems of treatment that existed during pre-colonial times can be classified into two groups: empirical and supernatural. Empirical systems of treatment were Ayurveda, Siddha, Unani, and Deshiya Chikithsa, while supernatural systems of treatment included Bodhi puja, chanting of pirith, propitiation of deities, exorcism, and sorcery.

Ayurveda, with a history spanning over 3000 years, is believed to have originated in India and been subsequently brought to Sri Lanka. Historical sources reveal that Ayurveda made inroads into this country following the advent of Vijaya and the intermittent Indian invasions that followed. Kumarasingha's (2007) book on the history of Ayurveda traces the beginning of Ayurveda in Sri Lanka and, following the arrival of Vijaya, examines different periods through which Ayurveda underwent a process of expansion in the country. The book explores the patronage of kings during the kingdoms of Anuradhapura, Polonnaruwa, Dambadeniya, Kurunegala, Gampola, Kotte, Seethawaka, Kandy, and Colombo towards the development of Ayurveda. The writer asserts that the development of Ayurveda was most evident when the king focused his attention and extended his patronage. For instance, Pandukabhaya, II Pethis, Dutugemunu, Mahasen, and Buddhadasa, Kings of Anuradhapura, Maha Parakramabahu of Polonnaruwa, Parakramabahu III of Dambadeniya, and Parakramabahu VII of Kotte, are believed to have rendered a great service towards the development of Ayurveda. The most unprosperous period for Ayurveda was during the reign of Buwanekabahu I of Dambadeniya and under the reign of certain monarchs during the Seethawaka and Kandy kingdoms (Kumarasinghe, 2007: 201-207).

Kusumarathna (2013) contends that the golden era of Ayurveda was definitely the pre-colonial period. Sri Lanka was the focus of international attention as a country with institutions teaching Ayurveda. The Vijayaba Pirivena in Thotagama is an excellent example in this regard. This monastic college was established by Venerable Thotagamuwe Sri Rahula, who was the adopted son of Parakramabahu VI of Kotte. In addition to Ayurveda, it also taught traditional law, Buddhism, Hinduism, and literature. This monastic college was an

example of an education system based on Ayurveda. The best-written text on the local medical system is the Besajja Manjusawa, which was written in 1267 BCE. It is believed that at least 10 texts on the local system of medicine used during the pre-colonial era were destroyed during colonial rule (Kusumarathna, 2013). Kusumarathna has identified Ayurveda, Deshiya Chikithsa, Siddha, and Unani as a unified system that operated as the indigenous system of treatment for diseases during pre-colonial days. However, Uragoda (1987), in contrast, has classified and explained Ayurveda and native treatments practiced during pre-colonial days separately from each other (Uragoda, 1987).

This illustrates that the responsibility of preserving health was borne by Ayurveda until Western medicine was established in Sri Lanka following colonial rule. According to Uragoda (1987), Ayurveda, as a native treatment procedure, was the predominant system of medicine during the presence of the Portuguese and the Dutch, fulfilling the health needs of locals and foreigners prior to the advent of the British.

Deshiya Chikithsa, also described as Sinhala medicine, existed long before Ayurveda was introduced to Sri Lanka. There is no written history or record of the genesis, philosophy, or theory of the early systems of treatment that were practiced in the country. These treatments were passed down through generations and not through any formal collection of writings, which makes them 'folk', 'tribal', and local. They were passed down from one generation to the next. Based on centuries of experimentation built on countless errors, successes, and failures, these systems of medicine were a collection of traditional beliefs, theories, and exercises practiced at the community level. Propagated through oral tradition, it could be described as a culture of public health (Chandrasekara, 1995). Accordingly, Sri Lanka's Deshiya Chikithsa, or Sinhala medicine, is one such practice. As a system of medicine that included the folk culture of Sri Lanka, it existed during pre-colonial times as a system with a unique identity. The system of Ayurveda practised in Sri Lanka during pre-colonial days, on the other hand, was influenced by the system of Ayurveda introduced by migrating Aryans and formed into a system unique to the country. Today, the native system of treatment has integrated with Ayurveda to such an extent that it bears no distinguishable identity.

The Siddha system of treatment was brought from South India. It is based on the fundamentals of Ayurveda. The Unani system of medicine was introduced by Arabs who visited the country for trade, which was principally with the coastal areas, resulting in the

Unani system being widespread among Sri Lankan Muslims living along the coastal belt. The fundamentals of Unani are closely linked to the fundamental principles of Ayurveda (Uragoda, 1987: 14). This rationalizes the fact that Ayurveda could be considered a common system of medicine in Asia. Dunn (1977) has divided official health care systems into three groups: local medical systems, regional medical systems, and cosmopolitan medical systems. According to Dunn, Ayurveda is a regional medical system.

In addition to the empirical systems of medicine in practise, there are non-empirical systems described as supernatural systems, which have been in existence since pre-colonial times and are extensively used in the task of preserving the health of the people. It is believed that the use of magic to cure diseases is as old as humanity. People in primary societies believed that diseases were brought about by sorcerers and witches who invoked the help of supernatural agents and invisible forces. These conditions were avoided by engaging in propitiations, making vows, wearing talismans and amulets, and resorting to sorcery. These practices may have begun centuries ago, and although we live in an era of numerous scientific definitions explaining diseases, these age-old beliefs and attitudes continue to prevail. Even to this day, a large percentage of people's responses to diseases in Sri Lankan society are centered on such archaic beliefs and rituals. Uragoda (1987) has described the account by Robert Knox in his book An Historical Relation of the Island of Ceylon (Eda Heladiwa) of the supernatural systems of treatment prevalent among locals during colonial rule.

Colonial Period

Sri Lanka was a colony of three foreign countries from 1505 to 1948. Having been under foreign control for nearly four and a half centuries brought about colossal changes to the country's traditional economic, political, cultural, and social fabric. The changes that came to Sri Lanka's health conservation system were equally enormous. It was under colonial rule that a totally alien system of medicine was introduced to the country, eventually establishing it as the orthodox system of medicine in Sri Lanka. By this time, the native system of healthcare that had hitherto provided all treatment requirements had been neglected to the extent that it had become distant from the people. Some observers have pointed out that the collapse of the native system of medicine began even before the advent of colonial control. The internal instability under the monarchical rule and the frequent shift in the capital of

the country were the main reasons. Sri Lanka became a colony during this inactive period in the local system of healthcare (Uragoda, 1987; Hettige, 1991). An inquiry into historical data reveals the relationship between the decline and development of local healthcare and the rise and fall of kingdoms during different epochs of Sri Lanka's past. Kumarasingha (2007) has opined that the golden era of Ayurveda as the predominant local system of medicine prevailed during the reign of kings who were focused on ensuring people's health and well-being. Other literature points out that Sri Lanka's becoming a colony under foreign rule and the eventual advent of Western medicine led to the decline of Ayurveda. The establishment of Western medicine in Sri Lanka and the decline of the native healthcare system as a result have been expounded by writers such as Uragoda (1987); Wanninayake (1982); Hettige (1991); Liyanage (2000); and Kusumarathna (2013).

The development of Western medicine during colonial rule can be examined in three main stages. Accordingly, it can be examined under the rule of the Portuguese (1505-1656), the Dutch (1656–1796), and the British (1796-1948). Western medicine was first introduced during the reign of the Portuguese. With advanced navigation, there is evidence to suggest that various foreign nationals travelled to Sri Lanka for trade even before 1505. However, Portuguese control did not wield sufficient influence to establish Western medicine in the country. The Portuguese established hospitals along the coastal areas of Colombo, Galle, Jaffna, and Mannar, which were mainly for their use. There were instances when local medicines were used to meet the needs of the Portuguese as well. The Portuguese, therefore, had no intention of destroying the native system of medicine, but they were also not inclined to promote Western medicine in the country. In fact, they had, in many instances, admired the local knowledge of medicines (Uragoda, 1987; 67). The Dutch, on the other hand, wielded a larger influence in establishing Western medicine in the country. Although there were many healthcare institutions practising Western medicine during the Dutch period, they were off-limits to the local people. The Dutch had built a main hospital in Colombo, with smaller hospitals established in Galle, Jaffna, Matara, Trincomalee, Mannar, Batticaloa, and Kalpitiya. The Portuguese and the Dutch equally valued the native system of medicine, and by the latter half of Dutch rule, all their hospitals were employing native physicians. The chief surgeon would take along the local physician when visiting patients, making sure that his knowledge was put to good use in the process (Uragoda, 1987: 90–91).

The Dutch introduced a system of fostering local healthcare at the village level to circumvent the shortage of Dutch physicians to attend to the medical needs of the local population. However, Western medicine during Portuguese and Dutch rule was not established to the point of impacting Sri Lankan society. The reason was that they had no desire to fulfill the healthcare needs of the local populace and would themselves seek treatment from the native healthcare system to meet their requirements (Uragoda, 1987: 02, 11).

This demonstrates that the Portuguese and the Dutch did not work to wipe out the native healthcare system, nor did they attempt to establish Western medicine extensively. Their principal objective in coming to Sri Lanka was for commercial gain and to propagate Christianity. As the Portuguese and the Dutch did not link their trade objectives with Western medicine, it had the least negative impact on the continuation of the native healthcare system.

British rule, on the other hand, marked an important milestone in the history of Sri Lanka's health sector. Western medicine was decisively established throughout the country during this period (Uragoda, 1987: 104). The British had to use Western medicine to efficiently and effectively combat serious health issues that developed throughout the country (a large number of people were dying from Typhoid, Cholera, and Pneumonia) at the beginning of their rule. It also became a powerful medium for exploiting the people in its colonies. Jones (2004) writes, "Colonial medicine was implicated in the colonial project. It facilitated the establishment of Western hegemony by the legitimising colonial government. It was involved in the economic exploitation of indigenous peoples by helping to maintain the productive and reproductive health of labour" (Jones, 2004:270).

Economics was at the heart of the British objective of expanding Western medicine in its colonies. Uplifting the health of the local population was not the intent when Western medicine was introduced throughout the country. To the British, healthiness mattered in realising its objectives. This perspective has been extensively discussed in the theoretical framework of the political economy of health (Banerji, 1976–1977; Navarro, 1976; Illich, 1976).

Uragoda (1987) discussed the development of Western medicine in Sri Lanka under the reign of the British. The British had established a military medical corps to look into medical and health services at the very inception of their rule in 1796. From then on, the British left an

indelible mark on the expansion of Western medicine in the country. Accordingly, in 1798, hospitals to treat typhoid patients were built in Colombo, Jaffna, Trincomalee, and Galle. Administering immunisation to the hand had begun by 1802. Having established a Civil Medical Authority in 1859, the British built the Colombo National Hospital, the de Soysa Maternity Hospital, the Lady Havelock Hospital, the Victoria Memorial Eye Hospital, the Mental Health Institute in Angoda, and medical clinics in various parts of the country. Sri Lanka's first medical school was established by the British in 1870. In 1913, sanitation boards were established. In addition, steps were taken to ensure the prevention of diseases and to uplift the standard of health of the local population. Establishing a Ministry of Health in 1931 in accordance with provisions of the Donoughmore Constitution was an important event in the history of Sri Lanka's health sector (Uragoda, 1987: 104–107). By 1946, when the British were on the threshold of leaving the island, 183 hospitals, including 45 village hospitals and specialised hospitals, had been established (Uragoda, 1987: 123). The establishment of Western medicine under British governance led to drastic alterations in the healthcare culture that had been used by the natives. Every community, according to Banerji (1982), has a healthy culture that reveals cultural attitudes, its own meaning of its health problems, health practices and systems, and access to such systems. Colonial states developed complex health cultures in colonies from a pre-industrial health environment. Their advent allowed the creation of an environment that led to the collapse of existing health cultures. Several traditional methods were so advanced as to ensure healing and contentment. Ayurveda, practised in India, was one such system (Banerji, 1977:262). The introduction of a new system of medicine under colonial rule and its expansion led to changes in the health practices hitherto used by the Sri Lankan people. Although Western medicine was entirely new to the people, certain unique features therein attracted many to it. According to Hettige (1991), people in urban areas as well as villages had shown an interest in acquiring the services of Western medicine, and the following reasons impacted this change:

1. Even the least educated villagers could not totally ignore the newly introduced Western system of medicine.
2. Having obtained treatment from state hospitals, people came to understand the empirical validity of Western medical treatment.

3. The fact that Western medicine administered healing within a complex structure that is devoid of conflict, notions, and beliefs was another reason for it to be preferred.
4. The validity of Western medicine and its social estimation can swell just as much as it can offer relief from diseases through its therapies (Hettige, 1991:34).

Under the British, Western medicine acquired a special place within Sri Lanka's health culture, propelling it to the position of the orthodox system of medicine in the country. Despite this development, the local population continued to access native forms of treatment for diseases. People living in the villages, who comparatively had less access to facilities associated with Western medicine, continued to seek native treatment for their healthcare needs. Moreover, people in the villages were well acquainted with local healthcare practices (Hettige, 1991:39). While people continued to access native systems of treatment, the presence of dispensaries, hospitals, and mobile clinics drew more people towards Western medicine for treatment. Visiting a hospital for the slightest ailment became an important component of their health routine.

The social status and cultural role of Western medicine cannot be discussed in isolation as part of general health services, the reason being that there is an interplay between social, political, economic, and cultural forces. For instance, free education has led to an increase in the rate of literacy in Sri Lanka, which in turn has given way to nurturing a positive attitude towards Western medicine. The rise of an anglicised elite in Sri Lanka led to an increase in Western values and ideas, while local institutions and medical systems went into eventual obliteration. The local elites had a high degree of social mobility owing to their wealth and social status (Hettige, 1991:35-37). Locally, there emerged a group of people who, through their lifestyle, provided the impetus for the efforts of the administrators to expand Western medicine in the country. Native healthcare practices naturally suffered a setback under such circumstances, which almost drove them to a position of destruction. However, unlike in other colonies, native healthcare treatment practices in Sri Lanka were not completely annihilated. Patriotic forces that led the struggle for independence from the British ensured that these age-old treatment procedures remained safeguarded. Although Western medicine was established in the changing social, cultural, economic, and political context of colonial Sri Lanka, the fact that the people continued to use native treatment ensured that the country inherited a complex pattern of patient behaviour (Liyanage, 2000:79).

It would be unreasonable to arrive at conclusions regarding the ascendency of Western medicine, the stable position it achieved in the country, and the subsequent relegation of the native medical system to a subordinate position based on its empirical legitimacy. Western medicine, on its part, was responsible for successfully dealing with the increasing incidents of epidemics and lowering the high rate of maternal and infant mortality. Moreover, Western medicine ensured that people abandoned harmful health habits while uplifting sanitary conditions, which led to a decrease in the rate of diseases and deaths. Western Europe, at this point in time, was experiencing a scientific renaissance. As word spread about this resurgence in science, there emerged an appreciation of Western medicine among the people of Sri Lanka. Under such developments, Western medicine acquired strong empirical validity in the existing society of the time. With complete state patronage, Western medicine acquired hegemonic status.

According to Endagama (1997), the British considered all indigenous institutions, religious worship, and beliefs in Sri Lanka and in all its colonies inferior, unimportant, and archaic (Endagama, 1997: 64). This same attitude extended to the native medical system, which it considered a meaningless system that was followed by people without any scientific basis. Uragoda has written that the British operated on the premise that the locals must be saved from rogue physicians (Uragoda, 1987: 123). Despite such notions, the British did not attempt to completely annihilate the native system of healthcare. It was not an easy task to eliminate the native medical system completely. There were many reasons for this.

1. Given the fact that the cost of establishing Western medical health services uniformly throughout the country in order to allow the entire population to access Western medicine was high, allowing the majority to seek treatment from traditional systems was an advantageous alternative.
2. Foreign administrators did not desire any internal agitation among the local population by encouraging the extensive use of biomedical interventions. Biomedicine was significantly used only when health challenges intensified beyond political necessities (Jones, 2004:58–86).

On the other hand, taking people away from the native system of healthcare that had been the foundation of their culture was not a simple undertaking. In time, the British could not completely dismiss or ignore the country's native system of medicine with the intensification

of action by patriotic movements. Led by this development, administrators were forced to take steps to improve the native system of treatment at the beginning of the 20th century. An aspect of this improvement included registering native medical practitioners, providing them with training, and establishing an organisational structure that was similar to the professional status ascribed to Western medicine. British administrators upgraded the status of native medicine not because they appreciated the native system of medicine but because of constant requests from the local elite. However, the development of the two systems of medicine during this time did not occur on an equal footing. Western medicine, as the orthodox system, was progressing swiftly with complete state patronage, while Ayurveda was moving at a snail's pace. Despite a lack of state patronage during colonial rule, the Ayurveda system of medicine in Sri Lanka continued to fulfill an important role (Liyanage, 2000:79). As Ayurveda remained with the people, there developed a complex set of behavioural traits in treatment within Sri Lankan society. Several researchers have pointed out that the genesis of medical pluralism sprung under colonial rule (Jones, 2004:103). Although there existed a plethora of treatment systems from pre-colonial days (Sinhala medicine, Ayurveda, Siddha, Unani, and other non-empirical systems), they were devoid of complex differentiations and were based on common principles.

Post-Colonial Period

The post-colonial period began in 1948, which marked the country's independence from British rule. The 20th century can be considered a remarkable period in relation to the health sector in Sri Lanka. 48 years of the 20th century were under colonial rule, while 52 years belonged to the post-colonial period. The beginning of the 20th century witnessed various developmental stages in Ayurveda and, in general, in the system of native medicine. As stated earlier, this improvement, in comparison to the rapid development that occurred in Western medicine, was slight. Native medicine in post-colonial Sri Lanka underwent a revival. Ayurveda physicians were in the vanguard of the independence struggle carried out by the Pancha Maha Balawegaya—the five great forces of the Buddhist clergy, the workers, the Ayurveda physicians, the teachers, and the farmers. This Sinhala nationalist movement subsequently developed into a political movement, leading to a massive victory for the party that led the campaign for a revival of the indigenous culture (Hettige, 1991:43). The government that came into power in 1956 extended state patronage towards the development of Ayurveda. Subsequently, the Ayurveda Act of 1961 contributed to the

development of Ayurveda within the context of a non-governmental conservation system. It was given the same treatment as Western medicine. However, the gap between the two medical systems in terms of dispersion, preference, and status remained unchanged. Nonetheless, it was during the post-colonial period that the Ayurveda Research Institute was set up, while indigenous medical schools were granted university status, public dispensaries, and hospitals were established, the Ayurveda Pharmaceutical Corporation was established, and a separate Ministry for Ayurveda was established (Wanninayaka, 1982:53–55). Still, the development that Ayurveda experienced was inadequate to make it equal in status to Western medicine. The native system of medicine could not stand on par with Western medicine in terms of socio-political influence, economic preferences, teaching faculties, hospitals, public health programmes, primary health conservation programmes, professional and educational institutions, research, and state patronage. Both systems have formal structures at the national level, which has led to conflict between the two (Hettige, 1991:31). Hettige (1991) further contends that the formal organisational structure that was established to manage the operations of Ayurveda was a prototype of the structure used in Western medicine. This, in turn, led to the collapse of the independence of the native system of medicine (Hettige, 1991:43). Several writers have examined the reasons for the failure of Ayurveda, which experienced significant progress during the beginning of the post-colonial period and had a bearing on its long-term development (Hettige, 1991; Kusumarathna, 2013). According to Hettige (1991), attempts to develop Ayurveda were not made to preserve its identity and independence. Because the development of Ayurveda was carried out along the lines of Western structures (especially in the case of including components of Western medicine into the curriculum of the Ayurveda medical courses, hiring Western medical practitioners as trainers, subjecting treatments administered by native medicine to laboratory tests, and setting up corresponding institutional structures), it eventually adjusted to accommodate Western medicine rather than preserve its uniqueness. Waxler has stressed that there is no significant difference between Western medical practitioners and Ayurvedic practitioners within Sri Lanka's plural medical system (Waxler, 1988:531). Kusumarathna (2013) has pointed out that the foundation for an expansion in Ayurveda had been well placed towards the end of colonial rule. But the national committee that was set up to initiate the development of Ayurveda consisted of lawyers, economists, and politicians from the local class of elites. There was only one Ayurvedic physician on the committee. Therefore, the members of the committee that represented the local elites worked with a

mindset that imitated the West, which dictated their decisions, in turn preventing them from fulfilling their expected roles. He asserts that it is important to have people with knowledge of Ayurveda on committees that are set up to take decisions that aim to develop Ayurveda (Kusumarathna, 2013).

Myrdal (1972), in his book "Asian Drama: An Inquiry into the Poverty of Nations," states the following: After the overthrow of colonial powers during the post-war period, a native ruling elite took power. Conforming to the "soft stable," these new rulers made "lofty" egalitarian pronouncements while using essentially the same machinery bequeathed to them by former colonial rulers. This ensured that the fruits of dependence benefitted them most and perpetuated their hold on the government", (Myrdal, 1972; p. 201).

Myrdal's (1972) observations are in concurrence with the ideas expounded by Hettige in 1991 and had the local leaders of post-colonial Sri Lanka dealt with the country's native systems of medicine devoid of Western colonial mentality, it could have achieved the desired development while ensuring that its independence remained intact. Countries such as India and China ensured that their indigenous systems of medicine operated minimally parallel to Western medicine. Although Sri Lanka's native system of medicine has been institutionally structured similarly to Western medicine, it did not receive the same treatment in the case of developmental action. This eventually relegated native medicine to secondary status, propelling Western medicine to preeminence as the orthodox system of medicine in the country.

However, the Western assumption that all other alternative systems of medicine in the world would gradually die away in the face of the hegemonic dominance of Western medicine has not come to pass. Instead, medical pluralism has emerged universally. Most countries practice several native healthcare models. Sri Lanka, too, has a highly developed native medical system. Developments initiated during colonial times, such as the establishment of the Department of Ayurveda, the Ayurveda Act of 1961, the establishment of the Ayurveda Research Institute, dispensaries, and hospitals, the affiliation of the Ayurveda Medical College with the university in 1972, and the founding of the Ministry of Indigenous Medicine in 1980, indicate that Ayurveda has been established as a state-sponsored official system of medicine. Accordingly, Sri Lanka clearly has a pluralistic system of medicine. Sri Lankans adequately utilize the various divisions in this pluralistic system to address their

health-related issues. However, it seems that in terms of policy formulation and decision-making, the country's pluralistic medical system does not receive sufficient consideration.

Wolffers (1989) maintains that human civilisation throughout history has been marked by conflicts and adaptations between cultures. A similar fact can occur between different health cultures as well: they can be in conflict and adapt. Such conflicts lead to cultural absorption, integration, and pluralism. Absorption is a result of conflict between two cultures, where the stronger culture subordinates the weaker one. There is integration between cultures when two systems with different cultural backgrounds come together to form a new cultural system. Pluralism is born when the concepts of the cultures of two groups of people remain independent (Wolffers, 1989: 8–9). Western medicine introduced to Sri Lanka following colonisation is entirely different from the health culture and treatment systems that pre-existed in the country. Although the people did access Western medicine owing to pressure from colonial rulers and their attempts to get people accustomed to the new medical system, the local health culture was not abandoned. Instead of the absorption and integration that Wolffers (1988) writes about, the result was the establishment of pluralism. Although absorption may have taken place to a certain extent, integration between the two has yet to happen. Western medicine and Ayurveda in Sri Lanka operate as opposing systems instead of giving birth to a much-needed new health culture for the country.

Western medicine and Ayurveda operate under state patronage among multiple treatment procedures in Sri Lanka's plural medical system. But the nature and scope of state patronage extended to the two differ from each other. Western medicine is developing at a rapid pace and operates as the orthodox system of medicine in Sri Lanka. However, Sri Lanka's health sector is blighted by many grave issues. Although certain health indices may demonstrate positive improvements, the majority of the population of Sri Lanka suffers from non-communicable diseases. Meanwhile, there is an indication of an increase in the spread of communicable diseases as well. Western medicine, as the orthodox system of medicine in the country, has failed to successfully manage these issues. Statistics pertaining to the spread of several leading non-communicable diseases in the country are a manifestation of the limitations of Western medicine. Prior to the advent of Western medicine, health conservation within the country was skillfully managed according to the concepts and theories of Ayurveda. Ayurveda in Sri Lanka is a system well-integrated and harmonious

with the native social, economic, and cultural framework. Contained within Ayurveda are the doctrines of longevity through healthiness.

Selected Studies on Sri Lanka's pluralistic medical system

Closely associated with this study are the findings of medical sociological and medical psychological studies conducted on Sri Lanka's plural medical system. Nancy Waxler's study on plural medicine in Sri Lanka: Do Ayurvedic and Western medical practices differ? Published in the Journal of Social Science and Medicine in 1988, it deduces that while Western medical practitioners can successfully treat certain diseases, similarly, Ayurveda too can effectively treat certain ailments, especially chronic ailments. Waxler, who builds her argument on functionalism, concludes that both Western medicine and Ayurveda have been well-established in the Sri Lankan social, economic, and cultural milieu, and the demand for either system does not depend so much on their differences. The reason for this could be deduced from the lack of glaring differences in the services of the two treatment systems. Waxler goes on to state that there are no large differences between factors such as identifying a disease, physical examination and the tools used for it, the relationship between doctor and patient, the time taken for examination, and the prescription of medicines in the two systems. But Ayurveda faces many challenges. Nordstrom (1988) argues that Sri Lanka not only has Western and Ayurvedic medical systems and supernatural ritual practices as treatments, but Ayurveda itself is wide-ranging, which makes Sri Lanka's medical system a complex and pluralistic one. This complexity, according to Nordstrom, allows the patient to choose from a variety of treatment procedures.

Explaining the challenges confronting Ayurveda, Waxler writes that the lack of appropriate medicines to ensure efficient treatment and their high prices, the requirement to utilise medicines that have already been prepared, and the inability to levy high fees from patients are overcome by some Ayurveda physicians by adapting to the Western system (Waxler, 1988:21-544).

Ivan Wolffers published a research paper titled 'Traditional Practitioner's Behavioural Adaptations to Changing Patient's Demands in Sri Lanka' in the Social Science and Medicine Journal in 1989, in which he arrived at the following conclusions following a study of village and urban communities in Sri Lanka:

A. Ayurveda practitioners adapt their behaviour according to patient's expectations.
B. They adapt therapeutic techniques from cosmopolitan medicine.
C. 50% of Ayurveda practitioners in his survey work in cosmopolitan style and they charge a higher fee.
D. Those who work in the traditional way also make a great contribution to national healthcare.
E. Different behavioural patterns of indigenous medical practitioners are due to patients' demands.

The studies conducted by Waxler, Nordstrom, and Wolffers are contemporary, although their descriptions of the nature of supply in the local healthcare market differ from each other. Nordstrom contends that in a plural medical system like ours, patients have much to gain from a choice of treatment systems that they can pick from. But Waxler's observation is to the contrary, where she states that the choices are limited. The reason, according to Waxler, is that there is hardly any differentiation in the services dispensed by indigenous and Western medical practitioners. She also states that it is easy to identify the use of treatment by Sri Lankans. However, all three researchers agree on the fact that indigenous medical practitioners have adopted Western medical practices in response to the increasing demand for Western medicine among patients.

Hettige (1991), in his paper 'Western and Ayurvedic System of Medicine in Sri Lanka: Some Preliminary Observations," analyses the interface between the newly introduced Western system of medicine and the pre-existing Ayurvedic system in Sri Lanka, as Western medicine was established under colonial rule. Colonial rulers had made great efforts to expand Western medicine in most parts of the country, and the result, according to Hettige, was that the indigenous medical apparatus that was the standard bearer of conserving health among the populace of a Sinhala society was marginalised.

Hettige (1991) contends that although indigenous cultures under colonial rule were not completely annihilated, they nevertheless significantly declined. The introduction of Western education and the rise of a westernised local elite engendered the spread of Western values and ideas. In the meantime, indigenous institutions and the indigenous medical system were obliterated. He explains the background that enabled Western medicine to take root in the country's social, economic, and cultural contexts while explaining the reasons for

the indigenous medical system to remain in society despite its decline during colonial rule. The decline of indigenous medicine may have begun even before the advent of Western colonial rule, states Hettige. Political instability characterised the period before colonial rule under the dominion of the monarchy, which may not have facilitated any significant development in the local system of healing, including the generation and dissemination of knowledge and the development of new techniques (Hettige, 1991: 27–64).

Obeysekare (1976) studied the influence of Ayurvedic concepts on the culture and individuals in Sri Lanka. This study comprises both physical and religious aspects of Ayurveda. He has conducted research in the Kandy area and made an inclusive and in-depth analysis of Ayurvedic principles and behavioural standards in the current society. In addition to the principles of Ayurveda, he studied the cultural concepts associated with Ayurvedic principles. According to him, the hot-cold classification can be used to understand equilibrium among the three humours that maintain the health state of an individual. Additionally, it is considered an impact of Ayurvedic ideas on Sri Lankan culture, especially with reference to the Sinhalese. Obeysekare's study has become important to the present study because it has discussed how much Ayuvedaya is related to the Sri Lankan socio-cultural context. However, it has not been discussed by Obeysekare about Ayurveda's capacity to provide resolutions for the present health hazard.

Liyanage (2000) offers a medical-sociological perspective on patient behaviour among the local populace. She carries out a broad analysis of the social, economic, and cultural aspects that determine the use of treatment procedures among locals while also examining Sri Lanka's plural medical system, the nature of the market involved in the conservation of health, and the behaviour of the forces that operate it. Liyanage points out that although Sri Lanka has a plural medical system, people do not have the freedom to choose what they desire, and instead culture determines the response according to the symptoms exhibited by a patient. The implementation of that decision, though, depends on several factors. She further reasons that Sri Lanka's plural medical system does not operate as an alternative system but in cooperation as a collection of additional systems. In other words, Liyanage points out that those patients have no freedom of choice in a plural medical system. The question is whether each medical system can be a suitable alternative to the other. It is important to ascertain whether all other medical systems in Sri Lanka are capable of being a possible alternative to the popular and highly demanded Western system of medicine.

Ayurveda is a viable alternative for some diseases. Whether a particular medical system is a viable alternative to another does not solely depend on quality. It is important to scrutinise the studies mentioned, as they will be relevant to this study, which will discuss the conditions that drive the demand for Western and Ayurvedic systems of medicine, respectively.

Ayurveda in 20th-century Sri Lanka: A Sociological Analysis by Kusumarathna (2013) offers an alternative argument to the above studies, where he does not accept the majority assertion that Ayurveda was sorely neglected under colonial rule. He argues that British colonial rulers, in their attempts to introduce and expand the Western system of medicine, did not, in the process, try to destroy the indigenous system of medicine. Instead, in response to requests from members of the local elite, the British rulers took steps to institutionalise Ayurveda as a medical system during the latter part of their regime here. Kusumarathna argues that the local elite, in turn, failed to implement appropriate measures to develop Ayurveda in post-colonial Sri Lanka. According to Kusumarathna, Ayurveda experienced its highest level of inattention in the post-colonial era, where the ruling elite did everything to conserve it as a cultural heritage rather than develop it as a system of treatment (Kusumarathna, 2013: 247–249).

Conclusion

As discussed above, medical pluralism can be identified as the utilization of more than one medical system or the use of both conventional medicine and complementary and alternative medicine (CAM) for health and illness. Accordingly, biomedicine and homeopathy were born in Western Europe, while Ayurveda is a predominant system in South Asia, Chinese and Korean systems of medicine are from East Asia (Acupuncture), and Unani is of West Asian origin. In addition, every society has its own home-grown systems of treatment. Sri Lanka is one of the best countries that can be identified as having a more advanced and complex medical pluralistic system. However, it can be identified as the result of the gradual historical evolution of these medical systems over various time periods. So, this study was mainly focused on the development of the plural medical system under the pre-colonial, colonial, and post-colonial eras and the factors that determined the demand from patients in such a plural system. Finally, it is evident that, although globalization and

other social changes are taking place, such pluralistic systems are still being implemented and have survived for the different treatment purposes of people in society.

However, considering the stratified nature of such multi-medical systems in society, each of these systems has not received the same opportunities and recognition. It is clear that the Western medical system has dominated society, and other medical systems have not had the same opportunities. It is not only the empirical accuracy and validity of the Western medical system that have caused it; other political and economic factors have also triggered it. It was discussed above how this situation was very evident during the colonial period as well as after the independence era. Because of this, the need for academic research on the impact of the Western medical system on other local medical systems is highlighted. Because the real benefits of a medical pluralist society can be achieved by establishing a more integrated medical system rather than one chosen and dominated by one medical system in society.

References

Banerji, D. (1975) *Social and Cultural Foundation of Health Service system of India*. Inquiry, 12: 70-85

Banerji, D. (1977) "Public Health Population Control", *S.C Dube* (ed.) India since Independence: Social Report on India. 1947-1972. New Delhi: Vikas.

Banerji, D. (1978) *Political Issues in Health Population and Nutrition*. Social Scientist 07: PP 159-68

Banerji, D. (1982) *Poverty, Class and Health Culture in India*, New Delhi: Prachi Prakashan.

Democratic Socialist Republic of Sri Lanka (1961) *Ayurveda Act* (1961) No 31.SL: The Government Publication Bureau.

Dunn, F.L. (1976) "Traditional Asian Medicine and Cosmopolitan Medicine as adaptive systems", *Asian Medical Systems: A Comparative Study*, C. Leslie (ed.), University of California Press, Berkley, Los Angeles, London, PP 133-155.

Hettige, S.T. (1991) "Western and Ayurveda Systems of Medicine in Sri Lanka: Some Preliminary observations", *Journal of Social Science, V*, (1)-PP 27-54.

Illich, I. (1975) *Limits of Medicine*, Marion Boyars, London.

Illich, I. (1976) *Limits of Medicine: Medical Nemesis, the Exploration of Health*, London, Calder and Boyars.

Jones, M. (2004) *Health Policy in Britain's Model Colony: Ceylon (1900-1948)* New Delhi, Orient Longman.

Kusumarathna, K.L.S. (2005) *Indigenous Medicine in Sri Lanka*, Sarasavi Publishers, Nugegoda.

Kusumarathna, K.L.S. (2013) *Ayurveda in the 20th Century in Sri Lanka*, S. Godage and Brothers (Pvt) Ltd, Colombo.

Liyanage, J.H.C. (2005) *Social Production of Health in Rural Sri Lanka.* Unpublished Thesis (PhD) University of Delhi, India.

Myrdal, G. (1972) *Asian Drama: An Inquiry into the Poverty of Nations*. Harmsworth: Penguin.

Navarro, V. (1976) *Medicine under Capitalism*, New York: Parodist.

Nordstrom, C.R. (1988) "Exploring Pluralism – The Many faces of Ayurveda", *Social Science and Medicine* 27(5): 479-489

Obeyesekare, G. (1976) "The Impact of Ayurveda ideas on the culture and the Individual in Sri Lanka.", *Asian Medical systems*, Ed. chors Leslie. Berkeley, University of California Press.

Silva, K.T., A.W., de Silva Amarasiri, Banda, T.M. Wijekoon. (1994) "Access to Western Drugs, Medical Pluralism and choice of Therapy is an Urban Low Income Community in Sri Lanka", *Medicine: Meanings and Context*, ed. Nina L. Edkin and M.L. Tan, Quezon City, Philippines Health Action Information Network. 1994.

Uragoda, C.G. (1987) *A History of Medicine in Sri Lanka*. Colombo, Sri Lanka Medical Association.

Wanninayake, P. (1982) *Ayurveda in Sri Lanka*. Colombo, Ministry of Health, Sri Lanka.

Waxler, N.E. (1984) "Behavioral convergence and Institutional Separation: An Analysis of Plural Medicine in Sri Lanka", *Culture, Medicine and Psychiatry*, 8: 187-205.

Waxler, N.E. (1988) "Plural Medicine in Sri Lanka: Do Ayurvedic and Western Medical Systems Differ?" *in Social Science and Medicine*, 27: 531-544.

Wolffers, I. (1989) "Traditional Practitioners "Behavioral Adaptations to changing Patients" Demands in Sri Lanka", *Social Science in Medicine*, 29.

Wolffers, I. (1988a) "Illness behavior in Sri Lanka: Results of a Survey in Two Sinhalese Communities"*, Social Science and Medicine*, 27(5): 545-552.

Wolffers, I. (1988b) “Traditional Practitioners and Western Pharmaceuticals in Sri Lanka" *In the context of Medicine in Developing Countries*, ed. S. Vander Geest and S.R. Whyte Dorderct, Kluwer.

ඇඳගම, එම්. (1997) ශ්‍රී ලංකාවේ ගම්සභා ක්‍රමයේ ඉතිහාසය, කර්තෘ ප්‍රකාශන.

කුමාරසිංහ, ඒ. (2007) විවේචන සහිත සංක්ෂිප්ත ආයුර්වේද ඉතිහාසය. කොළඹ: ආයුර්වේද දෙපාර්තමේන්තුව.

කුසුමරත්න, එස්. (1989) වෙද මහතා සහ ගැමි සමාජය. වේයන්ගොඩ: ප්‍රභා ප්‍රකාශකයෝ.

චන්ද්‍රසේකර, අ. දොා. (1995) “සිංහල වෙදකම” ආයුර්වේද සමීක්ෂාව, පළමු වෙළුම, පළමු කළඹ. කොළඹ: ආයුර්වේද දෙපාර්තමේන්තුව, 27-28.

රංවල, ආර්. එම්. පී. (2009) “දේශීය කැඩුම් බිඳුම් වෙද පරපුර පිළිබඳ ඉතිහාසය, ව්‍යාප්තිය හා එම වෙදකමේ සුවිශේෂී ලක්ෂණ” තාක්ෂණික සැසිය: 21 වන සියවසට කැඩුම් බිඳුම් වෙදකම, ජන: 22 හා 23, කොළඹ: බන්ඩාරනායක ජාත්‍යන්තර සම්මන්ත්‍රණ ශාලාව.

රණසිංහ, එස්. ජී. (2005) ප්‍රාමාණික නව්‍ය ඖෂධවේදය (මූලධර්ම) තෘතීය භාග. කොළඹ: පවන ප්‍රකාශකයෝ.

ලියනගේ, ජේ. එච්. සී. (2000) රෝගී චර්යාව: සමාජවිද්‍යාත්මක විවරණයක්, මුල්ලේරියාව, විජේසූරිය ග්‍රන්ථ කේන්ද්‍රය.