Asia Research Institute
Working Paper Series No. 251

Coping with Illness and its Uncertainties in Rakhine (Myanmar): An Anthropological Study of a Pluralistic Therapeutic Field

Céline Coderey
Asia Research Institute, National University of Singapore
ariceli@nus.edu.sg

MAY 2016

The **ARI Working Paper Series** is published electronically by the Asia Research Institute of the National University of Singapore.

© Copyright is held by the author or authors of each Working Paper.
ARI Working Papers cannot be republished, reprinted, or reproduced in any format without the permission of the paper's author or authors.

Note: The views expressed in each paper are those of the author or authors of the paper. They do not necessarily represent or reflect the views of the Asia Research Institute, its Editorial Committee or of the National University of Singapore.

Citations of this electronic publication should be made in the following manner: Author, "Title," ARI Working Paper, No. #, Date, www.nus.ari.edu.sg/pub/wps.htm. For instance, Smith, John, "Ethnic Relations in Singapore," ARI Working Paper, No. 1, June 2003, www.ari.nus.edu.sg/pub/wps.htm.

Asia Research Institute Editorial Committee
Michelle Miller – Chair
Eli Elinoff
Fiona Lee
Eric Kerr
Valerie Yeo

Asia Research Institute
National University of Singapore
469A Tower Block #10-01,
Bukit Timah Road,
Singapore 259770
Tel: (65) 6516 3810
Fax: (65) 6779 1428
Website: www.ari.nus.edu.sg
Email: arisec@nus.edu.sg

The Asia Research Institute (ARI) was established as a university-level institute in July 2001 as one of the strategic initiatives of the National University of Singapore (NUS). The mission of the Institute is to provide a world-class focus and resource for research on the Asian region, located at one of its communications hubs. ARI engages the social sciences broadly defined, and especially interdisciplinary frontiers between and beyond disciplines. Through frequent provision of short-term research appointments it seeks to be a place of encounters between the region and the world. Within NUS it works particularly with the Faculty of Arts and Social Sciences, Business, Law and Design, to support conferences, lectures, and graduate study at the highest level.

Coping with Illness and its Uncertainties in Rakhine (Myanmar): An Anthropological Study of a Pluralistic Therapeutic Field

Céline Coderey
Asia Research Institute, National University of Singapore
ariceli@nus.edu.sg

ABSTRACT

Based on fieldwork conducted among the Buddhist population living in Rakhine State (western Myanmar) since 2005, this paper elucidates how people understand health and ill-health and how they deal with them as well as with the uncertainty related to them by relying on conceptions and practices originated from Buddhism, astrology, spirit cult, indigenous medicine and Western medicine. I argue that although some of the components of this therapeutic pluralism occupy an higher position than others – whether because they are formally recognised or because they are attributed an higher value – they are in some ways lacking and it's only the combination with the other components which grant – at least ideally – the maintenance of the individual, social and cosmic harmony on which people's health depends. Navigating between medical and religious anthropology, this paper aims to question the boundaries between the religious and medical, Buddhist and non-Buddhist, worldly and otherworldy, and natural and supernatural.

INTRODUCTION

Asked about the best way to prevent illnesses and other unpleasant events, most Buddhist villagers living in the Thandwe area, in Rakhine State, respond: «practicing *dana, thila, bawana* », (« generosity, morality and meditation »), the three practices forming the core of the Buddha's teaching, whereas to the question "what do you do in case of illness?" they generally answer :« I go to buy some medicines or to the see an "English" (biomedical) doctor ». Interestingly, these answers locate prevention and cure at two different levels – the first one pertaining to religion and more precisely to Buddhism – with *dana, thila, bawana* protecting from ill-health by virtue of the improvement of the karma and the spiritual progression they are deemed to grant – and the second one to medicine which cures by acting on the biological, physical aspect of the disease. Even more interestingly, when observing people's everyday practices, one realises how much those answers are just but a partial reflection of the reality. In facts, not only these different practices are often combined within the preventive and curative processes but also and especially they are completed by other recourses such as offering to planetary forces and to guardian spirits, wearing amulets, reciting Buddhist auspicious formulas, respecting dietary rules, consulting specialists of indigenous medicine, astrologers, mediums and exorcists and so on. Even though within this plurality the « Buddhist » and « medical » ways play an important if not dominant role, this role is seldom exclusive; the appeal to other recourses seem to be the norm rather than an exception. There is, however, a certains diversity among different people regarding the importance they attribute to the different practices and the way they actually choose among them and use them, with an important difference in terms of health outcome.

Through this paper I wish to reflect on what makes this plurality necessary and examine how people navigate it: how and why they choose to resort to such or such practices and how and why they combine them. I do believe with Arthur Kleinman (1980: 24) that « *In every culture, illness, the responses to it, individuals experiencing, and treating it, and the social institutions relating to it are all systematically interconnected. […]* » and that for this reason the "health care system" must be studied in its integrity, as a whole. Embracing a similar perspective, this paper will take the plurality as its main object and try to deconstruct it. Only considering this plurality one can understand the positions the different components occupies in relation to one another and appreciate how they allow people to cope with health issues. Because of the accent I intend to put on the relations between the components and their relative positions, I prefer to speak of "field", in the Bourdieuian's sense (Bourdieu, 1971), rather than of "system". And, following Dozon and Sindzingre (1986 : 43-52) I will use the qualitative of "therapeutic" to refer to this field as well as to the plurality of conceptions and practices because this term can integrate elements of different nature and not only those commonly qualified as "medical".

This reflection is all the more relevant for Myanmar today given the important transformation the country is living in particular since 2011 with the transition from a military dictatürship lasted fifty years to a democratic government and the opening of the economy, a change which is impacting on the field of health in it different dimensions: offer, demand and health practices. It is also particularly important given the extremely negative condition of the population's health which is among the worst in Southeast Asia (Grundy et al., 2014).

THE STUDY OF THERAPEUTIC PLURALISM AND THE DISCILINARY SPLIT

Even though the plurality of practices – be they qualified of religious, medical or other – and their use to maintain and restore people's wellbeing are directly observable in people's daily life, this complexity has never been studied for Myanmar and seldom elsewhere in Asia – where a similar plurality is attested – with the exception (to my knowledge) of the works of Golomb (1985) on Thailand, Guillou (2009) on Cambodia and Das (2015) in India. For Myanmar the absence of study on the plurality of health-related practices is mainly the consequence of the longterm military dictatorship which has hindered the possibility of conducting longterm fieldwork with an holistic approach. This reason, combined with discipline's trends have led most scholars to focus on Buddhism and political history. In Asia more generally the rarity of study adopting an holistic approach is certainly related to a certain disciplinary division within the field. Different conceptions and practices related to health have been examined separately, splitted between religious studies, medical anthropology and ritual studies. The strong accent at least initially put on texts – which play a central role in the religious and medical traditions under study – also contributed to widen the disciplinary gap in the same time as it has hindered the possibility to see how much those traditions are intertwined with each other in the daily reality[1]. This separation has thus contributed to perpetuate the idea that some practices only pertain to religion and others to medicine as stated also by Guenzi and Zupanov (2008 : 11), in their book which is an attempt to bridge that gap through different studies on the Indian continent.

This said, even though studies in these fields have seldom considered all conceptions and practices pertaining to health but only a selection of them, those developed in Buddhist studies and medical anthropology did elaborate significant reflections on how these conceptions and practices are related to each other. It's in my view by combining these approaches that we can access to a more accurate understanding of the reality.

Pluralism in Buddhist Studies and Medical Anthropology

The reflection on plurality of conceptions and practices has occupied an important space in Theravada Buddhism Studies. One of the main concerns for the first anthropologists approaching Buddhism in the field was to understand how to conceive the relationship between Buddhism and the other traditions embraced by local populations. This said, their main interest being religion they mainly focused on spirits cult which they considered religious. The majority of scholars working on Burma – Mendelson (1961 and 1963), Nash (1963 and 1965), Brohm (1963) and Pfanner (1966) – very much alike other scholars working on other Theravada societies – Obeyesekere (1963) and Ames (1964) on Sri Lanka, Kirsch (1977), Tambiah (1970, 1984 and 1985), and Terwiel (1994) on Thailand, have understood Buddhism and spirits cults as part of a single religious system dominated by Buddhism which provides the conceptual framework and system of value within which the other practices are integrated. If Obeyesekere and Kirsch stress the division of labour between Buddhism – turned to other-worldly aims – and spirit cults – turned to worldly aims – Nash and Tambiah recognise that Buddhism itself is used for both aims. From his side, Spiro (1967 et 1971) has considered Buddhism and what he called supernaturalism as part of two different religious systems; he also defended the idea that, canonically, Buddhism is a religion of salvation but that while becoming a religion for the masses, it started to be used also for worldly concerns. Although Spiro's perspective has been largely criticised all the more so as it dominated the field for a long time (Brac de la Perrière, 2009), it must be recognised – as also Hayashi (2003) did for Thailand – that even

[1] The fact that in African and Amerindian studies this split was much weaker is likely to be related to the absence in those socities of text based religions and medicines.

Buddhists themselves differentiate between Buddhism and spirits cult in the same way, I would add, as they consider Buddhism distinct from medicine, astrology, etc. Yet, interestingly, the boundaries between what is Buddhist and what is not varies from one person to another or even by the same person depending on the discursive intention. As Brac de la Perrière (2009) states regarding spirits cult, the differentiation is crucial as it represents the basis on which Buddhist's hegemony lies. Indeed, it is by differentiating "Buddhist" from "non-Buddhist" concepts and practices and by subordinating the latter to the former, that the hegemony and ideal purity of Buddhism are maintained. The maintenance of distinction and hierarchy seems to be particularly important in Myanmar where Buddhism is an instrument of political power the Burmese central government uses to dominate the peripheral states.

On the other hand, keeping Buddhism separated from the other traditions prevent the possibility of seeing the similarities and overlapping among them. To my knowledge this exercise has been done by very few scholars, namely Nash (1965), Tambiah (1985) and Tannenbaum. Tambiah (1985: 88, 120) states:

> The Buddhist cosmology, and local systems of knowledge and technique such as meditation, astrology, alchemy, medicine (Āyurveda), all share an underlying scheme of classification and hierarchy and hence a coherence […] human actions, events in nature and cosmological notions are considered to be interrelated and to affect one another.

As for medical anthropology, the recognition of the coexistence of different medical and therapeutic traditions within a specific society – what Leslie (1980) called "medical pluralism", expression which has later been largely criticised and to which I prefer "therapeutic pluralism" – and the analysis of the way people navigate and make use of this complexity – through what has been called "health seeking process" or "therapeutic itinerary" – have long time been at the core of the reflections developed. Yet for Myanmar, with the exception of my dissertation (Coderey, 2011) and other articles (2009, 2010, 2015a) that this work partially summarises and the chapter Skidmore (2008) consecrated to the topic of "medical pluralism", no other works have been produced. If scholars working on other Theravada societies have been more prolific, the core of scholarly reflections on issues of pluralism has nevertheless emerged elsewhere in Asia, in the Americas and in Africa. Among the questions which have been addressed is the cognitive and conceptual coherence between the different medical traditions at stake. At this regard Leslie and Young (1992) speak of « *Asian medical systems* », meaning by this that the ensemble of medical traditions available in Asian societies makes a coherent whole. For Theravada countries, only Golomb (1985) and Pottier (2007 : 433, 477), addressed this question and also conclude in favor of a certain coherence.

Since the 1990s and especially since the turn of the century, the attention has shifted to the political and economic aspects underlying the situation of medical pluralism. Numerous anthropologists, including Asianists (Leslie 1980; Connor, 2001; Ferzacca 2002; Kleinman, Das, and Lock 1997; Lock and Nichter 2002; Das et al. 2003; Broom et al. 2009) have vigorously defended a critical and political approach to the situation of medical pluralism arguing that the health services available, their accessibility and hence utilisation by the population are entangled with social forces, political interests, and economics. Attesting that biomedicine which generally represents the main if not the only component of the official health system is generally accessible only to a tiny – rich and educated – part of the population, they consider medical pluralism as the expression of hierarchical social relations and inequalities in access to health services (Broom et al. 2009: 705). A similar position is taken by Skidmore (2008) who highlights the deficiencies of the biomedical services in

Myanmar as a consequence of the neglect from the military government and its underfunding of the health sector.

While supporting the political approach to medical pluralism, I believe that by focusing mainly on the political and economical aspects, many of these works have overlooked the very essence of the different recourses – not only the cosmologies and etiologies they convey but also their technical and material aspects and how they help people coping with health issues. Now, as I will show in this work, this is also an important factor – beside the political and economical ones – determining the relationship of complementarity and hierarchy among the different recourses.

If important reflections on pluralism have been developed both in Buddhist studies and in medical anthropology studies, it's only their combination which provides an ideal conceptual framework allowing a more comprehensive reflection on local realities. Hence, in tune with this approach and on the basis of my study of conceptions and practices pertaining to health in Rakhine State, I intend to show that the way people cope with health issues is highly determined by the hierarchical yet complementary relations through which the components of this pluralistic field are connected, relations which hold to reasons of different nature: cosmological, therapeutic, social, political and economic.

After a brief illustration of the fieldwork I will analyse the local therapeutic field starting with the conception of health and ill-health and continuing with practices employed to maintain and restore a state of wellbeing.

FIELDWORK

The primary data for this study were gathered from several fieldwork trips conducted since 2005 in different locations in Myanmar but more intensively among the Buddhist population living in Thandwe area in the central part of Rakhine State. Rakhine is geographically isolated from Central and Lower Myanmar through the massive Rakhine Yoma and is very lacking in terms of health care services but also in terms of roads system, transportation and electricity. The main focus were, beside the town of Thandwe itself, the coastal villages of Lintha, Watankwai, Myabin, and Giaiktaw where the majority of people live off fishing and agriculture, though some work in trades, food services, or hotels.

A PLURALISTIC THERAPEUTIC FIELD

The therapeutic field in Myanmar is composed by concepts and practices originated from different sources: Western medicine (*ingaleik hsay pynnia*), indigenous medicine (*taing-yin hsay pyinnya,* including herbal medicine, massage, alchemical medicine, esoteric diagrams, mantra), religious traditions and especially Theravada Buddhism, divination, astrology and spirit cults.

Among these only Western medicine and a modernised version of indigenous medicine largely focused on herbal medicine have an official status as components of the national health system. The first one has been formally introduced in the country by the British colonisers during the latter half of nineteenth century (Edwards, 2010). The second one has been created by the Burmese central government few years after the independence. The official intention was to revive this medicine and make it recognized as equivalent to Western medicine yet I believe that this project was also an instrument of the nation building process.

Despite the fact that both medicines are part of the official health system, they remain institutionally separated and biomedicine occupies the dominant and favored position. And yet both medical systems are highly lacking in quality services, medical professionals, medication, and equipment, especially in the remote areas (Skidmore, 2008; Coderey, 2015b). Indeed, the main Burmese cities such as Yangon, Mandalay and the new capital Nayipidaw host various private and public health services from small clinics to hospitals as well as pharmacies, while remote areas rely on largely unequipped health centers and (mostly unlicensed) medicines shops. Despite the low quality of the services, their cost is often very high especially because patients are expected to pay almost in full for health expenses (92% in 2010, the highest percentage in the world) (Yu Mon Saw *et al*., 2013).

These shortcomings have stemmed from a long-term negligence of the health sector by the government and international community but also from the historical hierarchical relationship between the central part of the country dominated by the Burmese and the peripheral areas inhabited by minority ethnic groups. Thein Sein, the president who has marked the transition to a more democratic government in 2011 has launched a reform of the health system and increased the State contribution to health and yet the improvements are still minimal especially in remote areas (Coderey, 2015b).

Beside this officially recognized health system, there are several other traditions – Buddhism, divination, astrology, spirit cult, forms of indigenous medicine excluded from the official system – which although not part of the system and not recognized as medical but as elements of religion (*bada*), tradition (*yoya*) or even superstition, also have a medical dimension but in a broader sense as they also deal with different non-physiological aspects of diseases – spiritual, social and cosmological aspects – and especially they don't deal only with health and illness but more generally with fortune and misfortune. All these traditions are very lively, widespread and relatively accessible even though, as we will see, there are some social factors hindering their access.

LOCAL CONCEPTION OF HEALTH AND ILLNESS

People understanding of health and illness is primarily informed by conceptions belonging to indigenous medicine as well as to the local – primarily Buddhist – cosmology. On the contrary, biomedical etiologies are the prerogative of medical specialists and remain largely unknown by the majority of the population. The main reason of this ignorance is the lack of communication between villagers and practitioners caused by the cultural and social distance separating them and the lack of trust their relationship is often imbued with.

The local term for sickness is *yawga*. With it people refer to a physical or mental disorder produced by an imbalance of the body elements – the air, the fire, the earth and the water – which can appear during specific periods of life such as childhood, old age, pregnancy, delivery and menopause but can also be generated by one or more of the following factors:

> *Kan*: karma, "action". The main way in which karma is understood is the Buddhist conception which sees karma as the meritorious (*kutho*) and demeritorious (*akutho*) deeds people accomplish during their successive lives. In this sense, karma determines a person's future rebirth in a superior, inferior or same form of existence, but also several aspects of the present life such as health and illness. In case of illness, karma determines the gravity and hence the chances of recovery. Beside this religious conception, karma is understood as the physical action of tbhe

body (the posture, the fact of sitting, standing, walking) which also impacts on the body elements and thus on people's health.

Gyo: the planets. All life long one is affected by the influence of planets. This influence can be positive (“cold”) or negative (“hot”) depending on the person’s birthday and the person’s constitution also conceived in terms of hot and cold. Planetary influence and karma are strictly related: not only the moment of birth is determined by the karma[2] but also when a person enjoys a favorable/defavorable planetary influence, s/he lives the positive/negative effects of the meritorious/demeritorious deeds accomplished during past lives.

Seik: the mind. When the person undergoes a period of stress or faces a shock, the mind can “overheat” (*seik bu de*) or “breaks down” (*phiette*); it will thus malfunction and eventually damage also the physical body.

Utu: climate and seasons. Climate and season change (from hot to cold and cold to hot) easily affects people’s health.

Ahara: the food. The ingestion of non-suitable food can impact negatively on the person’s health. The non suitability of the food is conceived in terms of incompatibility between the food and the person: cold people should avoid cold food and hot people should avoir hot food.

Payawga: troubles caused by vindictive and malevolent beings such as witches (*son*), sorcerers (*auklan hsaya*, “masters of the lower path”) and spirits (*tahsay, thaye or peikta*). Witches generally agress (*hpan de*) through mind power or via cursed food while sorceres use esoteric diagrams and spirits act either from far or through possession, as also attested by Spiro (1971) in central Myanmar.

The above six factors can act alone or in combination. Particularly, a person’s karma and hence planetary conditions often act as a barrier against the other factors while a negative karma and planetary influence allow the other factors to harm the person. This is particularly true for supernatural aggressions which are considered to be effective only if the person’s karmic and planetary state is unfavorable. Every illness pertaining to karma is considered a misfortune (*kan ma kaung bu*, “to have a bad karma”) similar to any other tragedy caused by a negative karma such as a car accident or a poor harvest. The primary role plaid by the karma – key Buddhist notion – in the local etiology clearly reflects and shows the hierarchical superior position of Buddhism. This hierarchy is nevertheless somehow nuanced by the fact that the other five factors sometimes act independently from the karma.

In the next sections I aim to describe the practices Rakhine villagers use in order to prevent and cure illnesses. I intend to show that the very performance of these practices is grounded on the idea that to maintain or restore health and attenuate or eliminate uncertainty related to one's vulnerability it is necessary to preserve or recover the balance at all levels. Yet, because of the large amount of

[2] The same relation of identity between planets and karma has been attested also in central Myanmar by Nash (1965: 185), as well as in Ceylon by Gombrich (1971: 172) and in India by Pugh (1983: 135), Chenet (1985: 104) and Guenzi (2004: 138). Similarly to other authors, Guenzi (2004 : 138) affirms that this conception is a sort of trick allowing authors of ancient astrological treatises as well as contemporary astrologers to legitimize the astrological practice.

factors involved, their unstable and unpredictable nature, a complete and permanent balance can never be achieved.

PREVENTIVE PRACTICES

Many practices people accomplish on a regular basis contribute in some way to protect them from illness and other dangers (*andaye kakue/kin*). These same practices are then reiterated in periods or moments of vulnerability such as during childhood and the post-partum period or when the karmic and planetary situation is adverse.

The majority of people begin and end their day with Buddhist devotions accomplished at the Buddha's domestic altar and eventually reiterated at the village pagoda. These devotions include offerings to the Buddha, recitations of protective formula (*payeik*[3]), prayers, and for some people, meditation, usually the *thamahta* (Pali *samatha,* "concentration") meditation practiced by concentrating on one's breath[4]. Most families also make daily offerings of food to monks. These practices are believed to "increase the person's karma and personal power (*hpon*[5]), purify the mind and induce the help of deities and powerful beings", as a farmer from Lintha reports. Meditation also grants mental stability and calm, peace and access to extraordinary powers *zan* (pāli, *jhāna*, « mental absorption »), such as the divine ear and the divine eye and the invulnerability to supernatural aggressions.

Upon completion of these acts, villagers share the merits they have acquired with all sentient beings by reciting a specific formula. This act of loving kindness (*myitta*) is primarily intended at helping beings living inferior abodes to acquire enough merits to be able to be reborn in a more pleasant existence. Yet it is also deemed to "help appeasing malevolent beings and neutralize the forces of nature and thus to protect people from harm"[6], as the abbot of the Myabin monastery explains. Buddha himself is said to have suggested to his disciples to resort to this technique in order to prevent dangers from the social, natural and supernatural world and up till now Buddhists consider it as one of the most powerful protective means.

Another important Buddhist practice which is crucial in all Therevada countries is the chanting by monks of Buddha's apotropaic or auspicious discourses like the *payeik* and the *Pahtan*[7]. Monks are invited to chant at several occasions such as Buddhist calendar rituals, rites of passage and when a family or a person undergoes an unlucky period. Depending on the occasion, chants can last from one hour up to several days. For these occasions, villagers bring along several objects (bottle of water, pot of sand, leaves, cotton thread) to consecrate. These are then used as protective fences

[3] The *payeik* are a collection of 11 discourses the Buddha pronounced or suggested his disciples or other individuals to recite as a protection or rescue from all kinds of dangers: fire, snakes, spirits, and planetary forces.

[4] For studies on meditation practices see King (1980) and Houtman (1990).

[5] *The notion of hpon combines the idea of charismatic* power and of psychophysical essence (Spiro, 1977: 236) but also of integrity, strenght and endurance (Coderey, 2011: 72). As noticed by Kawanami (2009: 224) the *hpon* helps protecting against dangers including people's malice.

[6] Seel also Schmithausen (1997) who describes how compassion protects from dangers represented by natural elements and notably wild animals.

[7] The Pahtan is the seventh book of the Abhidhamma which addresses the several (pa) causal (tthāna) relations of the material reality.

for the house and for the body: the sand and the leaves are spread around the house, the water placed on the Buddha's altar to be drunk in case of need, the thread used as bracelet for children or sick people.

Another regular practice contributing to prevent from sickness and other misfortunes is the offering of food to the tutelary spirits (*nat*) watching the house, the village, the city and natural places people have to cross for their daily activities. Villagers also pay a particular attention to the protection from different sorts of spirits (*asein-thaye*, *okzasaung* and others) haunting the territory and that tend to be malevolent and vindictive. Most people restrain themselves as much as possible from going out alone at night ; if they cross places they suspect to be haunted they recite some *payeik* or other protective formulas ; they give their children cotton strings empowered by monks' chants to wear as amulets, etc.

Beside the positive relationship with and the protection from the supernatural, the social harmony also plays an important role in the maintenance of individuals' wellbeing. This harmony is ideally maintained through the respect of several norms such as the main Buddhist precepts and the rules concerning the positions and movements of the bodies relative to the maintenance of the hierarchy between pure or superior and impure or inferior parts of the bodies as well as of the hierarchies of age and gender (Mi Mi Khaing, 1984: 2; Spiro[8], 1977: 236-237).

A preventive practice, probably the only one, focused exclusively on sickness, is the respect of dietary rules (Robinne, 1995) and the avoidance of showers in the coldest time of the day aimed at preserving the balance between the four elements and the hot and cold in the body.

Another fundamental preventive practice is the recourse to divination. Most people consult a diviner at least once or twice a year, especially when they are facing some problems or are about to engage in some important activities (new business, school exams, travel, etc.). In the region the two most popular divinatory practices are astrology and divination through the help of the *weikza* (a person who had acquired supernatural powers including the power of knowing people's future) or the deities of the Hindu-Buddhist pantheon (*daywa, nat*) diviners are able to contact with their mind. Diviners are able to read a person's astrological chart – the lot of fortune and misfortune – and advice strategies to benefit from positive moments and prevent negative ones. The more popular strategy is the *yadaya*. There are many kinds of *yadaya* (Coderey, 2011: 172-4) yet the most common is the offering to the pagoda of objects (flowers, candles, etc.) chosen according to astrological calculations and in particular on the basis of the symbolic association between days of the week, planets, letters, objects and cardinal points[9]. This technique is supposed to improve the karma and, if necessary to avert the planetary influence. Another common practice is the distribution of amulets, generally enchanted threads to be worn as necklaces or bracelets. Masters trained in this practice roll around the string a sheet of paper or metal on which they have inscribed esoteric diagrams[10], *in* or *sama*, combinations of letters or numbers referring to Buddhist and astrological concepts; as stated by Robinne (2000) these diagrams are often a representation of the cosmic order granted by Buddhism – the order this object is intended to transmit to the body.

[8] Other authors who have attested similar rules are Formoso (1987: 137, 138), Tannenbaum (1995: 75) and Lehman (1996: 27), all working on Thailand.

[9] These associations and use in astrological practices have been described in detail by Guenzi (2004) in her work on the astrologers from Benares.

[10] The same technique is attested elsewhere in Myanmar (Sangermano, 1966 [1833] : 148), Shway Yoe, 1910 : 43; Brohm, 1957 : 33; Spiro, 1967 : 36) and in Southeast Asia (Heisenbruch,1992: 299 and Hayashi, 2003: 179).

The choice of a diviner is often difficult as many of them are suspected to be charlatans eager for money. To reduce the risk of consulting a charlatan, most villagers appeal only to diviners they are familiar with, those whose reliability and power they – or someone they know – have already tested, and those who are very popular because popularity is a sign of power and thus of authenticity, as stated by Rozenberg (2001) in his study on charismatic monks. Likewise, people avoid those who explicitly request for money. Not asking for money is seen as a sign of Buddhist compassion and thus authenticity (Coderey, 2011).

As opposed to the different techniques I have just presented, biomedicine is rarely used as a preventive tool. The notion of prevention promoted by biomedical science with its focus on the physical body and generally on a specific disease is quite uncommon among locals who conceive prevention as a combination of acts preserving the harmony within the body and with the cosmos. This discrepancy has been reported also by Laderman and Van Esterik (1988: 747) for other Southeast Asian contexts.

Beside the conceptual gap other social and political factors hinder the adoption of biomedical preventive practices. For instance, as a restaurant owner from Lintha explains “although people know that condoms serve the purpose of preventing sexually transmitted diseases, many refuse to buy and use them either because they are not accustomed to do so, or because they feel ashamed and scared given the association of condoms with extramarital sex and especially prostitution, which is illegal and socially disapproved”.

People’s lack of understanding and willingness to accept such important disease prevention methods are also largely related to the shortcomings of the health system and problematic relationship between the staff and the villagers. For instance, concerning vaccination campaigns, a woman explained that “the nurses rarely go to look for those who do not come to get the vaccination, and if they do, they scold [the villagers] for not coming”. This attitude has certainly increased the resistance against vaccinations and reinforced people’s mistrust in public health programs. Indeed these programs have long been considered as instruments of control – a form of biopower in Foucault’s sense (1988 [1963]) – and expressions of false paternalism from the military government and, before it, the British colonizers, as attested by Naono (2009).

According to Rakhine villagers, the practices they engage with on a regular basis contribute, each in its own way, to protect them from the risk of illness and other forms of misfortune in the same time as they help them reducing the uncertainty concerning their vulnerability to illness. Among them Buddhist practices play a dominant role. By improving the person’s karma and personal power and granting the preservation of positive relationship with human and supernatural entities, Buddhist practices guarantee a wide-range of protection in the short and long-term. Moreover, the Buddhist belief that good deeds will result in good rewards is an essential source of hope for a better future and helps people to cope with the difficulties they are facing. Buddhism is also dominant in its providing people a system of value orienting their action, indicating what is good and reliable and what is not. Yet, Buddhist practices are limited in their capacity of mastering specific problems and uncertainty related to near future—hence the necessity to resort to other practices which are more focused on the short-term and specific protections. In particular divination plays a significant role in revealing the factors involved and particularly in determining the status of the karma and the planets, and, if needed, to act on them, hence providing people with a sense of control and agency. However, although para-Buddhist practices are necessary, the hierarchy remains because the efficacy of these practices is considered to depend on the person’s karma. Indeed they can be effective only if the events they are intended to avoid are not the consequence of a particularly bad act the person has accomplished in one of his/her lives. Moreover the efficacy of these practices is

guaranteed only if, in the current life, the person behaves according to the Buddhist morality. From a local point of view, if the combination of all these practices provides an ideal prevention, nobody is able to perform all of them in a duly manner. Moreover, from a biomedical point of view, the low acceptance of biomedical preventive practices represents a serious problem which further impedes a satisfying prevention and yet most people are not aware of this.

CURATIVE PRACTICES AND UNCERTAINTIES OF ILLNESS

Despite the multiplicity of preventive practices in which they engage on a regular basis people do happen to fall sick. In this case, people try to give a sense and find a solution to their problem by engaging in health seeking processes. Even more than for preventive practices, this process involves the participation of the family, kin and friends and especially a more frequent resort to healers. The way people navigate the plurality of recourses, i.e. the characteristic of each health seeking process, is determined by their availability, accessibility and reliability which depend on the interaction between on the one hand the political forces and the market law and, on the other hand, the structural position of the individuals in the society, namely their educational level, socio-economic status, gender, age and mobility but also their past experiences and the advices they receive from relatives and friends (Fassin, 1992 : 21, 22 ; Guillou, 2001 ; Samuelsen, 2004; Benoist, 1996 : 501).

Notwithstanding that every health seeking process is unique, I wish to present a case study to illustrate the complexity health seeking processes often entail and to introduce a broader analysis of such complexity and of the choices people make.

The Case of *Aye Tan Shin*[11]

Aye Tan Shin is a 32 year old woman living in Linthar. Struck by strong abdominal pains which persisted for one week, she decided to look for treatment at the Thandwe Hospital. The doctors diagnosed food indigestion and prescribed medicines, in addition to dietary restrictions that permitted porridge only. As the treatment failed to cure her, she wondered whether the symptoms were resulted from a previous incident where she had urinated under a tree in her garden and consequently dreamt an ugly figure (she thought it was a bad spirit that was living in the tree) standing behind her. Due to the failure of medicines the family then turned to the village monk, the most popular astrologer in the region and the one Aye Than Shin's family always resorts to. Based on the horoscope readings the monk identified bad karmic and plenatary influences affecting her and hence prescribed a reparative offering of rice and water to be made near the street in front of Aye Tan Shin's house. Despite the offering, the symptoms persisted and thus after four days they consulted Ma Shan Aye, a famous divination master in Giaiktaw. Ma Shan Aye made some astrological calculations and mentally contacted a *weikza*. The *weikza* informed her that the woman's karma and planets were not favourable and she had been tormented by a spirit for almost two weeks. The spirit wanted an offering of eggs, rice and beef to be made that evening near the house. Moreover the divination master gave Aye Than Shin some consecrated candles, incense sticks and bottles of water and advised her to meditate every morning at 5.

The same afternoon, at her home, Aye Than Shin was possessed twice by the spirit and in that state she shouted, cried, opened her blouse showing off her breasts and kicked her sister. At 6.30h p.m. Aye Than Shin's sister went outside to make the offering and then returned to sprinkle consecrated water on her. The spirit left.

[11] This case has been illustrated also in a previous publication (Coderey, 2015a).

The next day, Aye Tan Shin felt better but soon she had low blood pressure, headaches and pain in the abdomen. She continued to eat light food and to take biomedical drugs as prescribed by the doctors but she also tried some ready-made herbal medicine she purchased from the small shop just close to her house. These efforts being futile, she formulated a new hypothesis based on another previous incident where, after eating a fruit given to her by a neighbor, she had vomited. She now suspected that the food was bewitched. Under the advise of the monk, her family she decided to seek help from an exorcist living in Teiodo village, located at about one hour by bus and on foot from their house. The master started his consultation by invoking the Buddha's and the *weikza*'s help and by reading the horoscope, which indicated that the current troubles had been caused by a witch. When Aye Than Shin was questioned by the doctor about what she ate and from where, she mentioned the fruit which according to her was given by a witch. The master invoked the witch inside the victim's body and ordered her to bow three times first to the Buddha and then to him. He forced her to promise she would never again attack Aye Than Shin and ordered her to go away. Then he gave her some consecrated water to drink and provided her with a protective silver sheet inscribed with esoteric symbols. Right when Aye Than Shin's consultation session with the master ended she felt as if she woke up from a dream. Her sisters commented that it was the witch who had controlled her mind and body from the time she ate the fruit until the witch had been removed from her body. Thanks to the treatment Aye Than Shin recovered and all the family was relieved.

Dealing with (supposed) Natural Disease

In most cases, the symptoms are ambiguous and it's thus difficult to know the nature of the disease and to identify the factors involved. People generally take these symbols as signs of a natural disease caused by some food they have ingested, by the weather or simply by a natural variation of the body elements, and treat it as such. The idea of a possible implication of the karma, the planets or supernatural factors emerges only if the other treatments fail. In that case other resorts are taken.

In case of minor problems, of chronic diseases and whenever a specialist is not available or accessible or simply the recourse to him it's not deemed to be necessary, people resort to self-medication. This include home-made remedies (*hsaymido*, "quick fire remedies", Mi Mi Khaing, 1984), such as betel leaf for treating headache, and, like it has been the case for Aye Tan Shin, the purchase of medicines in shops. Both biomedical products and ready-made manufactured products from the indigenous pharmacopeia are sold in most general shops and specialised shops, including pharmacies. Licensed shops exist only in towns and cities, while the rest of the country relies on unlicensed shops or shops which have the license for several goods but not for medicines. Herbal medicines in the form of powder (single ingredient or combined ingredients) are sold in specialised shops which exist in most markets around the country. Nowadays, most people first have recourse to biomedical products, which, differently from herbal products, appease the symptoms very fast. This rapidity is particularly appreciated in case of acute symptoms like headache and malaria. Yet, everybody agrees that biomedical products have the disadvantage of producing side effects. On the contrary, there are a certain number of sicknesses for which people prefer indigenous medicine. For example, articulation pains, digestive and skin problems, some forms of cancers and also chronic diseases like hypertension. Indigenous medicine is considered particularly appropriate for these diseases firstly because it is deemed to be free from side effect and thus apt to be taken in the long term and, secondly because it is said to completely erase the sickness, to *myet phyat*/*pyet*, to "cut/break the root the sickness". Anyway, the two recourses are not mutually exclusive and actually are often combined.

If in many cases self-medication through medicines purchased in shops is successful in solving the problem the person is suffering from, it can also worsen it. In facts, this practice entails several risks users are not always aware of: risks derived from the loose character of quality and safety controls and – for biomedical products – risks related to the way the products are sold and purchased – singly, without the original box that indicates the registration number and the expiration date and without the leaflet and usually without explanations.

Although self-medication is a very common practice there are several occasions where people prefer to consult a specialist, yet not everybody can afford to do so. When symptoms do not diminish through self-medication or when more serious illnesses such as an acute diarrhea or strong abdominal pain occur, people usually refer to a biomedical specialist, be this a doctor or a nurse. Additionally, Rakhine villagers tend to consult doctors for injuries that require surgery. Overall, biomedicine is appreciated for its modern technologies that allow to "see and act inside the body in a very precise way", as a villager from Myabin states. As for specialists of indigenous medicine, they are usually appealed to in cases of chronic diseases, menstrual disorders, paralysis and some forms of cancers, for the treatment of which this medicine is considered particularly effective, in addition to instances where biomedical practices fail.

The access to these specialists – and biomedical specialists in particular – is not always easy and even when it is so, the inadequacy of the service and the dynamics of the encounter are likely to reduce the chance of the treatment being successful. All my informants complain that local biomedical services are highly inadequate. As described in a previous publication (Coderey, 2015: 282-4), in the Thandwe hospital the majority of doctors are general practitioners, while specialists are very rare. The service they can provide simple operations, basic tests and X-ray facilities. For more complex medical services such as tissue analysis, ultrasound imaging and large operations patients are referred to Yangon, which is highly costly and therefore unaffordable to many. Health centers also are understaffed and under-equipped. Health centers are run by a health assistant and a midwife while sub centers are run only by one midwife. Both are equipped to treat only minor symptoms such as cough, fever and diarrhea. People also complain that the staff is often absent and even when it is there it is very negligent and sometimes even rude, especially with people of low socio-economic status.

Despite the law quality of the services, their cost remains quite high and people have to pay out of pocket almost the totality of the medical fees. A fishermen from Lintha explains "the government supplies hospitals and health centers with medicines and materials intended to be given for free to patients, but these being very limited the staff is compelled to buy products also from outside and charge them to patients". This said, thanks to the health reform launched by the president Thein Sein in 2011, the stuation is improving at least in public hospitals where medicines, tests (for instance blood tests, x-ray, etc.) and operations are now provided free of charges especially for what concern emergencies and delivery; other medicines and services have to be paid but the cost is much inferior to what it used to be.

Compared to public services, private ones are generally considerd a better option because despite they are equipped only for treatments of minor cases, they have a good supply of medicines and doctors are more considerate towards patients regardless of the social status or financial backgrounds although, everybody states, "they don't do it out of loving-kindness but because the service they provide is subject to payment and the money goes directly in their pocket". The problem here is that these services, and especially those run by specialists, are more expensive and thus unaffordable to many people. They are thus generally chosen by wealthy people as well as by people living nearby for whom going to another service would anyway requests a cost.

If people base their choice on the suitability of the services to deal with their specific problem as well as on economic criteria, they also consider the geographical distance from the services as well as the nature, the character of the practitioners and the degree of familiarity they have with them: "I go to doctor Myin Naing because he is my neighbor and I am familiar with him", says a shop keeper from Myabin; "I go to Tet Win because differently from other doctors he does this job just to help people and not for money", says a fisherman from Giaiktaw. A good relationship helps reducing the social and cultural distance most people feel with these professionals and which often hinders the patient-practitioner communication with potential harmful consequences on the patient's behavior (especially in terms of compliance with the medical prescription).

For those who opt for indigenous medicine the choice is between the more traditional ones that operate outside the system recognised by the State and those belonging to this system – one public hospital and three private dispensaries all located in Thandwe. Most people in Thandwe prefer the former; they respect and trust them and highly appreciate their practical expertise and skills. The latter represent something people are not very familiar with and as much as biomedical services these services are seen as lacking in organization, instruments and material. Despite the preference for the traditional practitioners, the resort to them is becoming problematic: these masters are becoming rare because the new generations are not interested in continuing this tradition but also because of the concurrence represented by Western medicine and by the market.

Dealing with Illness as a Form of Misfortune

If after a certain period of time that the patient is following a medical treatment symptoms don't disappear – like in the case of Aye Tan Shin – or if, in addition to the disease, the person encounters other difficulties in his/her life, s/he will start considering the possibility that some karmic, planetary or supernatural factors are involved and prevent the medical treatments from being effective. As a result, the person turns to practices and healers dealing with misfortune. Most people would generally first resort to a diviner or an astrologer to know the state of their karma and, if needed, to be prescribed some *yadaya* or delivered some protective amulets. Some diviners, like Ma Shan Aye, are able to identify if the disease results from a supernatural aggression and chase away minor aggressor. Yet if this is a powerful one, like a witch or a sorcerer, the patient will need to consult an exorcist (*payagwga hsaya*) in order to perform an exorcism, as it was the case for Aye Tan Shin.

Even though diviners and exorcists are not difficult to find – as most villages have at least one of each – people consider several factors to make their choice of which one they will appeal to. For diviners and astrologers, most peoples, like Aye Tan Shin, would generally have recourse to the one they see regularly and who is generally living not too far from them (in the same or a close by village) but if the problem is serious or is not solved with that specialist, they will see a second one, preferably a famous one or someone they have been advised by some kin or friends. Some consult multiple diviners at the same time because they feel the need to have more opinions. With exorcists the situation is different: most people look for exorcists living far. The main reason is that exorcists are seen as ambiguous figures because they deal with occult forces and use mundane and esoteric techniques which can be used for good or for bad depending on the intention. If the master belongs to another community than the one of the patient, if they don't share the same social network, there are much less chances that the master would harm the person whether from his own or a third person's initiative. The ambiguity of these masters also make people not desiring to let other people know that they are consulting them because those could suspect that they have some malefic plan in mind. Lastly, there is the idea that what comes from far is more powerful than what one has close by and this seems to be particularly relevant when the occult is involved.

In both cases the economic factor doesn’t seem to represent an issue. These specialists seldom openly request for payment and people donate what they feel like.

“Maximizing the Chances of Healing”

Depending on the nature and the gravity, real or presumed, of the disease, and of the availability and accessibility (in geographic, economic and socio-cultural terms) of the resources, one's health seeking process can be more or less complex. More the process is complex and more the recourses are close to each other, more they translate and express the need to gain cognitive and pragmatic control on the illness and the uncertainty related to it. Complexity is also the reflection of a certain anxiety originated from the idea that misfortune is cumulative and contagious in that – if “untreated” – it can spread and affect other aspects of one person's life and also his/her relatives. The different recourses described in the previous section can be combined in different ways, which are seldom unidirectional. Hence although Aye Than Shin started with medical recourses and then turned to healers dealing with misfortune, she also kept having recourse to self-medication – by purchasing medicines – and following the doctors' advices. As stated by Pottier (2007) for Laos, such a diversity of resorts stems from the “wish to maximize the chances of healing” or “to solve all the possible causes of the disease” (p. 141). The different recourses are thus not incoherent nor contradictories as Skidmore suggests in her essay on medical pluralism in Myanmar (2008: 196); by acting on different causal factors they all contributes – at least potentially – to the healing as noted by Golomb (1985: 277) in Thailand and Fainzang (1986: 112, 117) in Burkina Faso. Hence, this study proposes to speak of compound healing where different layers of therapeutic practices eventually lead to the final recovery. It must also be noted that some resorts are particularly appreciated not much for their efficacy in attenuating the symptoms but for the sense they give to them, a sense which is easier to accept, or which can better help coping with the problem.

In the event the illness turns out to be incurable or a person dies from it, karmic actions are considered to be the cause. The karma represents the origin but also the limits of the space of freedom (Gombrich, 1971).

Medicines and especially biomedicine tend to play a central role in health seeking processes, much more than in the preventive processes. Because of its availability and the trust people have in its technological and scientific power, villagers turn more towards biomedicine as a first resort. Yet due to the inadequacy of the services and the several obstacles hindering their accessibility, people often renounce to appeal to them or rather fail to find in them the solution to their problems. If this certainly contributes to make people continuing having recourse to all kind of more traditional practices, it is not the only reason why people continue to do so. Indeed I don’t believe that if people had an easier access to good quality services, they would eventually abandon the other recourses as Skidmore’s (2008) seems to suggest. Indigenous medicine also has its own value and seems able to respond to some problems better than biomedicine. Moreover, biomedicine – like indigenous medicine in its modernised version – is not able to apprehend neither conceptually not practically the non-biological factors of an illness (Dozon, 1987: 17) nor they are able to help people coping with the uncertainties they face. In this aspect, it is noteworthy the role played by divination as it enables to attribute to the illness a meaning which is pertinent to the person’s biography, to provide strategies to cope with the illness and predict their degree of efficacy.

If Buddhist practices – at least as practices accomplished by the sick person – play a minor role here compared to what they do in prevention, they are central to the healers' practice, especially diviners' and exorcists'. Only the engagement in Buddhist practices and the contact with Buddhist superior beings allows to acquire prophetic powers and only the use of the Buddhist authority

conveyed by the *weikza*, Buddhist symbols and mantra enables to win the evil, proving the role of Buddhism as guarantor of the cosmic order. They also contribute to enhance the power of other practices when they don't determine it at the first place and provide the healers respectability and legitimation. This said, Buddhist practices accomplished by the patient (in the present and past lives) remain important as well given that it is the karma produced by them which determines the final outcome of every cure.

CONCLUSION

To understand and master health and ill-health, Rakhine Buddhists make use of a plurality of conceptions and practices of different nature. Whether they are labelled of Buddhist or astrological or other – their combination and entanglement and their co-contribution to the maintenance and restoration of health, leads to question the limits between religious and medical (Guenzi et Zupanov, 2008), Buddhist and non-Buddhist (Hayashi, 2003), worldly and other-worldly (Swearer, 1995), and natural and supernatural (Augé, 1984 ; Pottier, 2007).

If in preventive efforts taking place in daily life a large part when not the integrity of the plurality of conceptions and practices is mobilised, only a part is appealed to in case illness occurs and yet the entire panoply remains in the backround as potential option to turn to if needed ; it is also appealed to as soon as the recovery process is over because as stated by Csordas and Kleinman (1996: 19) the therapeutic process doesn’t start nor stop with that specific therapeutic event.

Within this plurality Buddhism and medicines (and notably Western medicine) have somehow a superior position. Buddhism provides the main features of the local comsology which sets the basis of the order of the world it itslef represents and embodies. It also provides the system of value which gives sense and orients people’s actions and represents an important source of efficacy and respectability. And it sets the limits within which individuals can shape their life (Gombrich, 1971). As for medicine, its dominant position stems from it being officially recognised and supported as *the* proper method to deal with illness and from its association to modernity and science which are highly valued. Nevertheless, despite their superior position, both Buddhism and medicine have limits (in terms of concepts, efficacy or accessibility) which make them unable to provide answers and solutions to all health-related problems. It’s only by combining them with other components of the system that people can achieve a better and more satisfying mastery of their wellbeing and of the uncertainty related to it.

The dominant position of Buddhism and medicine and especially the power attributed to them explain in some ways my informants’ answers which I started this essay with and which actually seem to express an ideal situation, where one is able to prevent illness by following the Buddha’s teaching and cure it with medicine. Those answers don’t reveal the fact that in reality the complex interplay between cosmological-etiological conceptions on the one side, and social, economic and political forces on the other side, makes the multiplicity of recourses a necessity.

The low accessibility of Western biomedical services and products of good quality need to be highlighted because the other recourses are not always able to fill the gaps with them. Therefore, the implementation of urgent country-wide medical reform is crucial in order to reduce the social and geographical inequalities that arise in the attempt by these communities to secure good quality biomedical services.

BIBLIOGRAPHY

Ames, Michael (1964), "Buddha and the dancing goblins: a theory of magic and religion", *American Anthropologist*, 66, 1, 75-82.

Augé, Marc (1984), "Ordre biologique et ordre social: la maladie comme forme élémentaire de l'évènement" in Marc Augé and Claudine Herzlich (eds.) : *Le sens du mal : anthropologie, histoire et sociologie de la maladie*, Paris, Archives Contemporaines, 35-92.

Benoist Jean (1996), " Conclusion : Prendre soin ", in Jean Benoist (ed.): *Soigner au pluriel, essais sur le pluralisme médical*, Paris, Karthala, 491-506.

Brohm, John F. (1963), " Buddhism and animism in a Burmese village", *Journal of Asian Studies*, 22, 2, 155-167.

Brac de la Perrière, Bénédicte (2009), "An overview of the field in Burmese studies", *Asian Ethnology*, 68, 2, 185-210.

Broom, Alex, Assa Doron & Philip Tovey (2009), "The inequalities of medical pluralism: hierarchies of health, the politics of tradition and the economies of care in Indian oncology", *Social Science and Medicine*, 69, 5, 698-706.

Bourdieu, Pierre (1971), "Champ du pouvoir, champ intellectuel et habitus de classe", *Scolies*, 1, 7-26.

Dozon, Jean-Pierre, Sindzingre, Nicole (1986), "Pluralisme thérapeutique et médecine traditionnelle en Afrique contemporaine", *Prévenir*, 12, 43-52.

Chenet, François (1985), "Karma et astrologie: un aspect méconnu de l'anthropologie indienne", *Diogène*, 129, 103-129.

Coderey, Céline (2009), "Maladie et pratiques thérapeutiques en Arakan (Ouest de la Birmanie) (Illness and therapeutic practices in Arakan) ", *Aséanie,* 24, 33-60.

Coderey, Céline (2010), "Du karma aux planètes : Les thérapeutes arakanais et leurs pratiques hétérogènes de soin (From the karma to the planets: Arakanese healers and their heterogeneous practices)", *Moussons,* 15, 29-53.

Coderey, Céline, (2011), *Les maîtres du "reste": la quête d'équilibre dans les conceptions et les pratiques thérapeutiques en Rakhine (Birmanie)*, PhD dissertation. University of Provence, Aix-Marseille I.

Coderey, Céline (2015a), "Uncertainty and risk related to health in Rakhine (Myanmar)", *Health, Risk and Society*, 17, 3-4, 263-284.

Coderey, Céline (2015b), "Accessibility to biomedicine in contemporary Rakhine State", in Renaud Egreteau & François Robinne (eds.), *Metamorphosis. Studies in Social and Political Change in Myanmar,* Singapore, NUS Press, 260-287.

Coderey Céline (2016, forthcoming), “Healing sounds. An anthropological study of Buddhist apotropaic texts in Rakhine (Myanmar)”, in Nathan Porath (ed.), *Sounds of Hierarchy and Power in Southeast Asian Societies*, Copenhagen, NIAS Press.

Connor, Linda H. (2001), “ Healing powers in contemporary Asia”, in Linda Connor and Geoffrey Samuel (eds.) : *Healing power and modernity traditional medicine, shamanism and science in Asian society*, Westport, CT, Bergin & Garvey, 3-21.

Csordas, Thomas J., Arthur Kleinman (1996), “The therapeutic process”, in Carolyn Fishel Sargent and Thomas Malcolm Johnson (eds.): *Handbook of medical anthropology: contemporary theory and method*, Wesport, Praeger, 3-20.

Das, Veena (2015), Affliction. *Health, disease, poverty,* Fordham University Press

Dozon, Jean-Pierre (1987), “Ce que valoriser la médecine traditionnelle veut dire”, *Politique africaine*, 28, 9-20.

Edwards, Penny (2010), “Bitter pills: colonialism, medicine and nationalism in Burma, 1870-1940”, *Journal of Burma Studies*, 14, 21-58.

Eisenbruch, Maurice (1992), “The Ritual Space of Patients and Traditional Healers in Cambodia”, *Bulletin de l’École française d’Extrême-Orient*, 79, 2, 283-316.

Fainzang, Sylvie (1986), *L'intérieur des choses. Maladie, divination et reproduction sociale chez les Bisa du Burkina*, Paris, l'Harmattan.

Fassin, Didier (1992), *Pouvoir et maladie en Afrique. Anthropologie sociale dans la banlieue de Dakar*, Paris, Presses Universitaires de France.

Ferzacca, Steve (2002), “Governing bodies in new order Indonesia ”, in Margaret Lock et Mark Nichter (eds.) : *New Horizons in Medical Anthropology. Essays in honour of Charles Leslie*, London et New York, Routledge, pp. 35-57.

Formoso, Bernard (1987), “Du corps humain à l’espace humanisé. Système de référence et représentation de l’espace dans deux villages du Nord-Est de la Thaïlande”, *Études Rurales*, 107-108, 137-170.

Foucault, Michel (1988 [1963]), *Naissance de la clinique*, Paris, Presses Universitaires de France.

Golomb, Louis (1985), *Anthropology of Curing in Multiethnic Thailand*. Urbana, University of Illinois Press.

Gombrich, Richard (1971), *Precept and Practice: Traditional Buddhism in the Rural Highlands of Ceylon*, Oxford, Clarendon Press.

Grundy John (2012), “The Responsibility to Protect: Inequities in International Aid Flows to Myanmar and the Democratic People’s Republic of Korea and their Impact on Maternal and Child Health”, *Asian Studies Review*, 36, 171–187.

Guenzi, Caterina (2004), *Destin et divinatio: le travail des astrologues de Benares*, Thèse de doctorat, Paris, École de Hautes Études en Sciences Sociales.

Guillou, Anne Y. (2009), *Cambodge, soigner dans les fracas de l'histoire*, Paris, Les Indes Savantes.

Hayashi, Yukio (2003), *Practical Buddhism among the Thai-Lao : Religion in the Making of a Region,* Kyoto and Melbourne, Kyoto University Press.

Houtman, Gustaaf (1990), *Traditions of Buddhist Practice in Burma*, PhD dissertation, London, School of Oriental and African Studies.

King, Winston L. (1980), *Theravada meditation: the Buddhist transformation of yoga*, University Park, Pensylvania State University Press.

Kawanami, Hiroko (2009), "Charisma, power(s), and the *arahant* ideal in Burmese-Myanmar Buddhism ", *Asian Ethnology*, 68, 2, 211-237.

Kirsch, Thomas A. (1977), "Complexity in the Thai religious system: an interpretation", *The Journal of Asian Studies*, 36, 2, 241-266.

Kleinman, Arthur (1980), "Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry. Comparative", *Studies of Health Systems and Medical Care*, Berkeley, Los Angeles, University of California Press.

Kleinman, Arthur, Das, Veena et Lock, Margaret (1997), *Social suffering*, Berkeley, UCR.

Laderman, C. Carol et Van Esterik P. (eds.) (1988), "Techniques of healing in Southeast Asia", *Social Science and Medicine*, 17, 747-87.

Leslie, Charles (ed.) (1980), "Medical pluralism in world perspective", *Social Science and Medicine* 14b, 4, Special Issue on Medical Pluralism, 190–196.

Leslie, Charles & Young, Allan (eds.) (1992), *Paths to Asian medical knowledge*, Berkley, University of California Press, 296 p.

Lock, Margaret and Mark Nichter (eds.) (2002), *New horizons in medical anthropology: essays in honour of Charles Leslie*, London and New York, Routledge.

Mendelson, E. Michael (1961), "A messianic Buddhist association in upper Burma", *Bulletin of the School of Oriental and African Studies*, 24, 3, 560-580.

Mendelson, E. Michael (1963), "Observations on a tour in the region of Mount Popa, Central Burma", *France-Asie*, 19, 179, 780-807.

Mi Mi Khaing (1984), *The World of Burmese Women*. London, Zed Books.

Nash, Manning (1963), "Burmese Buddhism in everyday life", *American Anthropologist*, 65, 2, 285-295.

Nash, Manning (1965), *The golden road to modernity; village life in contemporary Burma*, New York, John Willey & Sons.

Naono, Atsuko (2009), *State of vaccination: the fight against smallpox in colonial Burma*, Hyderabad, Orient Black Swan.

Obeyesekere, Gananath (1963), "The great tradition and the little in the perspective of sinhalese Buddhism », *Journal of Asian Studies*, 22, 2, p. 139-154.

Pfanner, David E. (1966), "The Buddhist monk in rural Burmese society", in Manning Nash (ed.), *Anthropological studies in Theravada Buddhism*, New Haven, Yale University, Southeast Asia Studies, Cultural Report Series, 13, 77-96.

Pottier, Richard. (2007), *Yû dî mî hèng*: "*être bien, avoir de la force*". *Essai sur les pratiques thérapeutiques lao*, Paris : École française d'Extrême-Orient.

Pugh, Judy F. (1983), "Astrology and Fate: the Hindu and Muslim experiences", in Charles F. Keyes and E. Valentine Daniel (eds.), *Karma, an anthropological inquiry*, Berkley, University of California Press, 131-146.

Robinne François (1995), *Savoirs et saveurs : l'identité culinaire des Birmans*, Paris, Presses de l'Ecole Française d'Extrême-Orient.

Robinne, François (2000), *Fils et maîtres du lac. Relations interethniques dans l'Etat Shan de Birmanie*, Paris, CNRS/MSH.

Rozenberg, Guillaume (2001), *Thamanya: enquête sur la sainteté dans la Birmanie contemporaine*. PhD dissertation, Paris, École des Hautes Études en Sciences Sociales, Paris.

Samuelsen, Helle (2004), "Therapeutic itineraries: the medical field in rural. Burkina Faso", *Anthropology and medicine*, 11, 1, 27-41.

Scheper-Hugues, Nancy (1990), "Three propositions for a critically applied medical anthropology", *Social Science and Medicine*, 30, 2, 189-97.

Schmithausen, Lambert (1997), *Maitrī and Magic: Aspects of the Buddhist Attitude toward the Dangerous in Nature*, Wien: Österreichischen Akademie der Wissenschaften, 76, 43-56.

Shway Yoe [U] (1910), *The Burman: his life and notions*, London, Macmillan.

Skidmore Monique (2008), "Contemporary medical pluralism in Burma". In Monique Skidmore and Trevor Wilson (eds.), *Dictatorship, disorder and decline in Myanmar*, Canberra, ANU E Press, 193-207.

Spiro, Melford E (1967), *Burmese supernaturalism. A study in the explanation of reduction of suffering*, New York, Englewood Cliffs, Prentice-Hall.

Spiro, Melford E. (1971), *Buddhism and Society. A Great Tradition and its Burmese Vicissitudes*, London, George Allen & Unwin.

Spiro, Melford E. (1977), *Kinship and marriage in Burma: a cultural and psychodynamic analysi*s, Berkley, University of California Press.

Swearer, Donald K. (1995), *The Buddhist world of Southeast Asia*, Chiang Mai, Silkworm Books.

Tambiah, Stanley Jeryaraja (1970), *Buddhism and spirit cults in Northeast Thailand*, London, Cambridge University Press.

Tambiah, Stanley Jeryaraja (1984), *The Buddhist saints of the forest and the cult of amulets: a study in charisma, hagiography, sectarianism, and millennial Buddhism*, New York, Cambridge University Press.

Tambiah, Stanley Jeryaraja (1985), *Culture, thought, and social action: an anthropological perspective*, Cambridge, London, Harvard University Press.

Tannenbaum, Nicola (1995), *Who can compete against the world? power-protection and Buddhism in Shan worldiew*, Ann Arbor, Michigan, Association for Asian Studies.

Terwiel, Baren Jan ([1975] 1994), *Monks and magic; an analysis of religious ceremonies in central Thailand*, Bangkok, Cheney, White Lotus.

Yu Mon Saw, Khine Lae Win, Laura Wen-Shuan Shiao et al. (2013), "Taking stock of Myanmar's progress toward the health-related Millennium Development Goals: current roadblocks, paths ahead", *International Journal for Equity in Health*, 12, 78.

Zupanov, Ines, Guenzi, Caterina (2008), "Introduction", in Ines Zupanov and Caterina Guenzi (eds) : *Divins remèdes. médecine et religions en Asie du Sud*. Paris, Éditions de l'École des Hautes Études en Sciences Sociales, coll. *Purusārtha*, 27.