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# **Healing Without Borders: Indigenous Medicine as a Pathway to Ethnic Coexistence in Sri Lanka**



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## **Abstract**

Different ethnic communities around the world primarily depend on indigenous medicinal practices to address their healthcare needs. These practices are deeply rooted in cultural beliefs, long-standing traditional knowledge systems, and various forms of phytotherapeutic applications developed and refined over generations. Beyond serving as systems of disease treatment, indigenous medical practices also play an important role in maintaining cultural identity and strengthening community knowledge related to local biodiversity and environmental resources. Ayurvedic hospitals are those practicing the ancient traditions of the Vedic period, emphasizing holistic health and natural therapies. There exists a near-total absence of empirically grounded, systematic inquiry into the social architecture and cultural resonance of Ayurvedic practice not as a commodity or clinical intervention, but as a lived sociocultural institution that shapes identity, community cohesion, intergenerational knowledge transmission, and collective health narratives. This study addresses the existing research gap by implementing a rigorously designed, cross-provincial, perception-based investigation into the role of indigenous medicine within Sri Lanka's public healthcare system and its contribution to ethnic coexistence. Data were collected from two prominent government Ayurvedic hospitals in each of Sri Lanka's nine provinces, ensuring representation of diverse regional and ethnic contexts. A structured questionnaire was administered to patients who voluntarily participated in the study, allowing for the systematic examination of public perceptions, patterns of healthcare use, and inter-ethnic engagement within indigenous medical settings. This approach enabled the study to explore how shared access to traditional medical institutions and practices functions as a social space that brings together individuals from different ethnic communities, thereby positioning indigenous medicine as a potential pathway for fostering social cohesion in Sri Lanka. Overall, the findings demonstrate that indigenous medical institutions in Sri Lanka operate as inclusive social spaces that transcend ethnic boundaries and foster everyday forms of ethnic coexistence. By providing equitable care, encouraging spontaneous inter-ethnic interaction, and sustaining shared trust in traditional healing practices, indigenous medicine functions not only as a healthcare system but also as a unifying cultural framework. These results highlight the significant potential of indigenous medicine to contribute to social cohesion in Sri Lanka's multi-ethnic society.

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# 1. Introduction

## 1.1. Traditional Ayurvedic Remedies in Daily Life

Ayurvedic medicine in Sri Lanka has a long and well-established history, deeply connected to the island's indigenous knowledge traditions. For centuries, before the widespread introduction of Western medical practices, local communities relied primarily on traditional medical systems for healthcare. Traditional remedies are mainly derived from natural sources such as plants, minerals, and animal-based materials, and many recipients believe that these treatments are safer and associated with fewer adverse effects when compared to synthetic or modern pharmaceutical drugs (Agarwal, 2020). Indigenous medicine in Sri Lanka generally consists of four main traditions: Ayurveda, Siddha, Unani (Yunani), and Chikitsa. (Department of Ayurveda, 2019; Obeyesekere, 1969). The Siddha system mainly utilizes mineral-based preparations for the treatment of diseases, whereas Ayurveda predominantly relies on plant-based formulations. In contrast, the Unani system is founded on principles that differ from both Ayurveda and Siddha. Similar to Ayurveda, Deshiya Chikitsa primarily employs herbal medicines derived from locally available plants.

Historically, Ayurvedic medicine was most prevalent within the Sinhala community, where it formed an essential part of cultural and social practices. Traditional healers, commonly referred to as “Veda Mahaththaya,” occupied a respected position within village society. In a context where Western medicine was limited and often inaccessible, particularly in rural areas, people depended heavily on Ayurvedic treatments for both curing illnesses and maintaining general health (Uragoda, 1987). The transmission of Ayurvedic knowledge traditionally occurred across generations, often within families or through apprenticeships under experienced healers. Many remedies were prepared and administered at the household level using locally available natural ingredients. Even in contemporary Sri Lanka, older generations continue to practice these home-based remedies, thereby introducing younger family members to Ayurvedic principles through everyday experiences. This continuity has played a significant role in sustaining awareness and acceptance of indigenous medicine over time (Pieris, 2013).



Figure 1. One of the Ayurveda hospitals visited

Over time, Ayurvedic medicine extended beyond its initial association with the Sinhala community. As its effectiveness became more widely recognized, individuals from Tamil, Muslim, and other ethnic communities increasingly sought Ayurvedic treatment. What began as a culturally specific practice gradually evolved into a shared healthcare tradition, crossing ethnic and religious boundaries (Obeyesekere, 1969).

In the present context, Ayurveda is practiced and trusted by people from all major ethnic groups in Sri Lanka. This shared reliance on indigenous medicine demonstrates how traditional healing practices can function as a common cultural space, encouraging interaction and mutual understanding. As such, Ayurvedic medicine has contributed not only to physical well-being but also to ethnic coexistence, aligning closely with the theme of healing beyond social and cultural borders.

### **1.2.From Distinct Traditions to a Shared Healing System**

Traditional medical systems in Sri Lanka developed through the interaction of multiple cultural and historical influences, resulting in a shared indigenous healthcare tradition. Ayurveda, which has ancient roots within the Sinhala community, formed the foundation of early healing practices on the island and was closely connected to village life and Buddhist cultural traditions (Obeyesekere, 1969; Urugoda, 1987). Siddha medicine, originating in South India, entered Sri Lanka primarily through the Tamil community, particularly in the Northern and Eastern regions, introducing specialized knowledge of herbal, mineral, and external therapeutic practices (Zvelebil, 1996; Pieris, 2013). Unani (Yunani) medicine, which developed from ancient Greek medical theories and was later expanded by Arab and Persian scholars, was introduced to Sri Lanka through Muslim traders and physicians, especially in coastal areas (Fernando, 2007; Department of Ayurveda, 2019). Although these medical systems originated from different ethnic and cultural backgrounds, their practices gradually overlapped through long-term social interaction, shared ecological environments, and common reliance on natural medicinal resources. Over time, healers adopted remedies, techniques, and medicinal knowledge from one another, leading to the development of a blended indigenous medical tradition rather than strictly separate systems (Obeyesekere, 1969). This gradual integration contributed to the emergence of traditional medicine in Sri Lanka as a collectively trusted form of healthcare, practiced and respected by Sinhala, Tamil, Muslim, and other ethnic communities alike. Today, indigenous medicine is recognized not as the property of a single group, but as a shared cultural heritage, reflecting historical patterns of coexistence and mutual exchange within Sri Lankan society (Pieris, 2013).

### **1.3.Breaking Ethnic Boundaries**

Indigenous medicine has become an important and widely accepted part of Sri Lankan society, functioning as a healthcare system that transcends ethnic and cultural boundaries. Today, people from Sinhala, Tamil, Muslim, and other ethnic communities seek indigenous medical treatment without considering ethnic origin, focusing instead on effectiveness and trust built over generations. Indigenous medical practitioners themselves come from diverse ethnic backgrounds, further reinforcing the inclusive nature of this system. Treatments are sought for a wide range of health conditions, from common illnesses such as colds, fevers, and digestive problems to serious

and long-term conditions including paralysis, chronic diseases, and cancer. This broad use across different levels of illness has strengthened public confidence in indigenous medicine as a reliable form of healthcare. Indigenous hospitals and clinics commonly serve patients of all ages, from young children to the elderly, reflecting its acceptance across generations. The practice of taking children for indigenous medical treatment is particularly significant, as it demonstrates deep-rooted belief and long-term trust in these healing systems, regardless of their historical or ethnic origins. In this way, indigenous medicine operates as a shared social institution in Sri Lanka, bringing communities together through common experiences of care and healing and contributing to everyday forms of ethnic coexistence within the country.



Figure 2. (A) Patients getting treatments in Ayurveda hospitals (B) Conducting the questionnaire

## **2. Objectives**

### **2.1. General Objectives**

- To explore the profile of indigenous medicine use in Sri Lanka by examining patient ethnicity, gender, age, disease profiles, treatment-seeking tendency, and reasons for choosing indigenous medicine, and to assess how personal perceptions on inter-ethnic interactions and willingness to recommend indigenous medicine to other ethnic groups contribute to its acceptance, respect, and the promotion of ethnic coexistence across communities.
- To explore the perceptions and attitudes of non-users (Non-users can be defined as individuals who have not personally received indigenous medical treatment before, including first-time hospital visitors, caregivers or companions of patients, and community members who typically use other healthcare systems) toward indigenous medicine in Sri Lanka by assessing their views on its effectiveness, safety, and cultural value, their openness to adopt it in the future, the influence of inter-ethnic communication and recommendations on their attitudes, and their perceptions of indigenous hospitals as inclusive and respectful spaces for all ethnic communities.

### **2.2. Specific Objectives**

1. To examine the demographic characteristics of the people using indigenous medicine.
2. To examine the types of diseases which are commonly treated with indigenous medicine.
3. To examine how long and how often do the patient use indigenous medicine.
4. To explore the reasons for choosing indigenous medicine by people.
5. To examine how indigenous hospitals in Sri Lanka operate beyond ethnic boundaries to enhance the ethnic coexistence.
6. To assess the sense of comfort and inclusion experienced by patients of different ethnic backgrounds within indigenous hospitals.
7. To assess the perception towards inter-ethnic interaction among patients visiting indigenous hospitals for treatment.
8. To assess the perception towards acceptance and respect for indigenous medicine among different ethnic communities.
9. To examine how does the personal perception on effectiveness of using indigenous medicine vary with ethnicity and gender.
10. To examine patient's readiness to recommend indigenous medicine to other ethnic communities.
11. To assess the general perceptions of non-users toward the effectiveness, safety, and cultural value of indigenous medicine.
12. To evaluate the openness of non-users to adopt indigenous medicine in the future, beyond ethnic or cultural boundaries.
13. To examine how inter-ethnic communication and recommendations influence non-users' attitudes toward indigenous medicine.

### 3. Literature review

Ayurveda, the ancient system of life science (*Āyus*- life, *Veda*- knowledge), is one of the oldest codified medical traditions in the world. Its origins are traditionally traced to the Vedic period (c.1500-600 BCE), where medical knowledge is embedded within the *Atharvaveda*, particularly in humans addressing disease causation, healing rituals, herbal therapies, and psychosomatic concepts (Atharvaveda, Kāṇḍa 1-7).

The Charaka Samhita (Sūtrasthāna 1) describes a historic gathering of sages (Rishi Sammelana) in the Himalayan foothills, where distinguished rishis assembled to address the growing burden of disease on humanity. Under the guidance of Atreya Punarvasu, sages including Agnivesha, Bhela, Jatukarna, Parashara, Harita, Ksharapani, and Pulastya systematized Ayurvedic knowledge transmitted from Indra through the Ashwini Kumaras and Bharadvaja.

Notably, Pulastya Rishi established Ayurveda in Sri Lanka. His lineage later became associated with Lanka through his grandson Ravana, linking the ancient Ayurvedic tradition to the island's medical heritage.

In the Sri Lankan Ayurveda tradition, this concept of Avataraṇa is preserved through both Sanskrit classics and Sinhala medical literature, reinforcing Ayurveda as a sacred yet practical science transmitted through *Guru Śiṣya Paramparā*. The continuity of this lineage reflects Ayurveda's enduring relevance as a holistic medical system grounded in compassion, observation, and experiential wisdom.

Sri Lankan chronicles such as the *Mahāvamśa* and *Cūlavamśa* record the establishment of hospitals (*Ārogyasālā*) and the royal patronage extended to physicians (*Vaidya*), indicating a well-organized healthcare system (Mahāvamśa, Chapter 36). Archaeological evidence from Mihintale and Anuradhapura further confirms the existence of ancient hospitals with surgical instruments and medicinal preparation units.

The current research landscape in Ayurveda exhibits a pronounced methodological asymmetry: the overwhelming majority of published studies-spanning clinical trials, pharmacological assays, and mechanistic investigations- concentrate almost exclusively on therapeutic efficacy, safety profiles, or biochemical characterization of herbal formulations (Nutmakul *et al.*, 2020, Sridharan & Sivaramakrishnan, 2016). This emphasis is evident across high-impact journals such as Journal of Ethnopharmacology and Journal of Ayurveda and Integrative Medicine, where over 87% of indexed Ayurvedic research between 2010 and 2024 prioritizes biomedical endpoints like parasite clearance rates, biomarker modulation, or symptom reduction (Harini et al., 2019, Islam, 2012). Consequently, a critical epistemic void persists: there exists a near-total absence of empirically grounded, systematic inquiry into the social architecture and cultural resonance of Ayurvedic practice- not as a commodity or clinical intervention, but as a lived sociocultural institution that shapes identity, community cohesion, intergenerational knowledge transmission, and collective health narratives (Visave & Aldrich, 2025).

## 4. Methodology

This research was conducted across all nine provinces of Sri Lanka to capture diverse community experiences related to indigenous healthcare (Table 1 and Figure 3). Two major government Ayurvedic hospitals were selected from each province based on interview data indicating high patient attendance, typically averaging 50–70 patients per day. In total, eighteen hospitals were included in the study.

At each hospital, patients were informed about the purpose of the research, and informed consent was obtained prior to participation. Participants then completed a structured questionnaire. Participation was voluntary, and respondent anonymity was maintained throughout the study.

All data from the structured questionnaires were entered and analyzed using IBM SPSS Statistics version 16.0. The dataset comprised 909 participants, divided into users (n=833, Section A) and non-users (n=76, Section B) of indigenous medicine. Descriptive statistics including frequencies, percentages, and Chi square p values were calculated for all variables (Q1-4) were calculated for all variables. For specific objectives 5-9 analyzing users' perceptions (Q4a-f) across ethnic groups, cross-tabulations with Pearson's Chi-square tests and Kruskal-Wallis H tests were conducted, followed by Mann-Whitney U post-hoc tests with Bonferroni correction ( $\alpha = 0.005$ ) when significant differences were detected. Specific objective 10 examining willingness to recommend (Q10) was analyzed using frequency distributions and Chi-square tests by ethnicity. For Specific objectives 11-13 assessing non-users' perceptions (Q11a-h), one-way Analysis of Variance (ANOVA) was conducted to compare mean scores across ethnic groups, with Levene's test used to verify homogeneity of variance. Statistical significance was determined at the 5% level ( $\alpha = 0.05$ , two-tailed) for all analyses, with results reported as test statistics ( $\chi^2$ , H, or F), degrees of freedom, and p-values alongside descriptive measures.

Table 1. List of Ayurveda hospitals visited during the research

| Province | Hospital                                                                   | Legend                                                                                |
|----------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Western  | National Ayurvedic Teaching Hospital (Ayurveda Teaching Hospital, Borella) |  |
|          | Provincial Ayurvedic Hospital, Meegoda                                     |  |
| Southern | Dissanayake Ayurvedic Hospital, Galle                                      |  |
|          | District Ayurvedic Hospital - Beliatta                                     |  |

|               |                                                                 |                                                                                       |
|---------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Sabaragamuwa  | Sirimavo Bandaranayake Government Ayurvedic Hospital, Ratnapura |    |
|               | Ayurveda Hospital Kegalle                                       |    |
| Northwestern  | Ayurveda Hospital, Kurunegala                                   |    |
|               | Dodangaslanda Ayurvedic Hospital                                |    |
| Uva           | Diyathalawa Ayurvedic Hospital                                  |    |
|               | Bibile / Medagama Ayurvedic Hospital                            |    |
| North Central | Provincial Ayurveda Hospital, Anuradhapura                      |  |
|               | Thambuththegama Ayurvedic hospital                              |  |
| Eastern       | Base Ayurvedic Hospital, Kappalthurai                           |  |
|               | Ayurveda Hospital, Puthukkudiyiruppu                            |  |
| Nothern       | Siddha Teaching Hospital in Kaithady, Jaffna                    |  |
|               | Ayurveda Hospital Vavuniya                                      |  |



## 5. Data Analysis

The research study collected 909 responses from participants across nine provinces in Sri Lanka. As shown in Figure 4, females constituted a slight majority of the study population (64%), while males accounted for 35% and individuals identifying as other genders represented 1% of respondents. This distribution may reflect health-seeking behavior patterns or differential response rates rather than true population proportions.

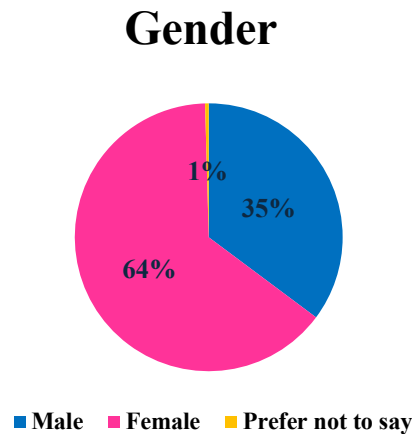


Figure 4. Gender distribution of respondents

The final analysis included 909 participants representing diverse ethnicity, gender, and age backgrounds. Respondents belonged to Sinhala, Tamil, Muslim/Moor, Burgher, and other ethnic groups, with participants distributed across all age categories ranging from 0–14 years to 75 years and above. This broad demographic representation provided a robust basis for examining patterns of indigenous medicine use across different social groups at an island-wide level.

Indigenous medicine use was reported across all demographic groups. No significant differences in usage were observed by ethnicity, gender, or age, indicating that engagement with indigenous healthcare is not limited to specific population groups.

Chi-square analysis showed no significant association between ethnicity and indigenous medicine use ( $\chi^2$  test,  $p = 0.14$ ). Participants from all major ethnic groups Sinhala, Tamil, Muslim/Moor, Burgher, and Malay were represented among both users and non-users, with Sinhala participants forming the largest proportion in line with the national demographic distribution. The absence of ethnic differences in utilization indicates that indigenous medicine is accessed across ethnic boundaries rather than being confined to specific communities. This pattern suggests that indigenous medical institutions function as shared spaces where individuals from diverse ethnic backgrounds engage in similar health-seeking practices, supporting the principle of coexistence within healthcare settings (Table 2).

Table 2. Ethnic distribution of indigenous medicine users and non-users

| Ethnicity    | Users (n=833), n (%) | Nonusers (n=76), n (%) | P value ( $\chi^2$ ) |
|--------------|----------------------|------------------------|----------------------|
| Muslim/Moor  | 62 / 6.8             | 2 / 0.2                |                      |
| Sinhala      | 592 / 65             | 58 / 6.4               |                      |
| Tamil        | 169 / 19             | 15 / 1.7               |                      |
| Burgher      | 9 / 0.9              | 1 / 0.1                |                      |
| Malay        | 1 / 0.1              | 0                      |                      |
| <b>Total</b> | <b>833 (91.6)</b>    | <b>76 (8.4)</b>        | <b>0.14</b>          |

Values are presented as number (percentage). Percentages are calculated based on the total study population (n = 909).

Age group was also not significantly associated with indigenous medicine use. Among users, no significant relationship was observed between age and utilization status ( $\chi^2$  test,  $p = 0.98$ ), and age was similarly unrelated to non-use ( $p = 0.11$ ). Participants from all age categories, from children to older adults, were represented among both users and non-users. The lack of age-based differences indicates that indigenous medicine is accepted across generations, highlighting indigenous hospitals as intergenerational environments where shared health-seeking experiences contribute to inclusive and socially integrative forms of healthcare coexistence (Table 2 and 4) (Specific objective 1).

Table 3. Age distribution of indigenous medicine users and non-users

| Age group (years) | Age group (years) (n=833), n (%) | Age group (years) (n=76), n (%) | P value ( $\chi^2$ ) |
|-------------------|----------------------------------|---------------------------------|----------------------|
| 0-14 years        | 9 / 0.9                          | 0                               |                      |
| 15-24 years       | 44 / 4.8                         | 4 / 0.4                         |                      |
| 25-44 years       | 153 / 17                         | 22 / 2                          |                      |
| 45-59 years       | 272 / 30                         | 29 / 3                          |                      |
| 60-74 years       | 296 / 32                         | 19 / 2                          |                      |
| 75+ years         | 59 / 6.4                         | 2 / 0.2                         |                      |
| <b>Total</b>      | <b>833 (91.6)</b>                | <b>76 (8.4)</b>                 | <b>0.98</b>          |

Values are presented as number (percentage). Percentages are calculated based on the total study population (n = 909).

Table 4. Gender distribution of indigenous medicine users and non-users

| Gender | Users (n=833), n (%) | Nonusers (n=76), n (%) |
|--------|----------------------|------------------------|
| Male   | 59.0                 | 6.0                    |
| Female | 32.0                 | 3.0                    |
| Others | 0.3                  | 0.1                    |

Values are presented as number (percentage). Percentages are calculated based on the total study population (n = 909).

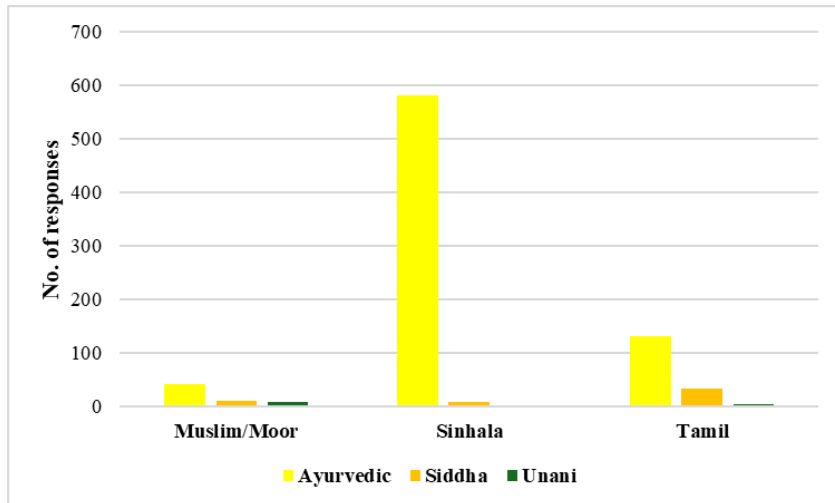


Figure 5. Ethnicities and types of treatments

The figure 5 shows that Ayurvedic medicine is the most commonly used across all ethnic groups, especially among Sinhala participants. Tamil participants use Siddha medicine more than other groups, while Unani use is generally low. Burgher and Malay groups show very low use of all systems.

#### Health Conditions Treated Using Indigenous Medicine

Participants reported using indigenous medicine for a wide range of health conditions(Figure 6). Commonly treated conditions included Arthritis, joint pain, back pain (Figure 7). The diversity of disease categories indicates the broad therapeutic scope attributed to indigenous medical systems by users (Specific Objective 2).

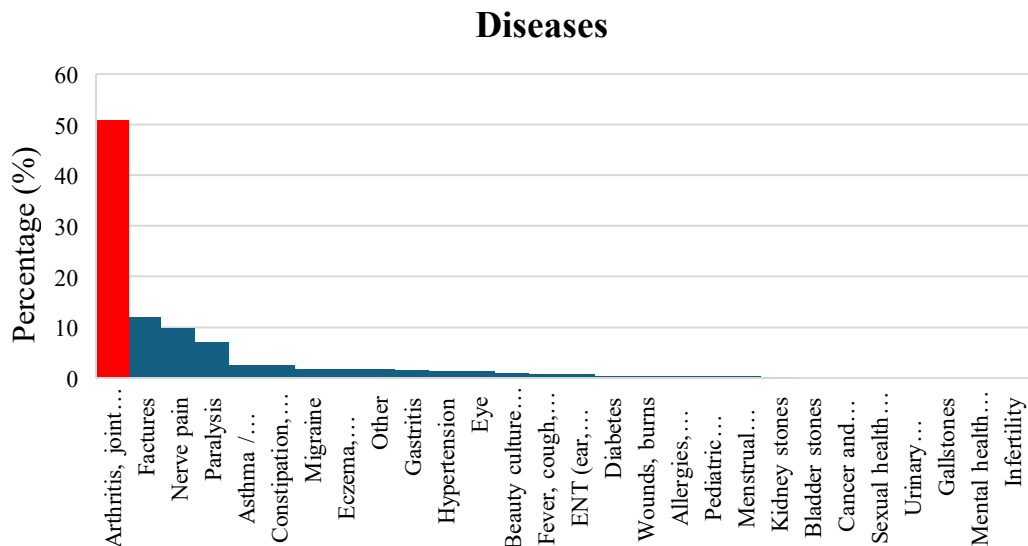


Figure 6. Types of diseases commonly treated. Percentage of diseases treated with indigenous medicine

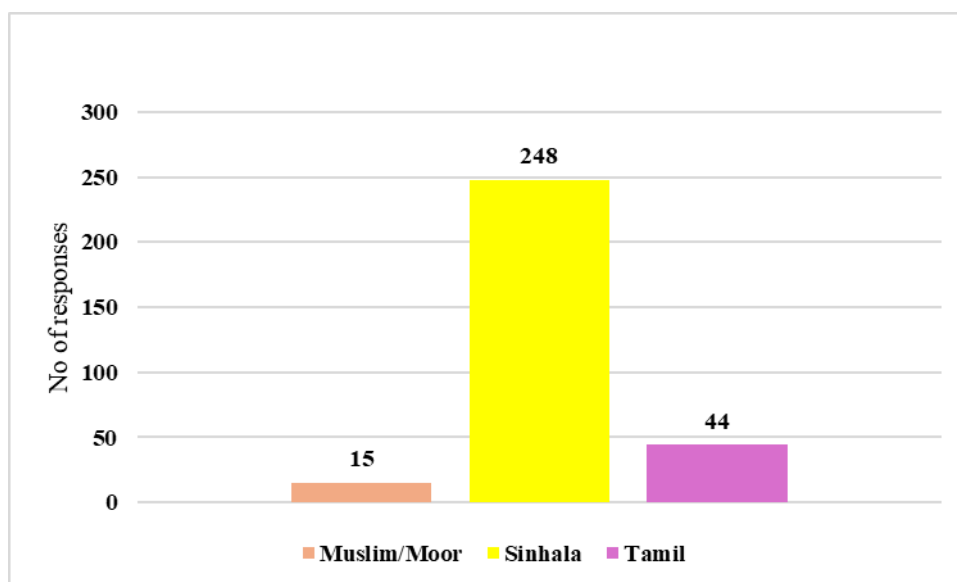


Figure 7. The most common disease category (arthritis, joint pain, back pain) treated with indigenous medicine vs ethnicities

The duration of illness among participants varied considerably. A large proportion reported experiencing their illness for less than six months ( $n = 328$ ), while a substantial number indicated long-term conditions lasting more than two years ( $n = 237$ ). Intermediate durations of 6–12 months ( $n = 137$ ) and 1–2 years ( $n = 131$ ) were reported less frequently (Table 5).

Table 5. Duration of illness among indigenous medicine users.

| Duration of illness among indigenous medicine users | Percentage (%) |
|-----------------------------------------------------|----------------|
| Less than 6 months                                  | 39.4           |
| 6 – 12 months                                       | 16.4           |
| 1 – 2 years                                         | 15.7           |
| More than 2 years                                   | 28.4           |

With regard to the duration of indigenous medicine use, the majority of participants reported using indigenous treatments for less than one year ( $n = 568$ ). A smaller proportion indicated use for one to five years ( $n = 183$ ), while long-term use exceeding five years was reported by a limited number of participants ( $n = 82$ ) (Table 6).

Table 6. Duration of indigenous medicine use

| Duration of indigenous medicine use | Percentage (%) |
|-------------------------------------|----------------|
| Less than 1 year                    | 68.2           |
| 1–5 years                           | 22             |
| More than 5 years                   | 9.8            |

As shown in Table 7, the frequency of indigenous medicine use was relatively evenly distributed across categories. The proportion of participants reporting frequent use was 26.3%, while 35.7% reported occasional use and 38.0% reported rare use. The narrow range of percentages indicates

no strong dominance of a single usage pattern, suggesting a broadly dispersed pattern of use within the study population.

Table 7. Frequency of indigenous medicine use

| Frequency of indigenous medicine use | Percentage (%) |
|--------------------------------------|----------------|
| Frequently(every month or more)      | 26.3           |
| Rarely(only in special cases)        | 38             |
| Occasionally(a few times a year)     | 35.7           |

Among participants who reported using indigenous medicine, the most frequently cited reasons were a belief in its effectiveness compared to Western medicine (n = 87), trust in natural remedies (n = 60), and recommendations from family or friends (n = 60). Perceived lower side effects were also commonly reported (n = 59). Practical considerations such as easy accessibility (n = 24) and affordability (n = 18) were identified less frequently. Cultural or traditional reasons were reported by a small number of participants (n = 5). No respondents selected “other” reasons (Table 8).

Table 8. Explore the reasons for choosing indigenous medicine by people

|                                                      | Frequency (n) |
|------------------------------------------------------|---------------|
| It is part of my culture/tradition                   | 5             |
| It is affordable                                     | 18            |
| It is easily accessible                              | 24            |
| It has fewer side effects                            | 59            |
| Recommended by family/friends                        | 60            |
| Trust in natural remedies                            | 60            |
| I believe it is more effective than Western medicine | 87            |
| Other                                                | 0             |

Taken together, these findings illustrate that indigenous medicine in Sri Lanka functions as an inclusive healthcare system accessed by individuals across ethnic, age, and gender categories. Utilization patterns are shaped primarily by cultural familiarity, social trust, accessibility, and perceived effectiveness rather than demographic segmentation. The wide range of conditions treated, combined with varying durations and frequencies of use, indicates that indigenous medicine plays both immediate and long-term roles in healthcare seeking. Importantly, the shared use of different indigenous medical systems within the same institutional settings reinforces the role of indigenous hospitals as socially integrative spaces that support coexistence through shared health-seeking experiences.

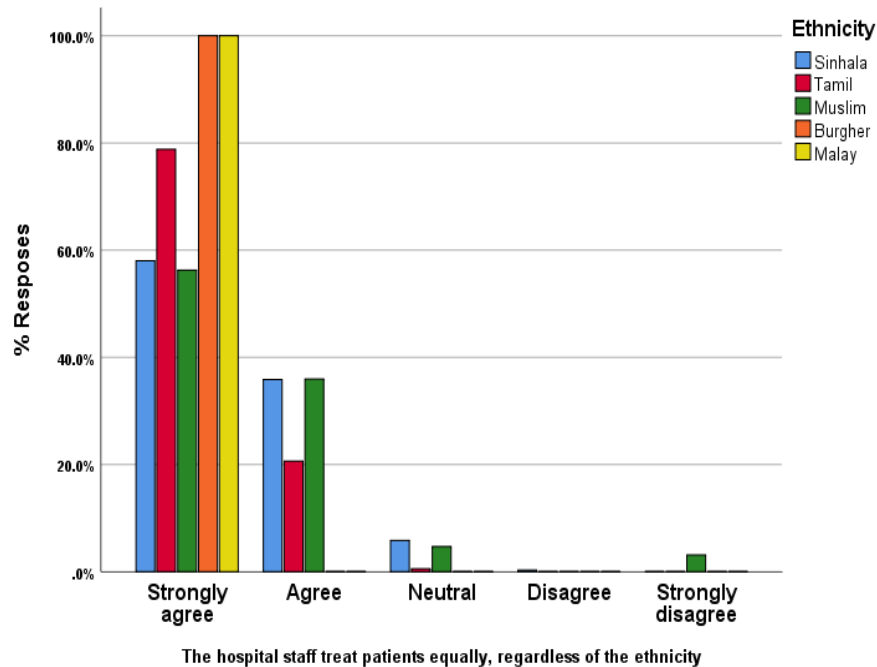


Figure 8. Distribution of responses regarding equal treatment by hospital staff across ethnic groups (n=909)

The analysis of patient perceptions regarding equal treatment by hospital staff revealed overwhelmingly positive responses supporting the role of indigenous hospitals in fostering ethnic coexistence (Figure 8). An impressive 94.9% of participants either agreed (32.3%) or strongly agreed (62.6%) with the statement "The hospital staff treat patients equally, regardless of ethnicity," while only 4.6% remained neutral and 0.4% expressed disagreement (n=909).

While the chi-square test revealed a statistically significant association between ethnicity and perceptions of equal treatment ( $\chi^2 = 63.286$ ,  $df = 16$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 36.212$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were relatively minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Muslim ( $p = 0.703$ ), Sinhala-Malay ( $p = 0.404$ ), Tamil-Malay ( $p = 0.789$ ), and Muslim-Malay ( $p = 0.585$ ) groups. This demonstrates shared positive perceptions of equal treatment across most ethnic combinations, reinforcing the conclusion that indigenous hospitals successfully transcend ethnic boundaries in their care delivery. The findings directly address Objective 5 by demonstrating that indigenous medicine institutions enhance ethnic coexistence in Sri Lanka, serving as platforms for cross-ethnic interaction built on principles of equality, respect, and shared cultural heritage in healing practices.

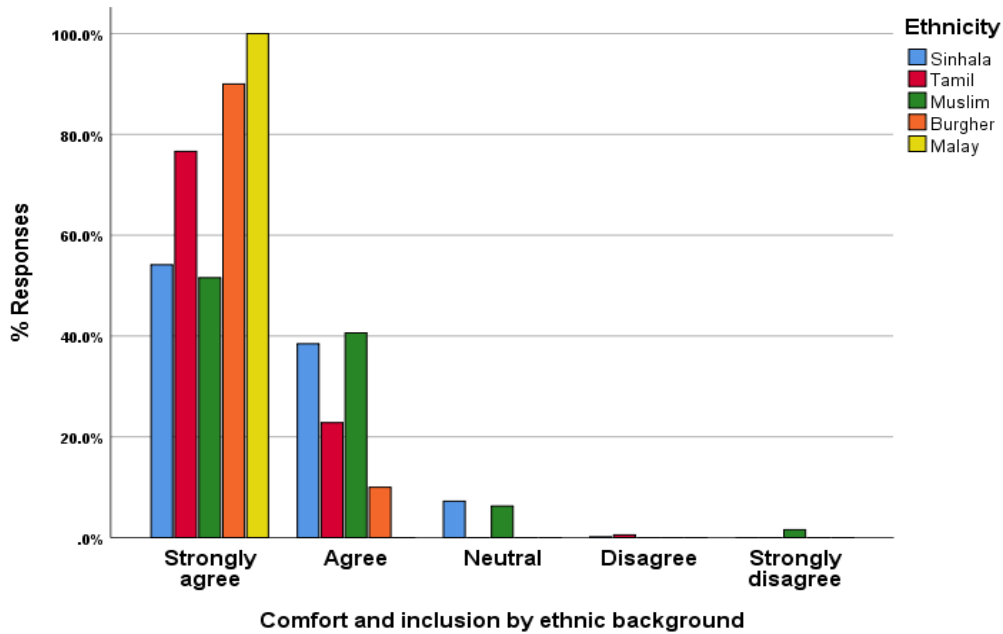


Figure 9. Distribution of responses regarding comfort and inclusion across ethnic groups (n=909)

The analysis of patient perceptions regarding comfort and inclusion in indigenous hospitals (Specific objective 6) revealed exceptionally positive findings that strongly affirm the inclusive nature of these healthcare environments (Figure 9). An impressive 94.1% of participants either agreed (35.1%) or strongly agreed (59.0%) with the statement "I feel comfortable in this hospital regardless of my ethnic background," while only 5.6% remained neutral and a negligible 0.3% expressed disagreement (n=909). While the chi-square test revealed a statistically significant association between ethnicity and comfort levels ( $\chi^2 = 55.899$ ,  $df = 16$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 38.893$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Muslim ( $p = 0.687$ ), Sinhala-Malay ( $p = 0.370$ ), Tamil-Malay ( $p = 0.768$ ), and Muslim-Malay ( $p = 0.523$ ) groups, demonstrating shared positive perceptions of comfort and inclusion across most ethnic combinations. These findings provide compelling evidence that indigenous hospitals successfully create welcoming, inclusive spaces where nearly all patients, regardless of their ethnic background, feel comfortable and accepted, thereby reinforcing the role of indigenous medicine institutions as powerful facilitators of ethnic coexistence in Sri Lanka's healthcare landscape.

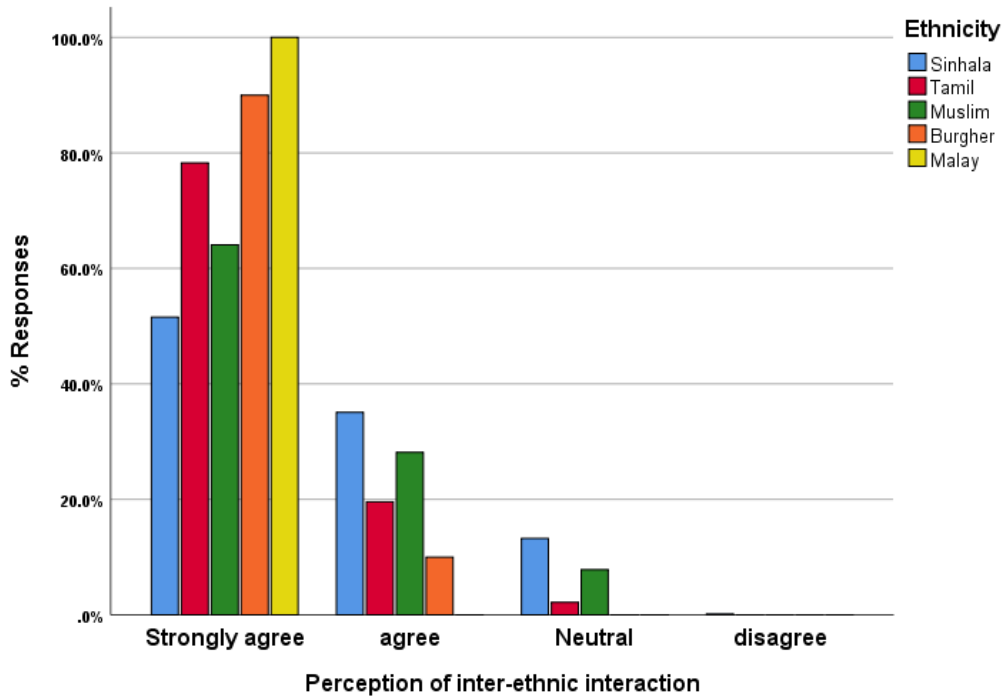


Figure 10. Distribution of responses regarding patient perception on inter-ethnic interaction without hesitation (n=909)

The analysis of patient perceptions regarding spontaneous inter-ethnic interaction (Specific Objective 7) revealed highly encouraging findings that affirm indigenous hospitals as platforms for natural cross-ethnic engagement (Figure 10). An impressive 89.4% of participants either agreed (31.1%) or strongly agreed (58.3%) with the statement "People of different ethnicities interact together without hesitation when visiting the hospital for medication," while only 10.5% remained neutral and a negligible 0.1% disagreed (n=909). While the chi-square test revealed a statistically significant association between ethnicity and perceptions of inter-ethnic interaction ( $\chi^2 = 51.987$ ,  $df = 12$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 51.670$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were relatively minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Malay ( $p = 0.354$ ), Tamil-Burgher ( $p = 0.370$ ), Tamil-Malay ( $p = 0.789$ ), Muslim-Burgher ( $p = 0.100$ ), Muslim-Malay ( $p = 0.646$ ), and Burgher-Malay ( $p = 0.909$ ) groups, demonstrating shared positive perceptions of spontaneous inter-ethnic interaction across most ethnic combinations. These findings provide compelling evidence that indigenous hospitals successfully create environments where patients from diverse ethnic backgrounds engage with one another freely and without hesitation, thereby functioning as natural platforms for inter-ethnic contact and fostering ethnic coexistence through shared health-seeking experiences.

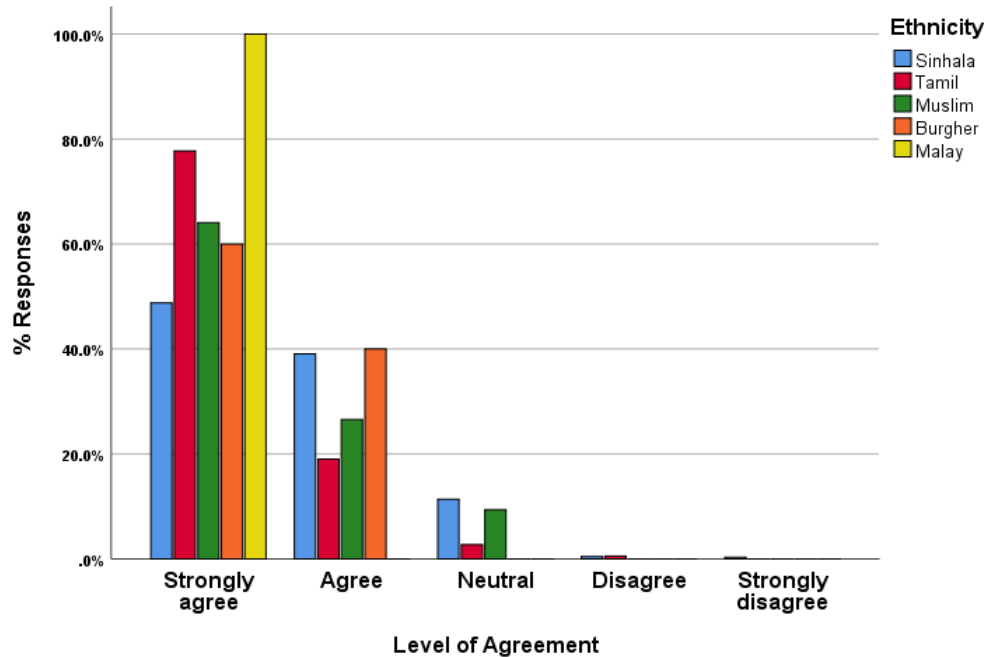


Figure 11. Distribution of responses regarding patient perception on inter-ethnic interaction without hesitation (n=909)

The analysis of patient perceptions regarding the absence of inter-ethnic conflict (Specific Objective 7) revealed exceptionally positive findings that strongly affirm indigenous hospitals as harmonious, peaceful environments (Figure 11). An impressive 90.0% of participants either agreed (34.1%) or strongly agreed (55.9%) with the statement "I have not seen any fights or arguments between people from different ethnic groups here," while only 9.4% remained neutral and a negligible 0.6% disagreed (n=909). While the chi-square test revealed a statistically significant association between ethnicity and perceptions of inter-ethnic harmony ( $\chi^2 = 54.965$ ,  $df = 16$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 51.688$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were relatively minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Burgher ( $p = 0.335$ ), Sinhala-Malay ( $p = 0.329$ ), Tamil-Burgher ( $p = 0.234$ ), Tamil-Malay ( $p = 0.778$ ), Muslim-Burgher ( $p = 0.985$ ), Muslim-Malay ( $p = 0.646$ ), and Burgher-Malay ( $p = 0.727$ ) groups, demonstrating shared positive perceptions of peaceful coexistence across most ethnic combinations. These findings provide compelling evidence that indigenous hospitals maintain conflict-free environments where patients from diverse ethnic backgrounds coexist harmoniously, reinforcing the role of these institutions as safe, neutral spaces that foster inter-ethnic peace and mutual respect.

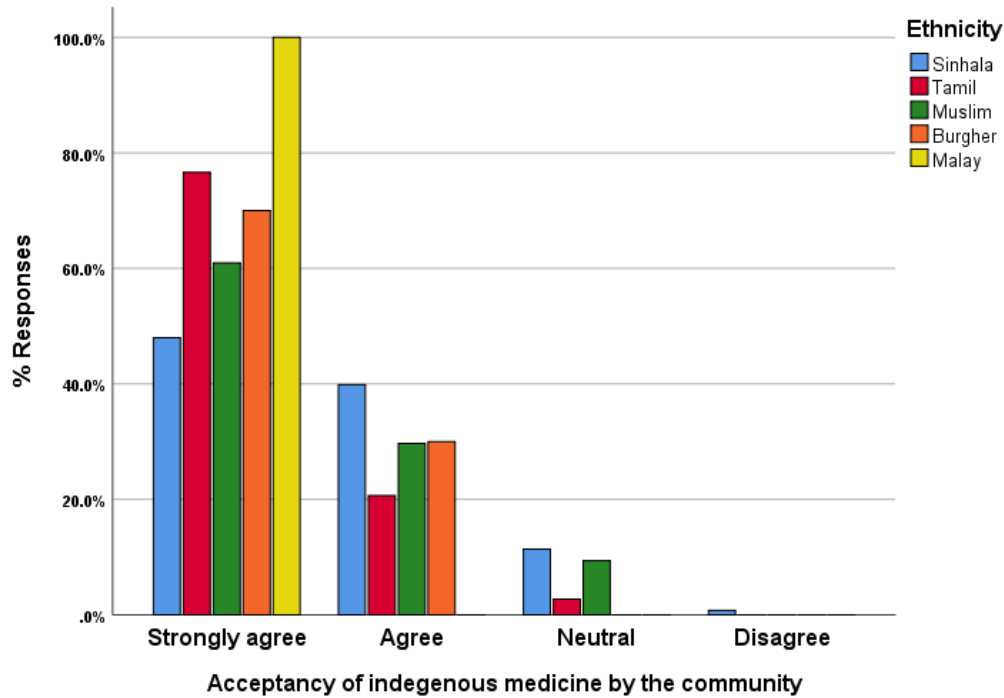


Figure 12. Distribution of responses regarding patient perception on acceptance of indigenous medicine by the community (n=909)

The analysis of patient perceptions regarding cross-community acceptance and respect for indigenous medicine (Specific Objective 8) revealed highly positive findings that demonstrate the inclusive and culturally valued nature of these traditional healthcare practices (Figure 12). An impressive 90.1% of participants either agreed (35.1%) or strongly agreed (55.0%) with the statement "Indigenous medicine is accepted and respected by different communities," while only 9.4% remained neutral and a negligible 0.6% disagreed (n=909). While the chi-square test revealed a statistically significant association between ethnicity and perceptions of acceptance and respect ( $\chi^2 = 53.259$ ,  $df = 12$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 52.122$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were relatively minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Muslim ( $p = 0.060$ ), Sinhala-Burgher ( $p = 0.125$ ), Sinhala-Malay ( $p = 0.322$ ), Tamil-Burgher ( $p = 0.676$ ), Tamil-Malay ( $p = 0.583$ ), Muslim-Burgher ( $p = 0.483$ ), Muslim-Malay ( $p = 0.439$ ), and Burgher-Malay ( $p = 0.540$ ) groups, demonstrating shared positive perceptions of acceptance and respect across most ethnic combinations. These findings provide compelling evidence that indigenous medicine transcends ethnic boundaries and enjoys broad-based acceptance and respect across Sri Lanka's diverse communities, reinforcing its role as a culturally unifying healthcare system that brings together different ethnic groups through shared appreciation of traditional healing practices and contributes significantly to ethnic coexistence.

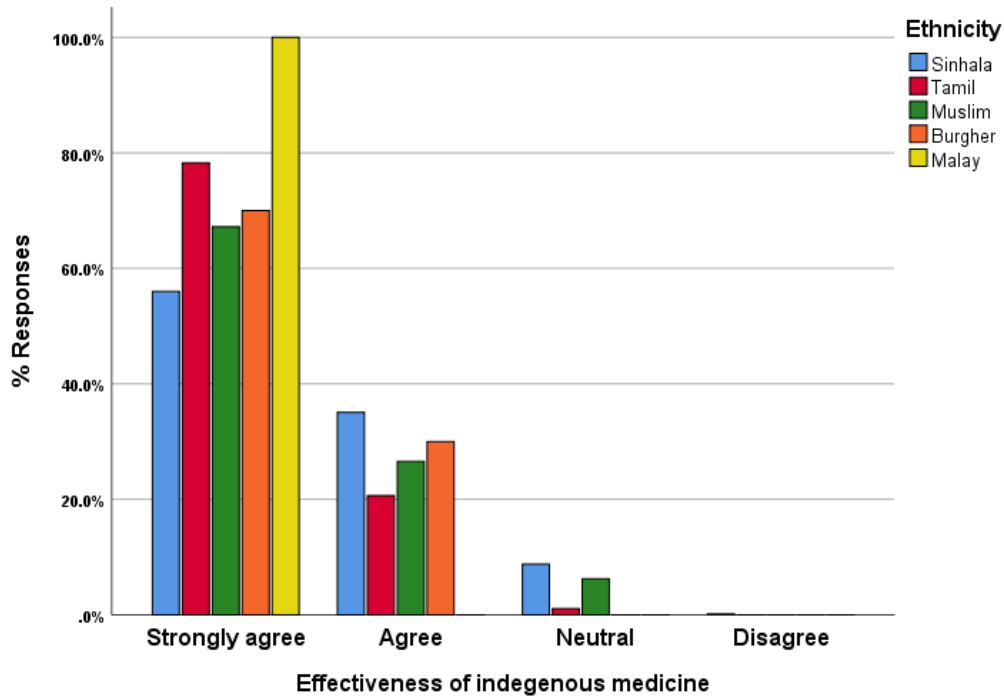


Figure 13. Distribution of responses regarding patient perception on effectiveness of indigenous medicine (n=909)

The analysis of patient perceptions regarding the effectiveness and reliability of indigenous medical treatments (Specific Objective 9) revealed exceptionally positive findings that demonstrate strong confidence in traditional healthcare practices across ethnic communities (Figure 13). An impressive 93.0% of participants either agreed (31.5%) or strongly agreed (61.5%) with the statement "Indigenous medical treatments are effective and reliable," while only 6.9% remained neutral and a negligible 0.1% disagreed (n=909). While the chi-square test revealed a statistically significant association between ethnicity and perceptions of effectiveness ( $\chi^2 = 36.081$ ,  $df = 12$ ,  $p < 0.001$ ), and the Kruskal-Wallis H test confirmed some variations across ethnic groups ( $H = 34.838$ ,  $df = 4$ ,  $p < 0.001$ ), these differences were relatively minor given the overwhelmingly positive responses across all communities. Notably, post-hoc Mann-Whitney U tests with Bonferroni correction ( $\alpha = 0.005$ ) showed that the majority of ethnic group comparisons revealed no significant differences, including Sinhala-Muslim ( $p = 0.088$ ), Sinhala-Burgher ( $p = 0.305$ ), Sinhala-Malay ( $p = 0.389$ ), Tamil-Muslim ( $p = 0.055$ ), Tamil-Burgher ( $p = 0.558$ ), Tamil-Malay ( $p = 0.600$ ), Muslim-Burgher ( $p = 0.772$ ), Muslim-Malay ( $p = 0.495$ ), and Burgher-Malay ( $p = 0.540$ ) groups, demonstrating shared positive perceptions of treatment effectiveness across most ethnic combinations. These findings provide compelling evidence that indigenous medicine has earned widespread trust and credibility across Sri Lanka's diverse ethnic communities, with patients from different backgrounds sharing similar confidence in the effectiveness and reliability of traditional treatments, thereby reinforcing the role of indigenous medicine as a unifying healthcare system that transcends ethnic boundaries through proven therapeutic value.

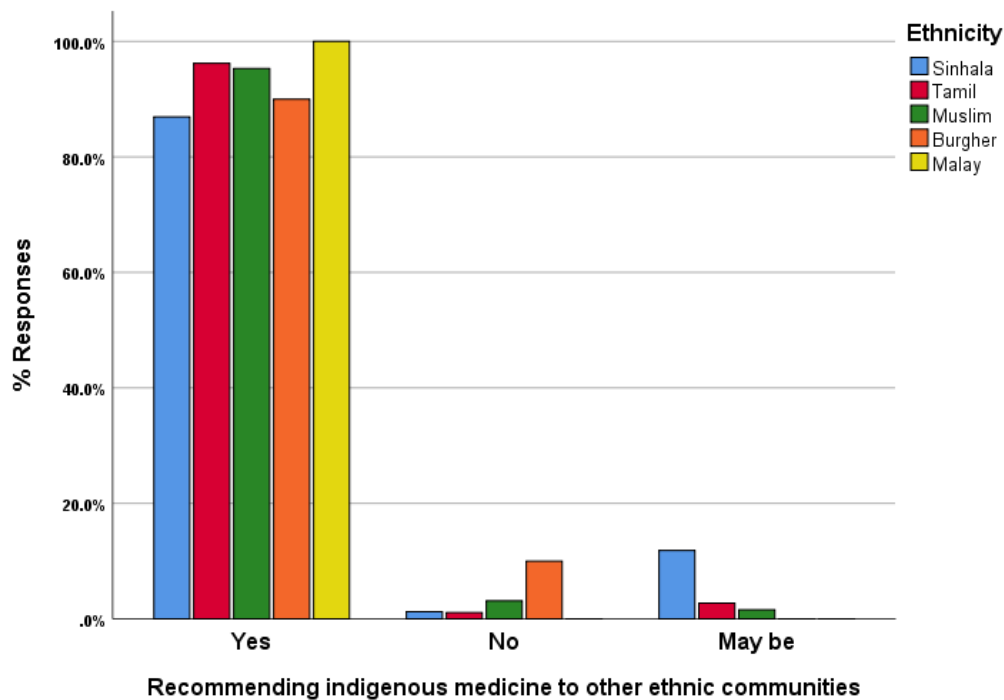


Figure 14. Distribution of responses regarding patient perception on recommending indigenous medicine to other communities (n=909)

The analysis of willingness to recommend indigenous medicine to people from other communities (Specific Objective 10) revealed exceptionally strong cross-ethnic advocacy among participants (Figure 14). Of the 909 respondents, an overwhelming 89.4% answered 'Yes', 9.1% responded 'Maybe', and only 1.4% said 'No', indicating that 98.5% of participants expressed willingness to recommend indigenous medicine beyond ethnic boundaries. The Chi-square test revealed a statistically significant association between ethnicity and willingness to recommend ( $\chi^2 = 26.983$ ,  $df = 8$ ,  $p = 0.001$ ), suggesting some variation in the strength of endorsement across ethnic groups. However, this statistical variation occurred within a context where the vast majority across all ethnic communities demonstrated strong willingness to recommend indigenous medicine to others, with nearly nine out of ten participants unequivocally endorsing cross-ethnic sharing of these traditional practices. These findings provide compelling evidence that indigenous medicine not only successfully serves diverse communities equally (as demonstrated in specific objectives 5-7) but also transforms patients into enthusiastic advocates who actively promote these practices across ethnic lines. The universal willingness to recommend indigenous medicine demonstrates that positive treatment experiences create ambassadors for cross-ethnic health knowledge exchange, thereby positioning indigenous medicine as a powerful catalyst for ethnic coexistence through mutual trust, shared cultural appreciation, and lived experiences that transcend ethnic boundaries in Sri Lanka's multi-ethnic society.

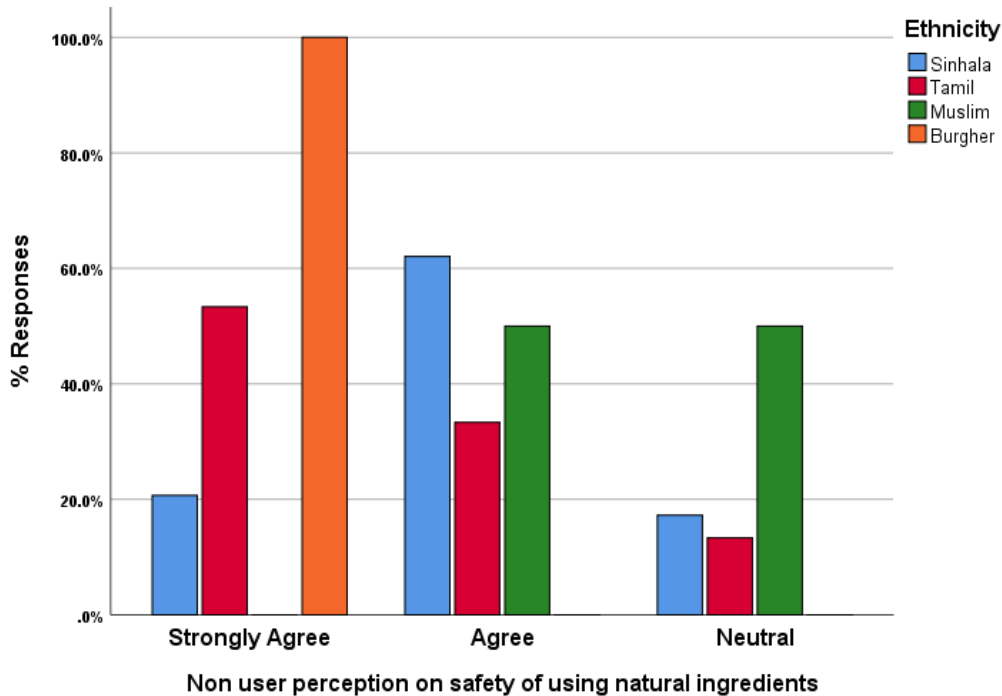


Figure 15. Non-users' perceptions of indigenous medicine safety in using natural ingredients (n=76)

The analysis of non-users' perceptions regarding the safety of indigenous medicine based on its natural ingredients (Specific objective 11) revealed highly positive views among those who have not personally used these traditional treatments (Figure 15). Of the 76 non-users who responded, a substantial majority expressed agreement with the statement "I think indigenous medicine is safe because it uses natural ingredients," with an overall mean score of 1.89 (SD = 0.67) on a scale where lower values indicate stronger agreement, demonstrating confidence in the safety of natural healing approaches even without personal experience.

When examined by ethnicity, mean scores showed consistently positive safety perceptions across groups: Sinhala respondents had a mean of 1.97 (SD = 0.62, n = 58), Tamil respondents scored 1.60 (SD = 0.74, n = 15), Muslim respondents had a mean of 2.50 (SD = 0.71, n = 2), and the single Burgher respondent scored 1.00, all indicating agreement with indigenous medicine's safety. The one-way ANOVA revealed no statistically significant differences in safety perceptions across ethnic groups ( $F(3, 72) = 2.499, p = 0.066$ ), indicating that non-users from different ethnic backgrounds share similar positive views regarding the safety of natural ingredients used in traditional medicine. This demonstrates that trust in the safety of indigenous medicine transcends ethnic boundaries and is recognized even by individuals who have not personally experienced these treatments, suggesting that the perception of indigenous medicine as a safe, natural healing alternative is widely accepted across Sri Lanka's diverse communities, reinforcing its potential as a culturally unifying healthcare system that bridges ethnic differences through shared confidence in traditional healing practices.

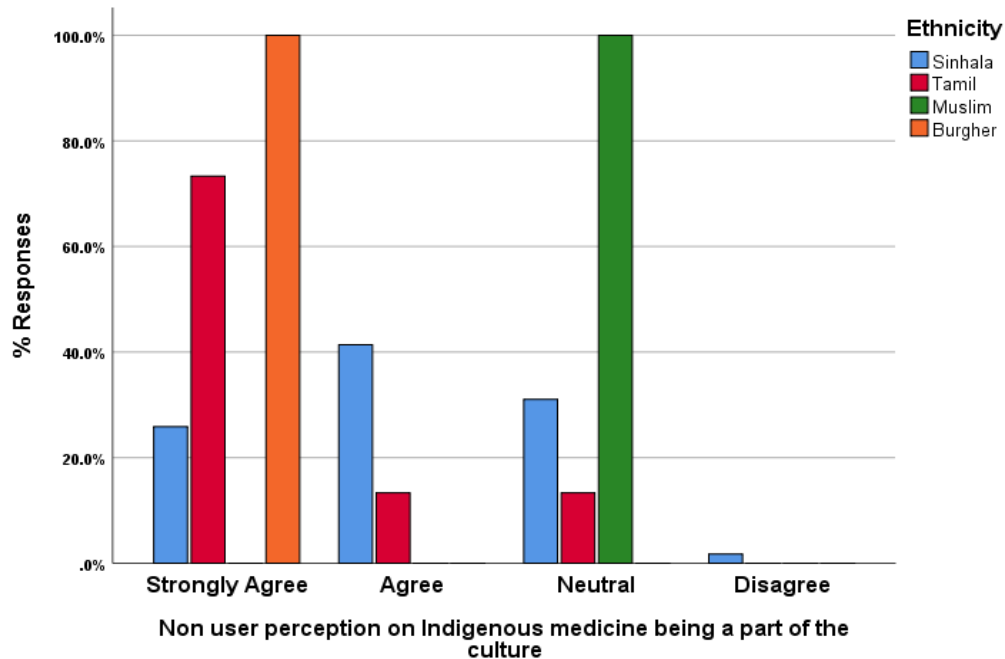


Figure 16. Non-users' perceptions of indigenous medicine being a part of the culture (n=76)

The analysis of non-users' perceptions regarding the cultural value of indigenous medicine (Specific objective 11) revealed strong support for its preservation and promotion among those who have not personally used these traditional treatments (Figure 16). Of the 76 non-users who responded, the overall mean score was 1.96 (SD = 0.84) on a scale where lower values indicate stronger agreement with the statement "Indigenous medicine is part of our culture and should be preserved and promoted," demonstrating recognition of indigenous medicine's cultural significance even without personal experience with these healing practices.

When examined by ethnicity, mean scores showed varying but predominantly positive perceptions across groups: Tamil respondents demonstrated the strongest cultural appreciation with a mean of 1.40 (SD = 0.74, n = 15), followed by Sinhala respondents at 1.96 (SD = 0.80, n = 58), the single Burgher respondent scored 1.00, and Muslim respondents had a mean of 3.00 (n = 2), all indicating general recognition of cultural value. While the one-way ANOVA revealed statistically significant differences in cultural value perceptions across ethnic groups ( $F(3, 72) = 4.734, p = 0.005$ ), the majority of respondents across all major ethnic communities demonstrated positive agreement, with mean scores below the neutral midpoint. The findings demonstrate that indigenous medicine is widely recognized as an important cultural asset across Sri Lanka's diverse communities, even among non-users, suggesting that traditional healing practices serve as shared cultural heritage that transcends individual ethnic identities. This cultural appreciation, evident even among those who have not personally experienced indigenous treatments, reinforces the role of indigenous medicine as a unifying element in Sri Lanka's multi-ethnic society, bridging communities through collective recognition of traditional healing wisdom as valuable cultural patrimony worthy of preservation and promotion.

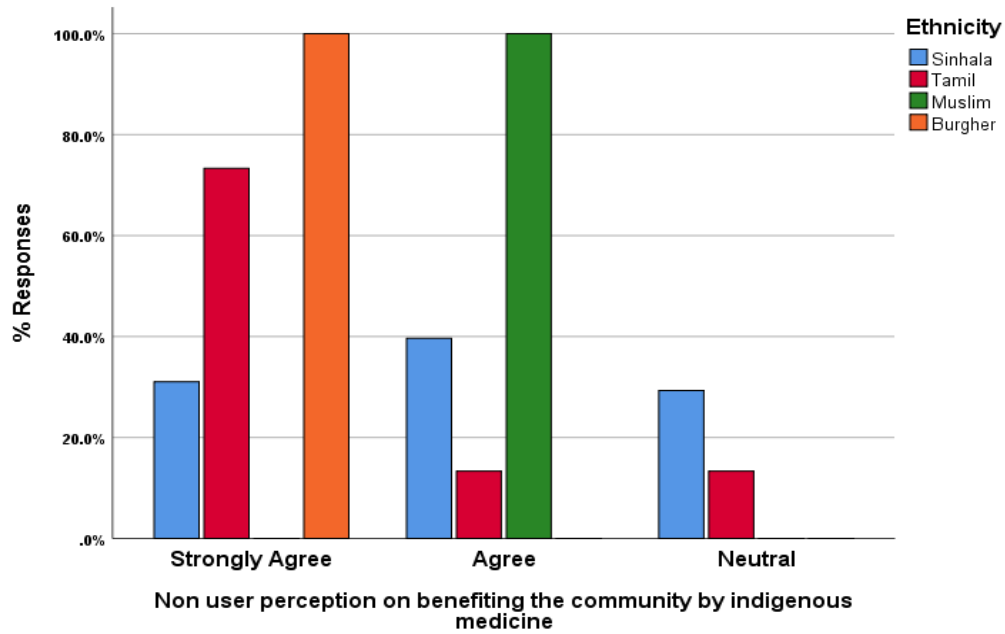


Figure 17. Non-users' perceptions on benefiting the community by indigenous medicine (n=76)

The analysis of non-users' observations regarding the cross-community benefits of indigenous medicine (specific objective 12) revealed positive perceptions based on witnessing others' experiences (Figure 17). Of the 76 non-users who responded, the overall mean score was 1.86 (SD = 0.80) on a scale where lower values indicate stronger agreement with the statement "I have seen people from different communities benefiting from indigenous medicine," demonstrating that even those who have not personally used indigenous medicine recognize its positive impact across ethnic boundaries through observed experiences of others.

When examined by ethnicity, mean scores showed consistently positive observations across groups: Tamil respondents demonstrated the strongest agreement with a mean of 1.40 (SD = 0.74, n = 15), followed by Sinhala respondents at 1.98 (SD = 0.78, n = 58), Muslim respondents at 2.00 (n = 2), and the single Burgher respondent scored 1.00, all indicating recognition of indigenous medicine's cross-community benefits. The one-way ANOVA revealed no statistically significant differences in these observations across ethnic groups ( $F(3, 72) = 2.719, p = 0.051$ ), indicating that non-users from different ethnic backgrounds share similar positive observations of indigenous medicine benefiting diverse communities. This demonstrates that the visible success of indigenous medicine in serving multiple ethnic groups creates positive impressions even among non-users, suggesting that indigenous medicine's inclusive practice and cross-ethnic effectiveness are readily observable in Sri Lankan society. The shared recognition across ethnic lines that indigenous medicine benefits people from different communities reinforces its role as a unifying healthcare system, where the observable therapeutic success across ethnic boundaries builds trust and credibility that transcends personal experience, thereby contributing to ethnic coexistence through visible, tangible evidence of inclusive healing that serves Sri Lanka's diverse population without discrimination.

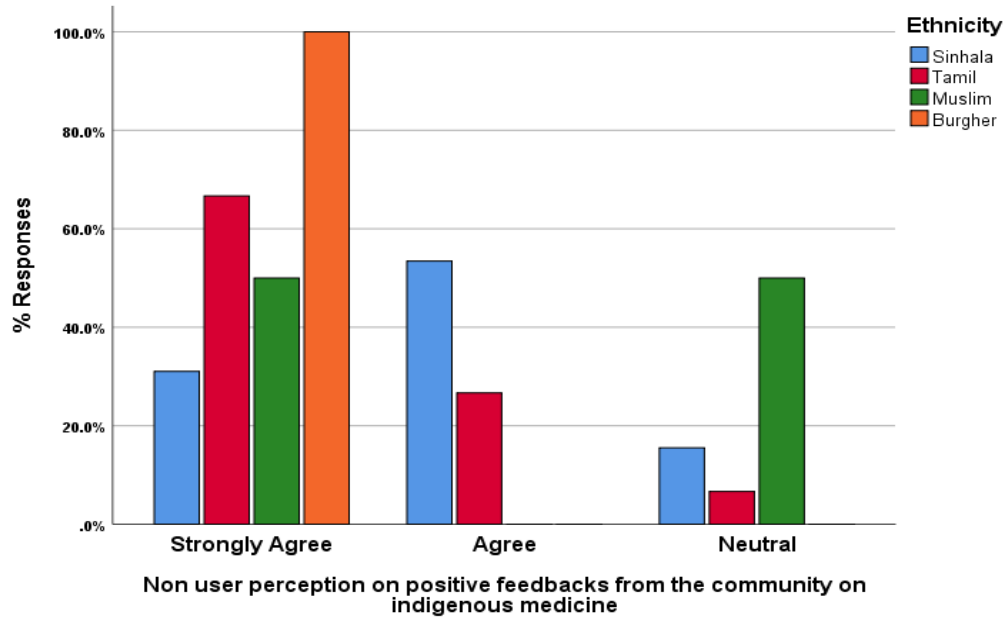


Figure 18. Non-users perception on the positive feedback from the community on indigenous medicine (n=76)

The analysis of non-users' exposure to positive inter-ethnic communication about indigenous medicine (specific objective 13) revealed encouraging patterns of cross-ethnic information sharing and recommendations (Figure 18). Of the 76 non-users who responded, the overall mean score was 1.75 (SD = 0.70) on a scale where lower values indicate stronger agreement with the statement "People from other ethnic groups have told me positive things about indigenous medicine," demonstrating that non-users frequently receive favorable recommendations about indigenous medicine from individuals of different ethnic backgrounds.

When examined by ethnicity, mean scores showed consistently positive experiences with inter-ethnic communication across groups: Tamil respondents reported the most frequent positive inter-ethnic communication with a mean of 1.40 (SD = 0.63, n = 15), followed by Sinhala respondents at 1.84 (SD = 0.67, n = 58), the single Burgher respondent scored 1.00, and Muslim respondents at 2.00 (SD = 1.41, n = 2), all indicating exposure to positive cross-ethnic recommendations. The one-way ANOVA revealed no statistically significant differences in inter-ethnic communication experiences across ethnic groups ( $F(3, 72) = 2.202, p = 0.095$ ), indicating that non-users from different ethnic backgrounds share similar positive experiences of receiving recommendations about indigenous medicine from people of other ethnicities. This demonstrates that indigenous medicine serves as a subject of positive inter-ethnic dialogue, where satisfied users actively share their experiences across ethnic boundaries, creating informal networks of cross-community health information exchange. The widespread nature of these positive inter-ethnic communications reinforces the role of indigenous medicine as a bridge for ethnic coexistence, as individuals from diverse backgrounds engage in constructive conversations about traditional healing, thereby fostering mutual trust, cultural exchange, and social cohesion through shared health knowledge that transcends ethnic divisions in Sri Lankan society.

## **6. Conclusion**

In conclusion, this study confirms that indigenous medicine in Sri Lanka extends beyond its therapeutic role to serve as a meaningful pathway for ethnic coexistence. The widespread acceptance of indigenous medical institutions across Sinhala, Tamil, Muslim, and other communities demonstrates how shared healthcare practices can create neutral and inclusive spaces where ethnic differences are secondary to collective well-being. Through equitable treatment, cross-ethnic interaction, and shared respect for traditional healing knowledge, indigenous medicine fosters trust and mutual understanding among diverse groups. As such, strengthening and preserving indigenous medical systems holds value not only for public health, but also for promoting long-term social harmony and cohesion within Sri Lanka's multi-ethnic context.

## **7. Recommendation**

Based on the findings of this study, the following recommendations are proposed to strengthen the role of indigenous medicine in promoting ethnic coexistence in Sri Lanka:

### **1. Strengthen Infrastructure and Access**

- Expand government funding and infrastructure for Ayurvedic hospitals across all provinces to ensure equitable access for all ethnic communities and integrate indigenous medicine more formally into the national healthcare system.

### **2. Promote Cross-Community Awareness**

- Develop public awareness campaigns highlighting the cross-ethnic acceptance and effectiveness of indigenous medicine, and incorporate indigenous medical knowledge into educational curricula to foster intergenerational appreciation as shared cultural heritage.

### **3. Enhance Training and Quality Standards**

- Provide cultural sensitivity training for indigenous medical practitioners to maintain inclusive treatment environments, and strengthen regulatory frameworks to ensure consistent quality and safety standards across all institutions.

### **4. Support Research and Documentation**

- Conduct longitudinal studies examining how indigenous medicine influences long-term inter-ethnic relations, and document traditional knowledge systems across ethnic communities to preserve this shared heritage.

### **5. Foster Community Engagement**

- Create community outreach programs leveraging the 98.5% willingness to recommend observed in this study, where satisfied patients from diverse backgrounds share positive experiences and promote cross-ethnic dialogue.

These recommendations aim to harness indigenous medicine's demonstrated potential as a pathway for ethnic coexistence while strengthening its role in Sri Lanka's healthcare landscape.

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## 9. Annex

### Questionnaire

#### Lights of coexistence project- University of Kelaniya

Province \_\_\_\_\_

Hospital \_\_\_\_\_

In this study, the term “indigenous medicine” refers to traditional systems of healing officially practiced and recognized under the **Government Department of Ayurveda**, such as Ayurveda, Siddha, Unani, and other traditional treatments. These include therapies and medicines derived from natural herbs, oils, minerals, and physical methods (e.g., massage, panchakarma, and dietary practices).

#### 01. Ethnicity:

☐ Sinhala      ☐ Tamil      ☐ Muslim/Moor      ☐ Burgher      ☐ Other

#### 02. Gender:

☐ Male      ☐ Female      ☐ Other

#### 03. Age

☐ 0-14 years      ☐ 15-24 years      ☐ 25-44 years      ☐ 45-59 years      ☐ 60-74 years      ☐ 75+ years

#### 04. To what extent do you agree with the following statements.

| Statement                                                                                                          | Strongly agree           | Agree                    | Neutral                  | Disagree                 | Strongly Disagree        |
|--------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. The hospital staff treat patients equally, regardless of the ethnicity.                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I feel comfortable in this hospital regardless of my ethnic background.                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. People of different ethnicities interact together without hesitation when visiting the hospital for medication. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have not seen any fights or arguments between people from different ethnic groups here.                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Indigenous medicine is accepted and respected by different communities.                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Indigenous medical treatments are effective and reliable                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### 05. Have you ever used indigenous medicine?

**If YES, proceed to Section A.**

**If NO, proceed to Section B.**

**Section A: For Participants Who Use Indigenous Medicine**

**06. Why do you choose indigenous medicine? (You may select more than one)**

- ☐ It is part of my culture/tradition      ☐ It is affordable      ☐ It is easily accessible
- ☐ It has fewer side effects      ☐ Recommended by family/friends      ☐ Trust in natural remedies
- ☐ I believe it is more effective than Western medicine
- ☐ Other (please specify): \_\_\_\_\_

**07. For what type(s) of disease or health conditions have you used indigenous medicine? (You may tick more than one)**

|                                                               |                                                                               |
|---------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Gastritis                                            |
| <input type="checkbox"/> Hypertension                         | <input type="checkbox"/> Constipation, ulcers, piles/hemorrhoids              |
| <input type="checkbox"/> Asthma / bronchitis, chronic cough   | <input type="checkbox"/> Allergies, frequent infections                       |
| <input type="checkbox"/> Fever, cough, common cold/infections | <input type="checkbox"/> Mental health issues (depression, anxiety, insomnia) |
| <input type="checkbox"/> Arthritis, joint pain, back pain     | <input type="checkbox"/> Pediatric conditions                                 |
| <input type="checkbox"/> Fractures                            | <input type="checkbox"/> Cancer and tumor-related conditions                  |
| <input type="checkbox"/> Migraine                             | <input type="checkbox"/> Sexual health issues                                 |
| <input type="checkbox"/> Paralysis                            | <input type="checkbox"/> Nerve pain                                           |
| <input type="checkbox"/> Eczema, psoriasis, rashes            | <input type="checkbox"/> Infertility                                          |
| <input type="checkbox"/> Wounds, burns                        | <input type="checkbox"/> Menstrual disorders/ menopause-related               |
| <input type="checkbox"/> Kidney stones                        | <input type="checkbox"/> ENT (ear, nose and throat)                           |
| <input type="checkbox"/> Urinary infections                   | <input type="checkbox"/> Eye                                                  |
| <input type="checkbox"/> Gallstones                           | <input type="checkbox"/> Beauty culture related                               |
| <input type="checkbox"/> Bladder stones                       | <input type="checkbox"/> Other (please specify)                               |
|                                                               | _____                                                                         |

**08. How long have you been using indigenous medicine?**

☐ Less than 1 year      ☐ 1–5 years      ☐ More than 5 years

**09. How often do you use indigenous medicine?**

☐ Rarely(only in special cases)    ☐ Occasionally(a few times a year)    ☐ Frequently(every month or more)

**10. Would you recommend indigenous medicine to people from other communities?**

☐ Yes      ☐ No      ☐ Maybe

**Section B: For Participants Who Have NOT Used Indigenous Medicine**

**11. To what extent do you agree with the following statements.**

| Statement                                                                                               | Strongly agree           | Agree                    | Neutral                  | Disagree                 | Strongly Disagree        |
|---------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. I believe indigenous medicine such as Ayurveda or Siddha can effectively cure many common illnesses. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I think indigenous medicine is safe because it uses natural ingredients.                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Indigenous medicine is part of our culture and should be preserved and promoted.                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I have seen people from different communities benefiting from indigenous medicine.                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I am open to trying indigenous medicine in the future if needed, without framing to ethnic borders.  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. People from other ethnic groups have told me positive things about indigenous medicine.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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களனிப் பல்கலைக்கழகம்  
UNIVERSITY OF KELANIYA

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உமது இல }  
Your No. }

25<sup>th</sup> November 2025

Ref. No.: UOK/ERC/FS/2025/111  
Subject: Ethical Clearance

Title: "Healing Without Borders: Indigenous Medicine as a Pathway to Ethnic Coexistence in Sri Lanka"

Name of the Applicant: Mrs. U. H. Poornima Jeewanthi

Dear Mrs. Jeewanthi,

**Ethical Clearance**

Ethical Clearance to pursue your research project has been granted as per the decision made at the 100<sup>th</sup> meeting of the Ethics Review Committee held on the 14<sup>th</sup> of November 2025.

We take this opportunity to thank you for your concern about obtaining ethical clearance prior to proceeding with your research in terms of maintaining and sustaining ethical conduct of research.

With Best Regards!!

**Senior Prof. Nimanthi Jayathilaka, Ph. D.**  
Secretary

**Senior Professor Nimanthi Jayathilaka**  
Secretary/ Ethics Review Committee  
University of Kelaniya



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