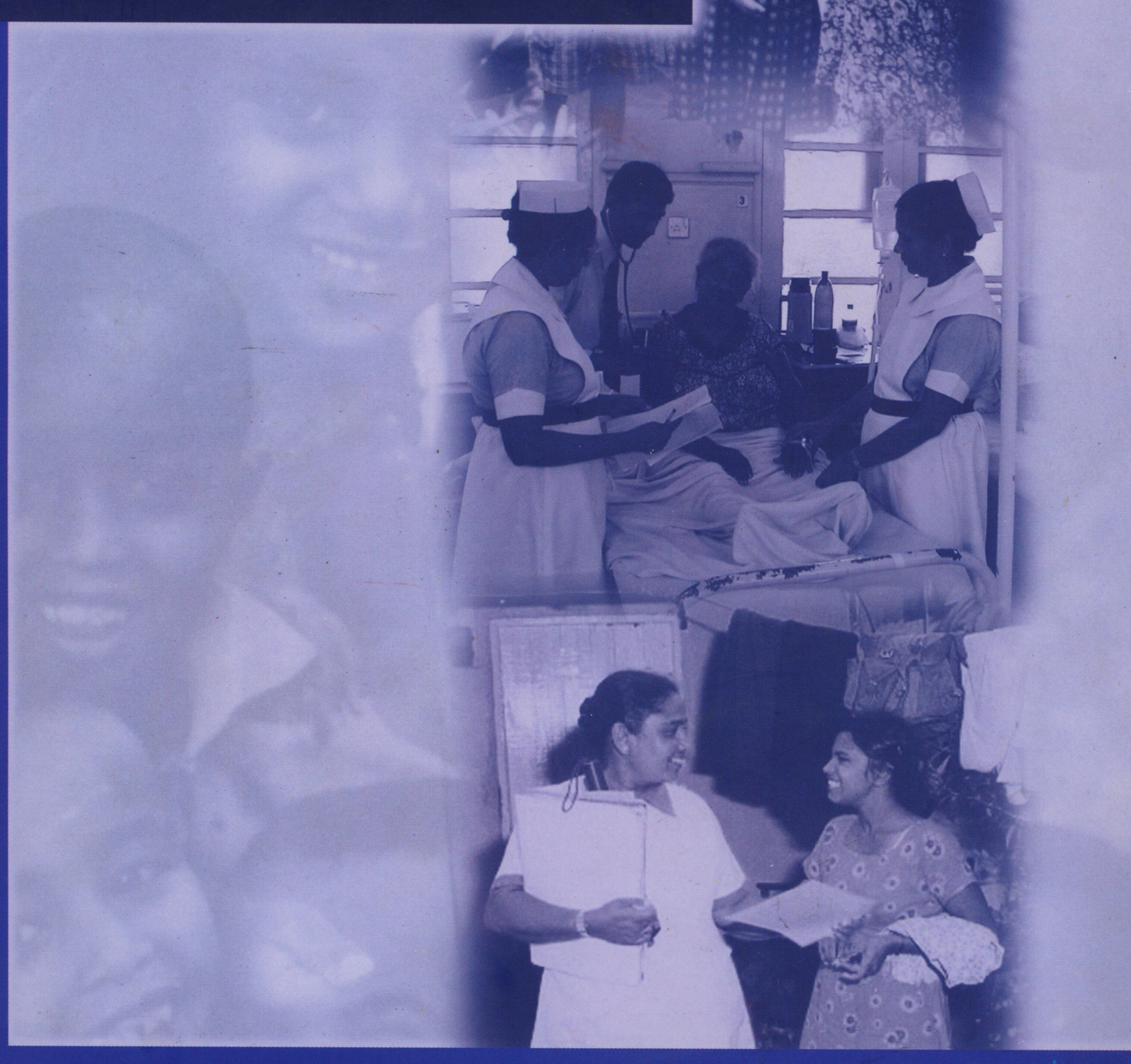
Health Development and Research Programme
University of Colombo

HEALTH SECTOR

In Sri Lanka



Current Status and Challenges

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THE HEALTH SECTOR IN SRI LANKA: CURRENT STATUS AND CHALLENGES

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CHAPTER 13

TREATMENT SEEKING BEHAVIOR

Chandani Liyanage

INTRODUCTION

The purpose of this paper is to describe the treatment seeking behavior in Sri Lanka. It is worth noting three important characteristics of Sri Lanka's health care systems. Firstly, geographic access to health services is very good when compared to other countries, and most villages are within 3 miles of a government health center[1,2]. Secondly, the health system is pluralistic and users have a wide range of treatment options. Finally, because of mass education, high literacy rates and relatively high levels of female autonomy, people in Sri Lanka are 'sensitised to illness' and use health services speedily and effectively to minimize the risk of death[3].

This paper describes 4 empirical issues based on a review of evidence from Sri Lanka and on the studies done by the author on treatment seeking behaviour in a peri-urban community:

1. Different institutions and systems available to a person who is ill
2. Pluralistic treatment seeking behavior
3. Behavior in relation to utilization of different systems
4. Explanatory models or belief systems in relation to illness

1. DIFFERENT INSTITUTIONS AND SYSTEMS AVAILABLE TO A PERSON WHO IS ILL

In Sri Lanka, people can choose from a wide range of providers, which include Western medicine (Allopathic), Ayurveda, Sidda, Unani, Homeopathy, indigenous herbal traditions (Desiya Chikithsha) and healing rituals, including religious activities[3,4,5]. The Indigenous medical system is often (and confusingly) called Ayurvedic medicine, but practices vary from those described in the classical texts to the more folk herbal preparations. Other practitioners who draw upon the Muslim tradition of Unani or the Tamil Hindu tradition of Siddha medicine, along with various hereditary folk healers are legally classified as Ayurvedic practitioners. According to the available statistics there are 147 Ayurvedic hospitals and central dispensaries in Sri Lanka[6]. The term Indigenous Medicine is used here to denote the Ayurveda tradition from India, Sidda, Unani and the indigenous herbal traditions (Desiya Chikithsha). Allopathic medicine and Ayurveda are the most institutionalized systems of medicine in the country and people have access to an extensive network of patient care facilities throughout the country. These facilities provide care based on allopathic or indigenous systems of medicine through the public and private sectors. (These are dealt in more detail in Chapter 4 and 5). A brief description of the Indigenous systems is given to supplement the above.

Different forms of Ayurvedic practitioners could be identified.

Government practitioners: They make up only 3% of the 15,359 registered Ayurvedic practitioners. They have been trained at the Institute of Indigenous Medicine (of the University of Colombo) or affiliated Ayurvedic Colleges and work in the government Ayurvedic hospitals or clinics.

Private registered Ayurvedic practitioners: They are the majority (around 10,000 of the 15,359), and have their own clinics, which are often difficult to distinguish from private clinics conducted by "qualified" Allopathic practitioners. To make matters worse, a proportion of the Ayurvedic practitioners (from state trained institutions as well as other sources) use Allopathic medicines in their practice.

Village vederala: These are practitioners of Ayurveda (especially the indigenous herbal traditions, Desiya Chikithsha, and healing rituals) have had no formal training and not registered under the Ayurvedic Act 1961. They are selected often through a hereditary connection to the trainer or train through a method of apprenticeship. They often have another occupation such as farming. These Vederalas fall into both the popular and folk arenas of Kleinman's typology[7];

- Traditional specialists: fracture-healers ("Kadum bindum"), healers for snake bite
- Religious healers: persons who make talismans, chant blessings ("yantara and mantara"), perform "devil" dancing (thovil), and visits and pray at temples or shriness ("seth kavi"). These also include individual Buddhist monks with healing powers
- Astrologers using mainly the Indian traditions of astrology
- Other local level healers: self-taught, mixing traditions and specialties

The list provides a rough categorisation, and avoids a simple dichotomy of Western and Ayurveda. In reality, many of the providers mix traditions, and adapt them as circumstances change. Accordingly, different institutions, systems and providers are available to a person who is ill in the Sri Lankan society.

2. PLURALISTIC TREATMENT SEEKING BEHAVIOR

Empirically, at least six categories of behavior can be identified[8]. Persons could resort to

- empirical medicine, either Western or Indigenous and remain within it for the entire duration of the illness
- ritual healing and remain within it for the entire duration of the illness
- ritual healing but subsequently shift to empirical medicine
- Western medicine but subsequently shift to Ayuvedi medicine
- Ayuvedi medicine but subsequently shift to western medicine
- multiple sources of relief simultaneously

2.1 Pattern of utilizing different institutions: A brief review of studies which have explored heath-seeking behavior is set out below. The dominance of Allopathic (or Western) medicine is evident in terms of both supply and demand. Table 1 shows available government curative services and the number of patients treated[6].

Table 1. Government curative services: Western and Ayurveda[6]

Type	No. of facilities	No. of Beds	No. of treated
Western	855	48,632	40,066,528
Ayurveda	147	2,203	957,932

As shown in Table 1, government Western facilities treat far more patients than the government Ayurvedic facilities. Comparable data for the private sector are not available. According to the Central Bank consumer survey (1996/97) nearly 88% of patients obtain treatment from physicians through hospital outdoor dispensaries and private consultations and only 6% of sick persons were reported to have sought hospital indoor treatment[9]. Table 2 shows the sources of treatment utilized by ill persons.

This data revealed a significantly increasing trend of treatment in all sectors. The share of patients attending government hospitals increased in 1996/97 particularly in the urban sector. Data also revealed a declining popularity of Ayurvedic private physicians for treatment[10].

Table 2. Sources of treatment utilized by ill persons (as a percentage)[9]

Source of treatment	Urban	Rural	Estate	All sectors
Ayurvedic (state)	1.7	2.0	0	1.9
Ayurvedic (private)	4.9	7.9	1.1	7.3
Western (state)	47.6	48.5	61.6	48.9
Western (private)	40.6	36.6	28.4	36.8
Homeopathy	0	0.2	0	0.2
Acupuncture	0	0	0.5	0.0
Other	1.2	1.3	4.7	1.4
No treatment	4.0	3.5	3.7	3.5
Total	100	100	100	100

2.1 Utilization of institutions during the first episode of illness in a peri-urban community: In a recent study covering a peri-urban population the author found that 52% of illness episodes were first treated by Western providers, and 31% through self-medication using Ayurveda or western remedies.[11] Only 7% of illness episodes were first treated by Ayurvedic practitioners (Table 3). The Table also shows similar health seeking behavior among poor and middle income users. However, Ayurveda tends to be a more popular first treatment for middle income groups while self-medication is more widespread amongst the poor. These patterns may reflect differences in purchasing power, a tendency for the poor to access low cost strategies, and a middle class concern with health promotion and long-term solutions as reflected in their greater utilization of Ayurveda.

Table 3. First treatment utilized by illness episodes[11]

Type of Treatment	Poor income group		Middle income group		Total	
Self-treatment	85	36%	104	29%	189	31%
Western	118	49%	201	54%	319	52%
Ayuvedic	2	1%	40	10%	42	7%
Ritual	4	1%	7	2%	11	2%
Other providers	13	5%	9	2.5%	22	4%
None	16	8%	9	2.5%	25	4%
Total	238	100	370	100	608	100

2.3 Pattern of utilizing Western institutions: With regard to utilization of Western medicine the study found that middle income group use private facilities more often than the poor. Of the low income people who first sought Western treatment 84% went to free government facilities while the remaining 16% went to private sector facilities. In contrast, in the middle income sample 71% went to private providers (mostly General Practitioners) and the remaining 29% went to government facilities. Table 4 shows that utilization of Western government facilities.

Table 4. Utilization of public sector health care institutions[11]

Facility	Low income group		Middle income group	
	Number	Percentage	Number	Percentage
North Colombo TH	77	78%	40	69%
Colombo National Hospital	5	5%	2	3%
Eye hospital	5	5 %	1	2%
Children's hospital	8	8%	1	2%
Peripheral hospital	3	3%	6	10%
Central dispensary (CD)	1	1%	8	14%
Total	99	100%	58	100%

As shown in Table 4 even among the public sector facilities the demand is for Teaching Hospitals, bypassing the referral system. The majority of the illness episodes of both social groups have utilized the North Colombo Teaching Hospital. The main reason for this is that it is the closest fully equipped hospital. The Central Dispensary located within the community was used during only 1% of the illness episodes in the poor income group, though it does not charge fees and easily accessible. In comparison during illness episodes of the middle income group 14% chose the CD for their initial treatment. This maybe related to the lack of rapport between the providers and the poorer patients.

2.4 Pattern of utilization according to type of illness: It appears that people prefer Western medicines for acute complaints or when a child is seriously ill. People use traditional home remedies and consult Ayurvedic practitioner for common ailments, which are known to be self-limiting. For chronic complaints, some use Western medicines, while others prefer the Ayurvedic system or use both. Snakebites or fractures are often reasons to see "local" (Indigenous) specialists. For mental illnesses people consult "aduras" or Buddhist monks (for chanting, offerings and counseling) and as a last resort they turn to Western facilities. Ayurvedic medicines does not play a role of any importance in the treatment of mental illnesses. The survey results are presented in Table 5.

Table5. Therapy options of the inhabitants of urban and rural communities in the case of fever and cough[11]

Treatment	Urban community	Rural community	
		1st step	2nd step
Self-treatment	25.6	95.0	0
Western	52.6	4.0	56.4
Ayurveda	21.8	0	1.0
Adura	0	1	36.6
None	0	0	5.9
Total	100	100	100

Self-treatment of fever and cough is common in both communities. If self-treatment is not successful, patients seek professional help: In the rural community 57% go to Western facilities while in a village 36.6% go to an "adura" for advice. The initial visits to facilities offering treatment linked to super-natural influences, is low. It is 1% and 2% in low-income and middle-income groups respectively. In all instances such visits were for mumps, measles and chickenpox. The low income group used the following modes of healing, though not always as the initial treatment: 8% of the illness episodes for exorcism, 6% to astrologers and 23% to shrines (or village "devale") to perform vows. Though this community strongly believes in the super-natural to identify, analyze and cure illnesses, major scale rituals were not seen because of the cost (even a small ceremony costs over Rs. 300). The middle class

utilized treatment linked to super-natural influences only when there were seriously ill, often with other forms of therapy and not necessarily as an initial treatment.

These findings are broadly in agreement with the results of an earlier study of treatment seeking behavior in an low–income community in Kandy[12]. This study reported treatment- seeking behavior for acute and chronic conditions, up to the fourth remedy for each condition, summarised in Table 6 and 7.

Table 6. Type and sequence of therapies used in acute illnesses (as percentage of seeking care)[12]

Type of therapy	Repeatad visits for illnesses			
	1st (n=844)	2nd (n=253)	3rd (n=89)	4th (n=35)
Home remedy (Western)	42.3	22.1	18.0	8.6
Home remady (traditional)	16.2	26.9	12.4	14.3
Western OPD	13.4	20.9	34.8	28.6
Western GP	5.3	10.7	7.9	28.6
Informal supply of Western drugs	4.7	4.0	4.5	0.0
No treatment	5.1	0.0	1.1	0.0
Ritual	1.1	4.0	1.1	5.7
Traditional practitioner	0.8	0.8	4.5	0.0
Ayurveda OPD	1.1	4.0	1.1	5.7
Mixed practitioner	2.3	1.2	0.0	0.0
Pharmacy	0.1	1.2	3.4	0.0
Other	6.5	6.3	6.7	14.3
Total (percentage)	100	100	100	100

Western home remedies were the most frequently used first treatment for acculte illnesses, followed by traditional home remedies and Western outpatient departments (OPDs), Table 6. Western forms of treatment were also the most frequent for the second, third and fourth treatments. Traditional home remedies were widely used for mild illness. Ayurvedic, traditional or ritual therapies were of limited significance.

Table 7. Type and sequence of therapies used in chronic illnesses (as percentage of seeking care)[12]

Type of Therapy	1st	2nd	3rd	4th
No treatment	13.0	0.0	0.0	0.0
Home remedy (traditional)	0.0	8.7	0.0	0.0
Home remedy (Western)	13.0	4.3	0.0	0.0
Traditional practitioner	8.7	0.0	0.0	0.0
Pure western practitioner	0.0	4.3	0.0	0.0
Western OPD	21.7	0.0	8.7	0.0
Western Hospital	4.3	8.7	0.0	0.0
Pharmacy /OTC	8.7	0.0	0.0	0.0
Informal drug supply	30.4	4.3	4.3	4.3
Not treatment required	0.0	69.0	87.0	95.7
Total (percentage)	100	100	100	100
Number	(23)	(23)	(23)	(23)

Similarly, chronic conditions were mainly treated using Western drugs (Table 7). Many were dependent on the informal supply of Western drugs or regular visits to a Western OPD or Western home remedies. The study did not find that Ayurveda was more widely used in the case of chronic conditions among the urban poor. There was also evidence that patients with chronic illnesses used their social network to find a way of obtaining their drug supplies through unofficial and official channels[1].

On the whole the above studies indicate a preference towards Western medicine. In the case of the urban poor, there is no particular shift from use of Western to traditional methods in acute conditions or chronic conditions or during the sequence of remedies (in either acute or chronic conditions). Instead there is some tendency to move from public to private sector remedies and from home remedies to institutional care as an illness progresses. This is particularly so in the case of acute conditions among the urban poor[12]. Accordingly, the medical pluralism in Sri Lanka functions not as alternative but as a complementary or additional source of treatment.

3. BEHAVIOR IN RELATION TO UTILIZATION OF DIFFERENT SYSTEMS

The attitude shown by a person towards an illness can be considered in terms of his/ her complexity of personal behavior. There are three stages of treatment seeking behavior:

- identifying symptoms of illness
- analyzing them and
- taking some action about them.

These 3 stages are closely related to each other and the treatment taken is often decided by analysis of illness.

The presence of a greater demand for Western medicine is clear from the above data. It is not possible to relate this pattern of behavior to skills and empirical validity of the Western medical system. Sick people and their families are generally highly pragmatic in selecting type of treatment. Their choices are based on various factors, including economic considerations, availability and accessibility of the different systems and practitioners. From the perspective of the users, there are both advantages and disadvantages in every treatment system.

The middle class appears to emphasize the advantages of Ayurvedic system and disadvantages of Western system. They believe that the Western medical system provides temporary cures, have adverse side effects and are "heaty" to the body. ("Heaty" foods are believed to stimulate phlegm and create an imbalance in the bodily humors). Likewise the Ayurvedic system provides a permanent cure, has no adverse side effects, and its medications are good for the body.

Of the low-income group, 79% believed that there was no disadvantage in the Western medical system. Similarly, a majority do not think that the Ayurvedic system is advantageous. Accordingly, there is no discrepancy between the perception and the behavior of the low-income group towards the two treatment systems. However, the data from the behaviour of the middle class is more of a paradox, because they emphasize disadvantages of Western system and advantages of Ayurvedic medical system. The answer lies in the analysis of the root causes that prompt these groups to preferentially seek Western systems rather than the Ayurvedic treatment system.

Accordingly, the labor class has shown preference to the Western, due to such factors as lack of a strict dietetic regimen, familiarity, cheapness and availability of "ready-made" medicine. All the respondents in this community who stated that a dietetic regimen was difficult, expressed their view by stating *"we have to eat what ever we get…."* The challenge faced by them is to satisfy their hunger and it is not practicable for them to adhere to dietary prescription. With this background, their attitude towards the Ayurvedic medical system is that it is unsuitable for them. This view is

confirmed by analysing the behavior of patients with piles. Ayurvedic treatment was resorted to only because temporary relief was obtained despite a long period of Western treatment. Even though the necessary medicines are available free of charge from the state Ayurvedic hospitals, the supplementary medicines required had to be provided for by the patient and being a peri-urban community, they had no home gardens to obtain the necessary medicinal herbs. This meant extra expenditures and preparation of certain decoctions by the patients. Further expenses were necessary to buy or prepare food in the dietary prescription. Therefore it is not wrong to infer that the labor class is not utilizing the Ayurvedic system mainly because of its economic impacts.

The labor class is used to utilizing Western medical systems for a considerable period of time. The empirical validity of the Western medical system and the fact that it does not in any way influence to change one's behavior, encourages them to utilize this system. Such a community, which is unable to satisfy their minimum basic needs, cannot afford any additional expense on treatment and often choose a treatment system that will cure them at minimum cost.

In choosing a treatment system from among the available medical systems, the middle class in comparison to the labor class is economically at a greater advantage. The utilization of Ayurvedic system is proportionately at a high level among the middle class, especially where chronic illnesses are concerned. There are a number of reasons why the majority of the middle class utilized the Western medical system. The chief among them is the availability of prepared ready to use medications (e.g. tablets), the ability to continue existing life style and rapid relief. The latter becomes an advantage in the context of a modern competitive world, where time is a very valuable asset. In the middle class, where the nuclear family concept has become very popular, every family member leads a busy and active life. Their desire is to use a treatment system that could be conveniently utilized, and brings quick relief. The Ayurvedic system is often labour intensive and time consuming whereas they prefer a treatment system that could be easily utilized while attending to their routine work. Accordingly the Ayurvedic medical system, which is closely bound with the 3000 years old indigenous thinking, culture and economy, is turning to be an unsuitable treatment system in the modern, competitive and busy society.

There are signs that the Ayurveda is adapting itself to face these challenges, The most important among them is the use of prepared ready-to-use medications for treatment. But the question is how far this medical system could adapt itself to the changing needs of the patient. In such an atmosphere, the major challenge for the middle class patient is whether to spend a long period of treatment and achieve a permanent cure through the Ayurvedic system or to utilize the Western system and receive temporary relief. In observing middle class behavior it is clear that they show preference for the latter. With chronic disorders, they see no permanent cure from the Western system and resort to Ayurveda. However, when they are unable to continue the Ayurvedic system for long, they again change to the Western system. Thus, the patient has little opportunity for free choice and circumstances appear to push most to choose Western system. While the economic factor is the most dominant among the labor class the time factor is most dominant among the middle class.

There is a great demand for private sector facilities from the middle class and there is a high demand for public sector facilities from the labor class. The majority of the middle class are not satisfied by the quality of the state sector facilities and therefore there is a strong demand among them for the private sector. Furthermore, there is a tendency developing among this class to seek the best treatment and to use social network to achieve this goal. The reasons for preferring private providers included faster services, greater private attention, better staff attitudes and easier access in terms of hours of services.

It has been the practice among the low-income group to always seek state sector treatment. The social networks play an important role on their decision to seek health care. Social networks decide to a large extent why patients seek treatment from a fee-levying practitioner, rather than from a

central dispensary (which does not charge money). Similarly, patients bypass grass- root level facilities and go to teaching hospitals, not merely to utilise their special facilities, but to conceal their identity and get the necessary treatment.

Silva, Russell & Rakodi (1997) carried out 8 focus group discussion with middle and low income people on treatment seeking behavior and levels of satisfaction with the services of alternative providers[1]. Both the urban middle and low income groups appeare to react to common illnesses in similar ways, namely by resorting to either Western or traditional home remedies, which can be easily and cheaply bought in the market in the form of pills or packets. For the poor, public hospitals were an important source of care, after self-medication. In contrast, middle income people prefer private general practitioners and channeled consultation, and only resort to public hospitals for serious illnesses. Differences in the sequence of remedies sought by poor and middle income groups are represented in table 8.

Table 8. Health seeking behavior of urban poor and middle classes[1]

Sequence	Urban poor	Middle class
1	Self-medication	Self-medication
2	Government hospital	Western private GP
3	Western private GP	Channeled consultation
4	Channeled consultation	Private hospitals
5	Ayurveda	Government hospital
6	Other folk remedies	Ayurveda

Middle income respondents were able to discuss the strengths and weaknesses of public and private providers. These different degrees of satisfaction explain their health seeking behavior and are briefly set out in Table 9[1].

Table 9. Summary comparison of public and private facilities

Public Facilities	Private Facilities
Free and cheaper	Expensive
Has many facilities and equipment	Limited facilities
Faith in staff	Excessive emphasis on diagnostic tests
Place to go in an emergency	Lack of connection with other health care facilities
Long queues and drugshortages	Convenience
Poor staff attitudes	More favourable staff attitudes
	Privacy with patients
Lack of cleanliness	cleaner environment
Staff have limited time & contact with patients	Specialists more willing to give time and discuss problems with the patient

4. BRIEF DESCRIPTION OF EXPLANATORY MODELS OR BELIEF SYSTEMS IN RELATION TO THE ILLNESS

People's treatment seeking behavior has often been explained by reference to their systems of beliefs or "explanatory models" about illness, what they believe to be the cause of illness, what explains the symptoms they suffer, and what they believe to be the most appropriate treatment to ensure a cure[7].

In the understanding of beliefs among Sri Lankans towards illnesses is that the concept of 'dosha' plays an important role. What is meant by the term "dosha" here is illnesses, troubles and unfortunate occurrences. In the analyses of illnesses, a few common "dosha" types could be identified.

- Three doshas (wind, bile and phlegm)
- "pretha dosha" (spirits)
- "yaksha dosha" (demons)
- "deva dosha" (gods)
- "huniyam dosha" (black magic)
- evil eye/ evil words/ evil thoughts
- planetary "dosha"
- "karma dosha".

The illnesses caused by each of these "doshas" is varied. Some illnesses can be the result of the influence of many "doshas".

Table 10 shows the predominant influencing factors in the belief system of the country's Sinhala Buddhists. The sources of influence on health and wellbeing, and what actions they believe have to be taken to eradicate them are tabulated.

Table 10. Sources of influence on health and wellbeing[8]

Source	Form of expression	Source of relief
Loka Dharma	Karma	Good conduct
Nature	Humours	Right life/medicine
Planets	Unfavorable periods	Merit/ benevolent gods
Gods	Protection / punishment	Propitiation of gods
Demons	Gaze/attack/ possession	Propitiation/appeal
Black magic	Sorcery(huniyam/vas)	Counter sorcery
Evil human beings	Evil eye/word /thought	Ritual protection
Prethas (spirits)	Possession	Merit transfer/exorcism
Toxic and poisons	Poisoning /snake bites	Removal/treatment/ritual
Accidents	Fractures, dislocations	Empirical treatment

A study of the treatment-seeking behavior of a peri-urban community shows the three "dosha" theory (the humoral theory consisting of wind, phlegm and bile) has a tremendous influence as regards recognition of illnesses and their causes. As shown in Table 10 they see the imbalance of the three "doshas" as the source of diseases such as fever, influenza, cough, wheeze, difficulties in breathing, asthma, catarrh, head-ache, rheumatism, eye-diseases and pain in the joints. Among the illness episodes, a majority gave excess of phlegm as the cause of fever and influenza. According to their beliefs an excess of phlegm causes various types of diseases (such as catarrh, wheeze, difficulties in breathing asthma) and the symptoms can spread from tonsils to asthma.

Foods are often categorized into "cool" and "heaty". They also categorize food as "bad for phlegm, bad for rheumatism and bad for bile". A majority considered "heaty" foods as a cause of sneezing while "cool" foods cause a dry cough or a productive cough. Although the lay people have no ability to analyze rationally the balance or imbalance of the three "doshas" they appear to believe that most diseases are caused by the imbalance of three "doshas" and have their own methods as to maintain them in balance with each other.

Western medicine and Ayurveda are the two most institutionalized systems of medicine in Sri Lanka and various studies have revealed the ways in which Sri Lankans often combine elements from different medical traditions[12]. In analyzing the patients' behavior, it is important to identify their perceptions concerning each system of treatment. Commonly assumed differences between

the two dominant medical systems in Sri Lanka are set out in Table 11. These observations suggest that people's health seeking behavior is probably driven by beliefs and also on how they perceive the services.

Table 11. Commonly assumed service differences between the dominant medical systems in Sri Lanka

Function	Western	Ayurvedic
Treat different disease types	• acute, life – threatening	• chronic
Experts in different specialties	• heart-disease, TB	• rheumatism, fractures, arthritis
Different treatment for the same problem	• strong / powerful • quick • unpleasant • side-effects	• weaker / balanced • slow-acting • palatable • no side-effects
Different socio-cultural position	• culturally alien or dissonant explanatory model	• culturally appropriate or coherent • share same belief system or explanatory model
Different personal styles	• asks only clinical questions • gives less time	• ask about patient's social and psychological state • gives more time
Different approach to diagnosis and treatment	• only examines the body and organs • separates body from mind, spirit or social context • focuses on medicine	• consider the patient's wider social context and states • bases healing on local knowledge of person • treats the whole person mind, body and spirit • gives advice and medicine

Eclectic treatment-seeking behavior indicates a medical domain in Sri Lanka which is pluralistic and unsystematised. A greater weight of evidence suggests that people's behavior is not governed deterministically by their beliefs in a given 'medical system'. Instead choice of therapy seems to be influenced by more immediate or pragmatic factors, such as financial cost, distance and time costs, familiarity with the practitioner or the family links with the provider through kin and social network[1,3,5,11].

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Editors note:

The authors book on Illness Behaviour: A Sociological Analyses published in Sinhala ("Rogi Charyawa," 2000, Wijesuriya Grantha Kendraya) gives in further detail her research findings from two peril-urban communities, This text is a ground breaking publication in Social Medicine in Sri Lanka as it collates many of the findings in Sinhala. The numerous publications on the subject in English are rarely accessible to the general public.