Beyond 'Buddhism' and 'Medicine': State Policies and Medical Pluralism in Contemporary Rakhine (Myanmar)

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Abstract: This paper explores how Buddhist communities in contemporary Rakhine State, Myanmar, engage with health and illness through a diverse range of beliefs and practices. Previous scholarship has often overlooked this 'therapeutic field', primarily because health-related beliefs and practices have been artificially separated into distinct categories—either as religious phenomena or medical matters. This division, rooted in etic (outsider) perspectives, has hindered a comprehensive understanding of local therapeutic systems.

In contrast, I argue that the emic (insider) categories used by Rakhine people—particularly their distinctions between 'Buddhism' and 'medicine'—hold both ethnographic and analytic value. These categories reveal the cultural, social, and political processes that shape the positioning and perceived legitimacy of different practices within the therapeutic field, as well as the hierarchical and complementary relationships between them.

I further demonstrate that the state has played a key role in shaping this therapeutic landscape by regulating and formalising Buddhism and medicine. These processes not only elevated these two categories above others but also redefined their content and function, restricting their therapeutic scope and altering their relationship with other healing traditions. Ultimately, I argue that the ongoing coexistence of formal categories (Buddhism and medicine) alongside the persistent hybridity of health-related practices contributes to therapeutic efficacy in ways that reproduce existing political power dynamics.

Keywords: Buddhism, medicine, pluralism, state policies, categories

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Ethnographic research[1] conducted since 2005 among Buddhist communities in Rakhine State, Western Myanmar, has revealed an extraordinary diversity of beliefs, explanations, and practices related to health and illness. Together, these elements form what I term the 'therapeutic field'. Borrowed from Pierre Bourdieu,[2] 'field' highlights the positions and relations of complementarity and competitivity between different actors based on their habitus, social, cultural, and economic capital, as well as on the field's rules. Drawing on Dozon and Sindzingre,[3] I use the term 'therapeutic' rather than 'medical' as it has a broader and more neutral meaning, not associated predominantly to Western medicine and the cure of physical disorders. This field incorporates a wide array of traditions including: indigenous medicine (B. *taing-yin hsay pyinnya*, 'local medical knowledge'), alchemy, mantra recitations and esoteric diagrams (often known as *weikza*, 'knowledge', practices),[4] Western biomedicine (*ingaleik hsay pyinnya*, 'medical knowledge from the British'), divination and astrology (*baydin pyinnya*), spirit cult practices (*nat pwe*),

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[1] Part of the material presented here has been published in a previous work, Coderey, 'Questioning the boundaries between medicine and religion in contemporary Myanmar'.

[2] Bourdieu, 'Champ du pouvoir, champ intellectuel et habitus de classe'.

[3] Dozon and Sindzingre, 'Pluralisme thérapeutique et médicine traditionnelle en Afrique contemporaine'.

[4] The term *weikza* refers to the practices, the knowledge acquired through those practices and the individuals who, through those practices and knowledge, acquired extraordinary powers including the one of extending one's life and being released from the cycle of rebirths. *Weikza* are now in a limbo waiting for the Future Buddha; by paying homage to him they will automatically enter nirvāṇa.

Buddhism (*Buda bada*).

These traditions frequently intermingle, often blending into single etiological explanations or therapeutic practices, making it difficult to draw clear boundaries between them. Further complicating this fluidity, many healers themselves combine techniques from different traditions, blurring the lines between their roles.

Despite this fluid reality, people often describe their practices and beliefs in ways that align them with particular categories—especially Buddhism and medicine. These two categories, in particular, are widely associated with legitimacy and respectability. This tendency to emphasise Buddhism and medicine over other traditions is also reflected in local etiologies and healing methods, where elements linked to these two domains are often perceived as more authoritative and effective.

I argue that how people understand and address health issues is closely linked to how the state has historically regulated the therapeutic field. Specifically, I explore how the institutionalisation and valorization of Buddhism and medicine the state has conducted as part of its nation building project—using them as instruments of control and domination—has entailed a purification, or redefinition of the boundaries of these categories and introduced a hierarchy between them and other traditions like astrology, alchemy, and divination. This process has bestowed on 'Buddhism' and 'medicine' a certain visibility, legitimacy, and authority to dictate what is deemed valuable or acceptable and hence forced the other traditions to adjust. On the other hand, it has limited their capacity to deal with people's health and wellbeing in a satisfying way. Buddhism has been narrowed to focus on supramundane goals, and medicine has been restricted to using herbal or chemically produced remedies for physical ailments. Furthermore, whilst Buddhism has been supported by the state, used as symbolic and economic capital, medicines have been largely neglected, being marginal in the political economy of the state medicines a powerful tool of Western and indigenous medicine have been largely neglected by the state and hindered by insufficient state support in terms of logistics and finances. This has made the appeal to other resources even more necessary. Their importance has increased, as they fill the gaps left by the more purified systems, contributing

a complementary role despite the hierarchical distinctions. Thus, hybridity persists.

By choosing to focus on state policy, I do not claim that this is the only factor shaping the relation between medicine and Buddhism nor the way people navigate the therapeutic field more broadly. Other factors exist, of course, such as Buddhist knowledge-production, mass Buddhist activism at the grass-root level and the lack of synchronism between the state- and society-making. However, I want to highlight how categorisations established by the state do shape the way people relate to the different resources and how they think about health, healing and salvation. Categorisations indeed inform institutions, regulations and policies of centralization versus neglect, thus impacting systems of values, as well as the accessibility and efficaciousness of the various resources.

A Scholarly Divide: Pluralism in Buddhist Studies and Medical Anthropology Studies

While this therapeutic plurality is central to everyday life, it remains underexplored in academic literature. This neglect applies not only to Myanmar but also to other Theravāda Buddhist countries with similarly diverse healing landscapes.[5] The core issue is that scholars have typically treated these practices as belonging to separate domains—either religious or medical—leading to a fragmented understanding shaped by disciplinary boundaries (religious studies, religious anthropology, medical anthropology, history of religion, and history of medicine).[6] Scholars have thus tended to focus only on traditions relevant to their particular disciplinary lens. Within their field, however, they have reflected upon the question of plurality of

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[5] Golomb, 'The Interplay of Traditional Therapies in South Thailand'; Monnais, 'Medical Traditions in Southeast Asia'; Pottier, *Yû dî mî hèng*; Guillou, *Cambodge, soigner dans les fracas de l'histoire*.

[6] The same division between medicine and religion was shown in the literature on South Asia by Zupanov and Guenzi, eds., *Divins remèdes*.

knowledge and practices and examined how these connect to one another.

Religious Studies

The largest body of academic work on Myanmar focuses on Buddhism. Moving away from the early Orientalist approaches, which primarily studied Buddhism through texts and viewed it as a purely supramundane religion, later anthropological research developed from the sixties onward explored Buddhism as it is practised in daily village life.

Early anthropologists confronted the challenge of understanding how Buddhism related to other local traditions—particularly spirit cults. Most scholars working on Burma,[7] as well as those studying other Theravāda societies,[8] came to understand Buddhism and spirit cults as components of a single religious system, with Buddhism providing the overarching conceptual framework and value system into which spirit practices were integrated.

While Obeyesekere and Kirsch highlighted the distinct functions of Buddhism (focused on supramundane concerns) and spirit cults (concerned with mundane affairs), Nash and Tambiah observed that Buddhism itself was employed to pursue both types of goals. This broader perspective, which incorporates spirit cults and other traditions into a cohesive framework, is particularly relevant to this work. Nash even argued that the categories of *nat* (spirit) worship, divination, and medicine were analytical distinctions imposed by

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[7] Mendelson, 'A Messianic Buddhist Association in Upper Burma'; Nash, 'Burmese Buddhism in Everyday Life'; Brohm, 'Buddhism and Animism in a Burmese Village'; Pfanner, 'The Buddhist Monk in Rural Burmese Society'.

[8] Obeyesekere, 'The Great Tradition and the Little in the Perspective of Sinhalese Buddhism'; Kirsch, 'Complexity in the Thai Religious System'; Tambiah, *Buddhism and Spirit Cults in Northeast Thailand*; *idem*, *The Buddhist Saints of the Forest and the Cult of Amulets*; *idem*, *Culture, Thought, and Social Action*; Terwiel, *Monks and Magic*.

anthropologists, whereas for local people they formed an integrated whole, of which Buddhism was an essential part.[9] This holistic approach—in which medicine, astrology, and alchemy all aimed at altering the body's 'magical balance'—represented an important step toward a more comprehensive understanding of local beliefs and practices.

However, the work that has arguably dominated Burmese religious studies for the longest period is that of Spiro. In strong opposition to others, Spiro framed Buddhism and what he called supernaturalism (including spirit cults, exorcism, and magic) as two distinct religious systems, dedicating separate volumes to each.[10] One of Spiro's primary concerns was to assess the degree to which the practices he observed deviated from the textual 'Great Tradition' of Buddhism. Based on this distinction, he introduced his influential typology of nibbanic, kammatic, and apotropaic Buddhism.

Spiro argued that while canonical Buddhism is fundamentally a religion of salvation, its adaptation into a religion of the masses led to the incorporation of mundane concerns and supramundane practices. In his view, these practices were often at odds with orthodox Buddhist doctrine, which was modified in response. This focus on cognitive dissonance and religious adaptation closely resembles Gombrich's work in Sri Lanka.[11]

A later generation of scholars, including Houtman, Swearer, and Brac de la Perrière,[12] further argued that the distinction between Buddhism and non-Buddhism is not only a scholarly construct but also a politically motivated process driven by the central government to advance nationalist agendas.

More recent research, on both Myanmar and other Theravāda contexts,[13] challenges the very concept of a 'pure, original, supramun-

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[9] Nash, *The Golden Road to Modernity*, 65.

[10] Spiro, *Burmese Supernaturalism*; *idem*, *Buddhism and Society*.

[11] Gombrich, *Precept and Practice*.

[12] Houtman, *Mental Culture in Burmese Crisis Politics*, Swearer, 'The Way to Meditation'; and Brac de la Perrière, 'An Overview of the Field in Burmese Studies'.

[13] Swearer 'The Way to Meditation'; Schopen, *Bones, Stones and Buddhist*

dane Buddhism' and the scholarly and political categories of Buddhism versus non-Buddhism, and mundane versus supramundane. These scholars contend that apotropaic practices—such as astrology and amulet use—have been integral to Buddhism since its inception and were even sanctioned in the canonical texts. It has also been brought to my attention by one of the anonymous reviewers of this work that preaching manuals and scholarly exegesis did not interpret 'religious' practices—such as the use of Buddhist protective texts, merit-making, or the veneration of benevolent deities—as merely 'mundane' or 'therapeutic' activities (as herbal medicine or magic might be). Instead, they regarded these practices as integral to proper Buddhist conduct, which brought both mundane and supramundane benefits, including improved health.

Medical Anthropology Studies

In Myanmar studies, no research has yet applied the concept of medical pluralism as developed by Leslie, who was particularly interested in how people actively navigate between different healing options and the cognitive or conceptual coherence they perceive between them.[14] Nash and Spiro come closest, offering detailed descriptions of health-related concepts and practices—though their focus was largely on supernatural healing, with minimal attention (or none, in Spiro's case) to indigenous and Western medicine.[15] More recently, beyond my own research, the only anthropological work on contemporary Myanmar's medical landscape is Skidmore.[16] Although her work is titled *Contemporary Medical Pluralism in Burma*, it focuses primarily on biomedical healthcare facilities, highlighting their uneven geographic distribution and severe inadequacies resulting from military

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Monks; Collins, *Nirvana and other Buddhist Felicities*; Patton, 'By the Power of All the *Weikzas*'.

[14] Leslie, 'Medical Pluralism in World Perspective'.

[15] Nash, *The Golden Road to Modernity*; Spiro, *Burmese Supernaturalism*.

[16] Skidmore, 'Contemporary Medical Pluralism in Burma'.

neglect—particularly in ethnic minority areas. While Skidmore briefly mentions indigenous medicine and alchemy, she does not provide detailed descriptions. Instead, she frames reliance on these alternatives largely as a response to the poor quality of biomedical care.

More comprehensive studies of medical pluralism exist for other Theravāda countries. For example, Guillou on Cambodia, Golomb and Salguero on Thailand, and Pottier on Laos, have all examined interactions between biomedical doctors, herbalists, and spirit practitioners.[17] Of these, Golomb is the only one to explicitly argue that they form a coherent system, explaining this coherence through a shared reliance on magical practices that manipulate supernatural forces—an argument reminiscent of Nash's view that Buddhism, medicine, alchemy, and astrology form an integrated whole.

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While important reflections on pluralism have been developed in both Buddhist and medical studies, no single approach has yet captured the full complexity of local realities. Most works focus exclusively on either religion or medicine, and typically consider pluralism in terms of a single dimension—whether conceptual, functional, or political. This fragmented approach is problematic because it artificially separates practices that, in reality, are deeply interconnected. It also imposes Western conceptual categories—such as 'religion' and 'medicine'—onto contexts where such distinctions may not map neatly onto local understandings.

In response to these issues, this paper adopts a comprehensive approach, examining the full spectrum of beliefs and practices that Rakhine Buddhists engage with to make sense of and respond to health and illness. I focus especially on the interplay between hybridity and categorisation, and on the socio-political processes that shaped the elevation of what has come to be called 'Buddhism' and

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[17] Guillou, *Cambodge, soigner dans les fracas de l'histoire*; Golomb, *An Anthropology of Curing in Multiethnic Thailand*; Salguero, *Traditional Thai Medicine*; and Pottier, *Yû dî mî hèng*.

'medicine' over other healing traditions. Finally, I consider how this hierarchical therapeutic landscape influences people's health-seeking behaviour and the perceived efficacy of treatments.

Setting the Context

My analysis is grounded on ethnographic research conducted among Buddhist communities located in the coastal and rural areas of Thandwe, in central Rakhine State, and notably in the villages of Lintha, Watankwai Myabin, and Giaiktaw.

Historical records describe Rakhine as an independent, highly Indianised kingdom until its conquest by the Burman King Bodawhpaya in 1784.[18] Since then, Rakhine has shared Myanmar's broader political history, including British colonisation (1824–1948) and decades of military rule (1962–2011), during which the central government sought to control and subordinate ethnic minority regions. After a brief period of partial democratisation (2011–2021), Myanmar returned to military rule in 2021.

Thandwe city was home to a mixed ethnic population, including substantial Muslim communities. However, in the rural areas and coastal villages, the majority of the population was Buddhist. Every village hosted one or two monasteries and an equal number of pagodas on average, which greatly shaped the rhythm of the community's religious life. Most villagers worked as farmers or fishermen, though some were employed in trade, the food industry, and the hospitality sector.

In terms of healthcare, the Thandwe area was served by a public hospital providing Western medicine, located in Thandwe city itself. This hospital oversaw a network of rural health centres spread across the surrounding villages. The private healthcare sector consisted of services established by professionals who also worked in the public system, most of whom were based in Thandwe city. In contrast, the villages of Lintha and Watankwai had no private healthcare services,

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[18] Phayre, *History of Burma*; Charney, 'Where Jambudipa and Islamdom Converged'; Leider, *Le royaume d'Arakan, Birmanie*.

while Myabin had one, and Giaiktaw had two. Myabin was also home to a clinic run by the French NGO, Association Médicale France-Asie (AMFA).

For indigenous medicine—in its modernised and institutionalised form—there was only one public clinic and three private clinics, all located in Thandwe city.

All these healthcare services were under-resourced, with shortages of staff, equipment, and medicine, and they could only offer very basic care. However, both the towns and villages were well supplied with other types of practitioners, including Buddhist monks, diviners, astrologers, and spirit mediums, who were available to assist those experiencing misfortune, including ill health. Additionally, specialists in traditional indigenous medicine were present, although they were increasingly struggling to compete with government-approved practitioners.

The State Regulation of the Therapeutic Field

Valorisation and Purification of Buddhism

The history of Buddhism in Myanmar likely spans over two millennia. Historians note that, like much of Myanmar, Rakhine received Buddhist influences—Theravāda, Mahāyāna, and Tantric—from India at various points in history.[19] The *Mahāvaṃsa*, a fifth–sixth century Pāli chronicle from Sri Lanka, records that Emperor Ashoka dispatched two monks, Sona and Uttara, to Suvarnabhumi (possibly Lower Myanmar) around 228 BCE. In 1057, Burman King Anawrahta of Pagan, having converted to Theravāda Buddhism under the influence of the Mon monk Shin Arahan, conquered the Mon kingdom of Thaton to obtain the Pāli Canon (*Tipiṭāka*), which he then used to establish Theravāda Buddhism as the dominant religion in Pagan.

As part of this religious consolidation, Anawrahta marginalised or

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[19] Gutman and Zaw Min Yu, *Burma's Lost Kingdoms*; Bernot, *Les paysans arakanais du Pakistan oriental*.

absorbed other religious and ritual traditions. Even the cult of protective spirits (*nat*), which he initially sought to eradicate, was ultimately incorporated under Buddhist authority. During the British colonial period, colonial authorities generally refrained from direct intervention in religious matters. However, after independence, successive governments—including the military junta—actively patronised Buddhism, sponsoring pagoda construction and other religious projects to enhance their legitimacy by aligning themselves with the legacy of Buddhist kingship.[20]

The state's control over religious practices in Myanmar has been particularly evident through the processes of nationalisation and 'purification' (*tan shin yay*, meaning 'cleaning' or 'purification') of Buddhism, first under U Nu (1948–1958, 1960–1962) and later under Ne Win (1974–1981) and Than Shwe (1992–2011).

Positioning himself as a righteous monarch, U Nu established a Buddhist Śāsana Council in 1950, tasked with propagating Buddhism and supervising the monastic community. Inspired by the example of King Aśoka and later Southeast Asian Buddhist monarchs, U Nu convened a saṅgha council to purify the dhamma and produce a revised edition of the Pāli canon. In August 1961, he further introduced an amendment in the Burmese Parliament to formally establish Buddhism as the state religion.[21]

Ne Win, who ruled from 1962 to 1988, intensified these efforts. Between 1974 and 1981, his regime convened the Congregation of the Saṅgha of All Orders for Purification, Perpetuation and Propagation of the Śāsana.[22] Ne Win launched a far-reaching purification campaign, which aimed to strip Buddhism of what the state deemed mundane practices—including astrology, alchemy, esoteric diagrams, spirit cults, and herbal medicine—in an effort to restore Buddhism's supposed original purity and refocus it on supramundane goals such as progression towards nirvāṇa.[23]

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[20] Brac de la Perrière, 'An Overview of the Field in Burmese Studies'.

[21] Swearer, 'The Way to Meditation', 111.

[22] Hayami, 'Pagodas and Prophets', 1091.

[23] Tosa, 'The Chicken and the Scorpion'.

This purification process can be understood through Latour's concept of purification as a process of separating hybrids and forcing them into rigid, dichotomous categories.[24] Ne Win also tightened state control over monks and monastic organisations to ensure they did not engage in 'non-Buddhist' practices. Notably, the state specifically targeted esoteric practices, especially *weikza* traditions using alchemy, esoteric diagrams and mantra, which it viewed as politically subversive. *Weikza* practices were particularly threatening because they were passed down in semi-secret networks often associated with millenarian and messianic movements.[25] Ne Win's government censored books on *weikza*, prohibited these groups from prophesying the arrival of a future king, and in 1979, outlawed the Shwei Yin Kyaw Gaing sect, arresting its leader, who had gained a significant following among both politicians and merchants.[26]

In recent decades, the meaning of Buddhist purification has further expanded. It has come to serve as a tool for projecting an image of Myanmar as a modern Buddhist nation, free from outdated superstitions.[27] This has been especially relevant following the country's economic liberalisation in 1996 and even more so after 2011, when the government sought to attract international tourism. This transformation highlights how spiritual capital can be translated into economic capital.[28]

The state's control and surveillance over the monastic order was renewed after the 2007–2008 Saffron Revolution when monks protested against the military regime, reminding the authorities that Buddhism and the monastic order are part of the order of the world

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[24] Latour, *We Have Never Been Modern*.

[25] Ferguson and Mendelson, 'Masters of the Buddhist Occult'. The existence of these *weikza* organizations was brought to light in the literature only in the mid-twentieth century. No premodern primary sources mention them. Yet, the existence of practices such as alchemy, esoteric diagrams, and mantra nowadays referred to as *weikza*, was already well attested.

[26] Hayami, 'Pagodas and Prophets', 1096.

[27] Sadan, 'Respected Grandfather, Bless this Nissan'.

[28] Hui, Hsiao, and Peycam, 'Introduction', 4.

and this relation can, at some point, take a more politicized form.

It should also be highlighted that this purification process is not specific to Myanmar. It is actually a common phenomenon among Theravāda countries, and detailed descriptions exist for Thailand and Cambodia as well, with scholars referring to it as a 'modernization process'.[29] That being said, countries differ in the extent to which reforms and purifications are implemented, but rarely has the centralization and standardization process been as strong as in Myanmar. The reason, I assume, is that the essentialization of Buddhism—the incessant delineation of pure Buddhism against a diversity of practices and conceptions—and its spread across the country is one of the main strategies used by the Burman central government to ensure its domination over the ethnic minorities and their territories.[30]

Institutionalisation and Purification of Medicine

Western medical practices, nowadays referred to as *ingaleik hsay* (English medicine), were first introduced to Myanmar in the seventeenth century through Christian missionaries, but the formal institutionalisation of Western medicine occurred in the latter half of the nineteenth century.[31] At the time, Myanmar was part of British India, and the colonial government developed medical infrastructure to provide health services and improve public health.[32]

The introduction of Western medicine also marked the first time medicine was conceived as a distinct, secular system of knowledge and practice, separated from religion and other healing traditions, and belonging strictly to the 'mundane' (*lokiya*). Before this, no formal concept of a medical system existed. Instead, healing practices were a kaleidoscope of techniques and beliefs drawn from diverse

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[29] Lopez, *Buddhism in Practice*; McMahan, *The Making of Buddhist Modernism*.

[30] Brac de la Perrière, 'An Overview of the Field in Burmese Studies', 202–03.

[31] Richell, *Disease and Demography in Colonial Burma*; Naono, *State of Vaccination*.

[32] Edwards, 'Bitter Pills'.

sources. Anything believed to possess *swan* (power) to prevent or cure both natural and supernatural afflictions but also other forms of misfortunes, and potentially also improving one's chances for salvation was considered *hsay* (medicine). This included herbal remedies, *weikza* techniques (such as alchemy and esoteric diagrams), protective amulets, and water consecrated through Buddhist incantations. If these practices were mainly used to deal with mundane (*lokiya*) issues, some were considered to help achieve the 'supramundane' (*lokuttara*) goal of salvation. Hence, if a certain distinction between the two realms existed in people's consciousness, they were not conceived as part of mutually exclusive fields of practices.

After independence in 1948, Myanmar's postcolonial governments expanded the Western medical system, seeing it as a symbol of modernity and a means of securing both domestic legitimacy and international recognition. At the same time, the government officially recognised indigenous medicine, integrating it into the formal healthcare system. This dual approach served not only to counterbalance the colonial legacy but also to support the broader postcolonial nation-building agenda—creating a modern, autonomous nation firmly rooted in its Buddhist traditions.

However, the 'national indigenous medicine' that was officially promoted was not a comprehensive representation of Myanmar's diverse healing traditions. Rather, it was a selectively crafted system, based predominantly on Burman Buddhist practices, and deliberately stripped of elements deemed politically or ideologically problematic—particularly *weikza* practices, astrology, alchemy, and esoteric rituals. These practices were excluded because they conflicted with the state's vision of rational, scientific medicine and because they were associated with anti-colonial movements and millenarian opposition groups.

This exclusion mirrors earlier colonial strategies. As Aung-Thwin recounts, the British had initially considered integrating indigenous medicine into the colonial healthcare system.[33] However, they ultimately abandoned the plan because traditional healers became closely

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[33] Aung-Thwin, 'Healing, Rebellion, and the Law'.

linked to the anti-colonial rebellion led by Saya San, who promised to restore the Burman monarchy, revitalise Buddhism, and expel the British. Saya San's movement also relied heavily on magical protection charms and tattoos, further reinforcing the association between esoteric practices and political resistance.

Interestingly, in the process of formalising indigenous medicine, its connection to Buddhism—particularly in relation to etiological concepts and some healing principles—has been not just preserved but also highlighted. I argue that this connection was maintained primarily to ensure the legitimacy and respectability of indigenous medicine. This 'Buddhisation' of medicine stands in contrast to the state-led campaigns aimed at purifying Buddhism by separating it from mundane practices, including medicine.

To further consolidate Burman control over this form of medicine, the transmission of its knowledge has been centralised in Mandalay, the final Burman royal capital and a stronghold of both Burman and Buddhist traditions.

Although both Western biomedicine and indigenous medicine are now part of Myanmar's official health system, they remain institutionally separated. Biomedicine holds a dominant and privileged position, as reflected in policy priorities, funding allocations, and legislative support. That said, both sectors suffer from severe shortcomings. Despite the symbolic importance the state has historically attached to medicine in the pursuit of its nationalist goals, the health sector has never received the same level of investment as other areas, such as military defence and border control. This chronic underfunding has decimated the healthcare system, leaving it with inadequate services, a shortage of medical professionals, and insufficient medication and equipment, particularly in remote areas.[34] Even with such poor quality services, the cost of care is often prohibitively high, with patients frequently expected to cover almost all their medical expenses out of pocket.[35]

In the following I will describe Buddhist Rakhine villagers' under-

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[34] Skidmore, 'Contemporary Medical Pluralism in Burma'.

[35] Yu Mon Saw et al., 'Taking Stock of Myanmar's Progress toward the Health-Related Millennium Development Goals'.

standing and mastery of health and illness and highlight how it has been shaped by the state's regulation of Buddhism and medicine.

The Pluralistic Therapeutic Field: Aetiologies and Practices

Explaining Health and Illness

When asked about illness and its causes, most of my informants described illness (*yawga*) as a physical or mental disorder caused by an imbalance among the body's elements—air, fire, earth, and water. They explained that these elements are intrinsically unstable, according to the Buddhist principle of impermanence (P. *thinkhaya*), but that they are mainly disrupted by external factors: B. *kan* (karma), the deeds performed during one's life cycle; *seik* (the mind), which can be shocked or stressed; the climate and seasonal changes (*utu*); and the ingestion of unsuitable food (*ahara*). Informants stated that these factors could act independently or in combination, with karma playing a particularly significant role. An elderly man from Lintha, in a conversation from February 2007, explained that 'a person's good karma acts as a shield against other factors, while negative karma, with its corresponding planetary influence, allows these factors to harm the individual'.

This understanding of health and illness aligns with indigenous medicine, which many informants said was closely linked to Buddhist doctrine, particularly regarding the four elements and the hot/cold dichotomy.

When asked to elaborate on illness causes or discuss specific cases, most villagers also acknowledged the possible influence of other factors outside of indigenous medicine and Buddhism, such as *hpon* (a spiritual, psychic, and physical essence) and *gyo* (planetary influences). Despite these external factors, my informants related them to karma. They believed the amount of *hpon* a person possessed was linked to their karma, and similarly, planetary influences were seen as reflections of one's karma.

Some individuals, however, fully embraced a purified version of Buddhism and medicine and denied the relevance of these external

factors, particularly planetary influences. They argued that astrology was not part of Myanmar's indigenous medicine, but rather an import from India, and thus irrelevant to Buddhist teachings. This view contrasts with the historical integration of astrology into Southeast Asian medical traditions,[36] as well as its role in Buddhist monastic education. Literature indicates that the relationship between Buddhism and astrology, as well as between Buddhism and medicine, has longtime been a source of debates among elite monastics, court literati and religious scholars and has fluctuated between unity and incompatibility.[37] I suggest that the dichotomous views expressed by my informants reflect pre-existing fractures within their culture, which have been intensified and solidified by postcolonial state propaganda aimed at distancing non-scientific, non-modern practices from both Buddhism and medicine through institutionalization, regulation, and standardization.

Although villagers were often reluctant to discuss it, many acknowledged a second kind of illness, *payawga*, which they described as an 'external disturbance' caused by aggression (*ahpan*) from malevolent forces, such as witches, sorcerers, and spirits. This explanation is attributed to 'local traditions' (*yoya*), distinct from both indigenous medicine and Buddhism. Yet, these illnesses were thought to still align with the causal factors of Buddhist and indigenous medical cosmology. For example, harm from such forces could only occur if the victim's karma was negative. Villagers' hesitance to talk about *payawga* was often rooted in a fear of the occult and a recognition that they were speaking to an ethnographer, whom they associated with modernist, positivist discourses that dismiss these beliefs as 'superstitions'. This reluctance may also reflect the influence of rational materialism promoted through education, technology, science, media, and state anti-superstition campaigns.

Villagers' understanding of illness rarely incorporated biomedical concepts, despite, or perhaps because of, the fact that biomedicine is

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[36] Skorupski, 'Health and Suffering in Buddhism', 153.

[37] Fiordalis, 'On Buddhism, Divination and the Mundane Arts'; Salguero, 'Healing and/or Salvation?'.

officially presented as the predominant form of medicine, representing science, modernity, and positivist thought. As such, it was also considered the standard by which other notions and practices were measured. Biomedical concepts were primarily understood and accepted by biomedical specialists. For the rest of the population, while many were familiar with some biomedical terms, few understood the principles of this medicine. Most people articulated these biomedical ideas in a way that aligned with more traditional beliefs drawn from indigenous medicine, Buddhism, or astrology. For instance, instead of identifying HIV as an immunodeficiency virus, they might define it as a 'hot disease', because the body becomes thin and the skin dries out. A woman from Lintha shared that her heart disease, which had been diagnosed by a doctor, lasted much longer due to the negative influence of a planet.

The weak integration of biomedical understandings within the local system of disease causality is less about a conceptual incompatibility between the two systems (the existing etiological framework already recognized strictly physiological illnesses unrelated to karma, planets, or the supernatural) and more about the inadequate implementation of public health and health education programs. This is compounded by the social gap and problematic relationship between medical professionals and patients. Due to poor working conditions, medical staff were often unable or unmotivated to fulfill their duties, including health education programs, effectively. Furthermore, many healthcare workers compensated for their low salaries by charging additional fees and focusing on their private practice, which gave the impression that they cared more about money than the well-being of their patients. This created a mistrust that hindered communication and the effective transmission of biomedical knowledge.

Maintaining and Restoring Health

When asked how they prevented illness and other misfortunes, most villagers responded: 'by practicing *dana*, *thila*, *bawana*' (generosity, morality, and meditation), the three practices at the heart of the Buddha's teachings. However, when asked what they did in case of illness, the most common response was: 'I go to buy some medicines

or see an "English" (biomedical) doctor'. Interestingly, these answers reflected a division between prevention and cure: prevention was tied to religious practices, specifically Buddhism, with *dana*, *thila*, and *bawana* seen as protecting one from illness through the improvement of karma and spiritual progress, while the cure was associated with medicine, addressing the biological and physical aspects of disease.

Yet, observing people's everyday practices reveals that these responses only partially reflect reality. The therapeutic repertoire they employed was much richer and less clear-cut. Not only were biomedical and Buddhist practices often combined in preventive and curative processes, but they were also, and especially, supplemented by a variety of other resources. The diversity of resources was common not just among health seekers but also among healers. Except for biomedical doctors and specialists of indigenous medicine operating in the official sector, most healers combined teachings and techniques from various traditions.

Although their responses were not matching their practice, they were revealing in terms of the values shaping people's choices. These answers reflected a hierarchy of traditions, placing Buddhism and medicine above other traditions in terms of legitimacy, respectability, and therapeutic efficacy. In this sense, these were seen as the 'right answers'—those the interlocutor expected to hear. Similarly to the way aetiology was presented to me, which often concealed or downgraded concepts classified as external to Buddhism or medicine, the narratives about practices tended to obscure non-Buddhist and non-medical traditions. The key difference was that people considered indigenous medicine more authoritative, but in practice, they were more likely to turn to Western medicine to address their health needs. I will return to this point later. By examining the practices people actually used to protect and restore their health, I aim to demonstrate that practices seen as belonging to Buddhist and to medicine were not the only resources people relied on, and they were afforded a prominent position by both laypeople and specialists.

I also suggest that my informants' answers represented an idealized scenario that could not be fully realized, and this impossibility stemmed from the limited capacity of Buddhism and medicine to address health issues due to their institutionalization and purification.

This situation has made the use of other practices even more necessary.

Preventive Practices

Religious activity was a crucial part of daily life. First, devotional gestures were performed at the Buddha's domestic altar—offering food, water, flowers, candles, and incense to the Buddha, reciting the formula for taking refuge in the Three Gems, reciting precepts, protective formulas (*payeik*), and prayers, and practicing meditation. Second, villagers made offerings of food to monks and listened to their chants. These practices were understood as central to Buddhist life, serving both as homage to the Buddha and his teachings, and as a way to improve one's present life, including health in the short and longer terms, and to prepare for a better future existence. They were believed to increase one's karma and power (*hpon*), purify the mind, and invoke the help of deities and powerful beings. As major source of comfort and hope, they helped people deal with daily life challenges and hardship. Villagers stated that Buddha himself recommended these practices to prevent dangers from the social, natural, and supernatural realms.

Another important aspect of maintaining well-being was the preservation of good relations with tutelary spirits (*nat*), who governed places where people lived—such as homes, villages, and cities—or places they frequented, like the sea, rice fields, and forests. By regularly honoring these spirits with food and drink, and through possession ceremonies led by professional mediums, people sought to maintain a harmonious relationship with these spirits to avoid their vengeance, which could result from neglect. Although scholars often regard this as a form of religion (*bada*), locals do not. They reserve the label of religion for Buddhism, which they accord greater respect. While this distinction is conceptual, in practice the two systems are often intertwined. However, military anti-superstition and purification campaigns have worked to separate them.[38] As a result of these

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[38] Sadan, 'Respected Grandfather, Bless this Nissan'; Brac de la Perrière, 'An Overview of the Field in Burmese Studies'.

campaigns, of lay-based Buddhism propaganda, as well as the rise of modernistic, positivistic thought, many people have begun to abandon or deny their involvement in these practices.

In addition to the *nat*, a second category of supernatural beings must be addressed: wandering spirits, who haunt street corners, old houses, and large trees; hungry ghosts; witches; and sorcerers. People protect themselves from these beings by reciting protective formulas (notably the *payeik*), hoping to generate 'emergency karma',[39] or to gain protection from deities or from Buddha himself.[40] People also wear amulets and tattoos for protection. The main amulets include the *payeik gyo* and the *lethpwe*, a special protection provided by exorcists (*payawga hsaya*). These amulets consist of a sheet of paper or metal inscribed with esoteric diagrams (*in* and *sama*), combinations of letters or numbers referring to Buddhist and astrological concepts, and are further empowered by the recitation of mantras or Buddhist formulas. The object is believed to neutralize negative planetary and karmic influences, protecting against harmful beings through the power of Buddhist authority embedded within it.

Exorcist practices were often said to 'have nothing to do with indigenous medicine' (*taing-yin hsay pyinnya*), a belief likely influenced by Western concepts of medicine as focusing solely on physical illness, leading to the exclusion of exorcistic techniques from institutionalized indigenous medicine. Similarly, people claimed that 'exorcist practices have nothing to do with Buddhism', because 'Buddhism only deals with the supramundane'. While the involvement of Buddhism in mundane matters has been a source of tension in its history,[41] the separation of Buddhism from other practices has been further reinforced by the government's purification campaigns and anti-*weikza* persecutions.

Nevertheless, people acknowledged Buddhism's importance in

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[39] Nash, *The Golden Road to Modernity*.

[40] Spiro, *Burmese Supernaturalism*.

[41] Swearer, 'The Way to Meditation'; Schopen, *Bones, Stones and Buddhist Monks*; Collins, *Nirvana and other Buddhist Felicities*; Patton, 'By the Power of All the *Weikzas*'; Hayami, 'Pagodas and Prophets'.

exorcisms, since it represents superior cosmic forces opposed to the beings targeted by exorcism.[42] The efficacy of exorcism stems primarily from the power imbued in Buddhist symbols and recitations, which is further enhanced by the exorcist's own power, developed through meditation and adherence to the precepts.

Another significant practice, crucial for maintaining well-being and preventing illness and misfortune, was divination (*baydin pyinnya*). The most common forms of divination in the region included astrology and consultations with the *weikza* (individuals released from the cycle of reincarnation) or the deities of the Hindu-Buddhist pantheon (*daywa*, *nat*), whom diviners could contact with their minds. Diviners would read a person's astrological chart, believed to reflect their karmic state, and offer advice on how to take advantage of positive moments and avoid negative ones. In addition to amulets, *payeik gyo*, and *lethpwe*, the most common technique used by diviners was the *yadaya*, a process that neutralizes negative planetary forces and improves karma to prevent or release one from harm and misfortune. This often involved offering items (such as flowers or candles) to the pagoda, chosen according to astrological calculations and the symbolic associations between days of the week, planets, letters, objects, and cardinal points.

Despite the widespread use of divination and astrology, most villagers were reluctant to admit to relying on these practices, often initially denying their use. Common statements included, 'I only follow the Buddha's way; this does not concern Buddhism', or 'According to the Buddha, the only thing that matters is your actions; you act, and you reap the fruits of your actions. *Yadaya* and planets cannot help'. Diviners and astrologers, fully aware of this cultural mindset, often emphasized the Buddhist aspects of their practices, both in how they performed them and in their explanations. For example, they might highlight their interactions with the *weikza* or deities of the Hindu-Buddhist pantheon while downplaying the role of astrological calculations. They also tended to frame their work as

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[42] Hayashi, *Practical Buddhism among the Thai-Lao*; Spiro, *Burmese Supernaturalism*.

being rooted in *mytta* (compassion) and rarely sought overt monetary compensation.

The only two practices focused specifically on the physical body and its elements, aiming to maintain balance between heat and cold, were diet rules and recommendations on the appropriate times for bathing. According to these rules, attributed to indigenous medicine, individuals should avoid consuming food that is too hot or too cold, and should adjust their diet according to their physical state. They should also avoid showering at the coldest time of day. Interestingly, preventive measures did not typically involve specialists in indigenous medicine, as people did not take medicine unless symptoms were already present.

Similarly, there was minimal use of preventive methods promoted by biomedical public health programs (such as immunization, vitamins, or condoms). Several factors contributed to this lack of uptake in the community. The main issue was a conceptual difference. Most people understood health and illness in traditional terms—as an imbalance in the body's elements due to karma, the mind, the weather, planetary influences, or supernatural forces. Thus, prevention was seen as actions aimed at addressing these factors. The biomedical approach, which focused on preventing specific disorders, was foreign to local people. They preferred a more holistic, inclusive approach. The general lack of understanding of, and reluctance to accept, these biomedical methods were also linked to the deficiencies in Rakhine's health system and the problematic relationship between villagers and health staff. Public health programs were long viewed as instruments of control and false paternalism by the Myanmar government and, previously, the British colonizers.[43]

Curative Practices

When symptoms appeared, they were often interpreted as signs of a natural disease and addressed accordingly. For minor issues and chronic conditions, if a specialist was unavailable or considered un-

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[43] Naono, *State of Vaccination*.

necessary, people often resorted to self-medication. This typically included following a special diet and using homemade remedies, which people viewed as foundational to indigenous medicine. Many also purchased medications in shops. Initially, most people would turn to biomedical products, as they were considered quick-acting compared to herbal remedies. However, indigenous medicine was preferred for certain ailments, particularly chronic disorders, for which it was considered more effective. If symptoms did not improve with self-medication, or if more serious illnesses such as acute diarrhea or severe abdominal pain arose, people typically sought care from a biomedical specialist, whether a doctor or nurse. However, deficiencies in these services, high costs, and strained relationships with specialists often made this difficult.[44]

Indigenous medicine specialists were typically consulted for chronic conditions, menstrual disorders, paralysis, and some forms of cancer, as these were believed to be particularly treatable with traditional remedies. Even though state-trained doctors were seen as more modern, most people—regardless of social status or education—preferred traditional healers, who operated outside the formal government system. These healers were regarded as more knowledgeable, experienced, and respectable, partly because their practice was tied to Buddhist morality, which was seen as essential to the effectiveness of their work. In contrast, 'modernized' doctors were often viewed as part of a system that was unreliable and inadequate. Even though indigenous medicine tends to be less expensive than western medicine the preference for indigenous medicine over western medicine is most of the time a question of attributed aptness or efficaciousness or familiarity rather than cost.

If a patient's symptoms persisted despite treatment or other complications arose, people began to consider the possibility of karmic, planetary, or supernatural influences hindering the effectiveness of medical treatments. At this point, they would turn to practices or healers who could address misfortune. Most would first consult a diviner or astrologer to assess the state of their karma and, if neces-

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[44] Skidmore, 'Contemporary Medical Pluralism in Burma'.

sary, prescribe a *yadaya* or provide protective amulets. However, if a witch or sorcerer was thought to be the cause, an exorcist (*payawga hsaya*) would be consulted. The exorcist would perform rituals using esoteric diagrams, mantras, and appeals to Buddhist spiritual forces.[45]

Although diviners and exorcists were not hard to find—with most villages having at least one of each—people carefully considered several factors when choosing whom to consult. They preferred those who followed the Buddha's way, adhered to Buddhist precepts, and practiced meditation, and who operated out of *mytta* (loving-kindness) and *saydana* (generosity), meaning they did not ask for money. Such traits were seen as signs of authenticity and increased efficacy. Even when a fee is not requested people always leave a compensation, the implicit rule seems to be around 3000 *kyat*, about the equivalent of a visit to the doctor. Diviners and exorcist can, however, become highly expensive when complex rituals are requested.

Health-seeking processes could become complex depending on the nature and severity of the illness, as well as the availability and accessibility of resources. However, choices were usually made with a certain logic that, while pragmatic, was seldom incoherent. As Skidmore notes in her essay on medical pluralism in Myanmar, people saw all actions as potentially contributing to healing by addressing different causal factors.[46] When people recovered, they often believed that all recourses contributed to the outcome. If an illness was incurable or resulted in death, karmic actions were viewed as the cause. Karma, in this sense, represented both the origin and the limits of one's freedom.[47]

Analysis

Fieldwork reveals that different notions and practices occupy various positions in the therapeutic field. These positions were

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[45] Spiro, *Burmese Supernaturalism*.

[46] Skidmore, 'Contemporary Medical Pluralism in Burma', 196.

[47] Gombrich, *Precept and Practice*.

complementary but hierarchical, with practices and beliefs associated with Buddhism and medicine generally enjoying higher legitimacy, respectability, and therapeutic power. Yet, these practices could not address all aspects of health, necessitating recourse to other resources.

In terms of representations of health and illness, factors related to Buddhism and indigenous medicine were viewed as the primary causes. Buddhism, in particular, held a higher status within these epistemic relations, with karma playing a central role. Karma determined the weight of other factors' actions and the severity of the disease.

Other conceptions, categorized as 'non-Buddhist' or 'indigenous medicine', were either reinterpreted to fit with other beliefs, discredited, or hidden. While these ideas did not disappear, they contributed to the overall understanding of health and illness. Despite the high legitimacy given to indigenous medicine in the local aetiological system, Western medicine remained relatively unknown and largely inaccessible to most people. This reflects the limited reach of biomedicine in Myanmar, where inadequate resources and staffing, combined with insufficient biomedical education, resulted in a weak public health system.

The strong reliance on notions drawn from indigenous medicine and Buddhist medical knowledge in rural areas shows the pervasive influence of Buddhism and indigenous medicine. It also points to the importance of local knowledge exchange networks, social support, and therapeutic care, often through monastic communities that functioned as centers of knowledge dissemination.

In the realm of prevention and cure, villagers engaged in a variety of practices and rituals that contributed to maintaining health and preventing illness. While Buddhism and both indigenous and Western medicine played a dominant role, they were not sufficient on their own. The limited role of Buddhism in prevention was particularly striking, as many informants noted that no one could fully follow Buddhist teachings, and karma from past lives could still have negative consequences. Despite these limitations, Buddhist practices remained important because they were seen as improving karma and personal power, and maintaining positive relationships with human and supernatural entities. However, more specific, short-term protections were often sought through practices outside Buddhism, such as

divination and exorcism.

In terms of curing, Western medicine held a dominant, though not exclusive, role due to the availability of biomedical products and their quick efficacy. However, because of the inadequacies in the biomedical system, many people still preferred indigenous medicine for certain ailments, particularly chronic conditions. Additionally, biomedicine failed to address the non-biological factors of illness, which were crucial to the local understanding of health. This gap was filled by traditional practices, particularly divination and exorcism. Though Buddhist practices played a lesser role in curing, they still contributed to the efficacy and respectability of the healing process, besides being a significant source of hope. Ultimately, Buddhist cosmology held a hegemonic force in determining the limits of what could be managed, with karma setting boundaries on healing possibilities.

The dominance of Theravāda Buddhism in both the social and therapeutic spheres can be traced to its comprehensive role as a religion. It provides the cosmology, a system of values that guided people's actions, and determined the boundaries within which individuals could shape their destinies. Its integrative nature also allowed it to accommodate other belief systems. The state's support and U Nu's declaration of Buddhism as the national religion further strengthened its social and epistemic authority.

This expansion of Buddhism occurred alongside the state's process of purification, which aimed to separate it from elements associated with what were perceived as backward superstitions. This purification impacted people's perceptions more than practices which most of the time remained hybrid. The narrative of Buddhism being a supramundane religion distinct from mundane practices started to filter into people's discourses; and Buddhism was regarded as highly respectable, while other practices were sometimes seen as uncomfortable, rejected, or hidden. Ironically, the purification process helped sustain the hybridity of the therapeutic field, making both Buddhist and non-Buddhist practices even more necessary. By positioning Buddhism as a religion for supramundane matters, its capacity to address mundane concerns was limited, creating a need for other resources. However, by being conceptually separated

and elevated to a purely supramundane realm, Buddhism gained increased legitimacy, respectability, and epistemic authority. This superiority of Buddhism extended into the therapeutic field, conferring it with a superior explanatory and therapeutic power. Practices, forces, and symbols linked to Buddhism—such as meditation, adherence to precepts, auspicious formulas, and Buddha images—were seen as enhancing the efficacy of other, para-Buddhist practices and symbols. In this way, practices not officially recognized as Buddhist were reinterpreted to align with Buddhist logic, preserving their legitimacy. Non-Buddhist practices were increasingly combined with Buddhist rituals to enhance their respectability and efficacy.

A similar dynamic occurred within the realm of medicine. The institutionalization and development of both Western and indigenous medicine contributed to their visibility and legitimacy. Indigenous medicine, in particular, presents an interesting case because the state did not merely redefine an existing category (such as medicine), as it did with Buddhism. Instead, the state created a medical system that previously did not exist by combining disparate forms of knowledge and practice while eliminating or modernizing the more esoteric and spiritual elements of local medical knowledge—elements seen as a potential challenge to state authority and not fitting within the Western model of medicine. Although the healthcare system aimed to replace 'old, superstitious' practices, this did not fully occur. The effectiveness of medical care was severely hindered by the state's long-term economic neglect, which resulted in inadequate resources and strict regulations that limited what medicine could do. This ongoing situation maintained the need for alternative resources. Ultimately, indigenous medicine, in its non-institutionalized form, remained the most legitimized and legitimizing form of healthcare, with challenges mainly coming from biomedical technologies and medicines with more advanced diagnostic or therapeutic powers.

Therapeutic efficacy, therefore, was shaped through an epistemic and conceptual hierarchy tied to political governance. The state's goal was to assert control over threatening forces, whether esoteric, millenarian, or tied to ethnic minorities. In this way, the maintenance of hierarchy within therapeutic practices reinforced the political authority on which state power depended. However, the persistence of

practices deemed 'other' or excluded from state approval highlights the limitations of state policies and the resilience and adaptability of the therapeutic field and its practitioners.

Conclusions

This paper has explored the various conceptions and practices used by Buddhist Rakhine villagers to address health and illness. By doing so, it brings together what has often been separated in Southeast Asian studies—medicine and religion. The health-related practices in Rakhine include both what scholars in the twentieth century have categorized as medical (scientifically provable remedies for natural disorders) and what they have defined as religious (complex symbols, rituals, and beliefs that connect human experience to the universe, providing cosmology and rules of behaviour, as well as supernatural influence).

By removing the etic categories of religion and medicine, we can fully appreciate the epistemic force of the emic categories, as crafted and redefined by the local people within their specific social, political, and religious context. The definition and positioning of these categories were significantly influenced by the Myanmar state's policies and their approach to the pluralistic nature of health-related practices. State intervention impacted how these components of the therapeutic field were implemented, made visible, and made accessible, as well as the scope they were allowed to cover. These policies also shaped how people engaged with and valued different aspects of the field, ultimately influencing health-seeking behaviour and outcomes.

This complex process of categorization and redefinition exists alongside the persistent hybridity of health-related notions and practices that cut across all categories. The coexistence of clear categories in people's representations and the blurred boundaries in practice reflects the interplay between biological, cultural, social, and political forces. This also influenced therapeutic efficacy in ways that both reflected and reinforced political power and interests.

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