Controlling Diabetes or Keeping Life under Control?
Experiences and Understandings of a Group of Sri Lankan Migrants in Australia with Type Two Diabetes

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Thesis Abstract

Diabetes is a key public health priority and a major health concern for many migrant communities including the Sri Lankan community here in Australia. Understanding people’s comprehensions of the disease and its management is essential to successfully address any related issues in order to avoid premature deaths and high public health costs. According to many health reports published over the past years Sri Lankan migrants have been identified as having a significantly higher prevalence of type two diabetes in Australia compared to the general Australian population. This ethnography revolves around a group of first generation Sri Lankan migrants with type two diabetes in Australia.

This thesis relates their story of encountering and dealing with difficulties and complexities of migrant life while having to build a ‘successful’ life in Australia and also having to concurrently manage a chronic illness. While arguing that understanding of diabetes management cannot be just reduced or confined to level of compliance to medical advice and blood sugar measurement readings on the glucometer, I point out in the research that the stories of Sri Lankans with diabetes in a developed country are different to the stories of other South Asian migrants with diabetes living elsewhere in the world as examined in other studies. I show how Sri Lankans, despite possessing several socio economic and cultural advantages in the land of settlement, still encountered significant challenges to manage diabetes effectively. I demonstrate in the thesis how each person’s socio cultural ‘baggage’ they bring to Australia during migration from their motherland, affects their transplanted lives and how it in turn affects their health care seeking behavior concerning managing diabetes.

I demonstrate that aspects that affect the Sri Lankans’ perceptions and actions regarding the management of diabetes derive from personal history, their attachment to the collective cultural history of the community, their aspirations of upward social mobility coupled with attaining a higher standard of living as well as from the pressure caused by the differences in their conceptualization of ‘control’ from that of the doctors.

This thesis will be of interest to medical anthropologists, sociologists and social science researchers of migration and migrant health; health care providers particularly teams who provide diabetes care to migrant patients; and community health care workers. It will also be of specific
interest to migrants with diabetes living in Australia and in other Western societies, who might be interested to understand the experiences and challenges of living with a chronic illness through the insights of a group of Sri Lankan migrants in Melbourne living with diabetes
Declaration

This is to certify that:

- the thesis comprises only my original work towards the PhD
- due acknowledgement has been made in the text to all other material used
- the thesis is less than 100,000 words in length, exclusive of tables, maps, list of references and appendices

Prabhati Basnayake

18th March 2014
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Chapter 1: Prologue

This thesis explores and analyses the lives of Sri Lankan migrants with type two diabetes (which I will refer to as diabetes from here onwards) living in Melbourne, Australia. I start by recalling my experience of the death of my aunty, who died from a myriad of complications stemming from uncontrolled diabetes. She died when I was in the middle of field work for my PhD research, which coincidently involved looking at Sri Lankan migrants’ experiences of managing diabetes. The event of her death still evokes profound sadness in my mind every time I recall it. However the experience of revisiting Sri Lanka for three weeks for the funeral, and listening to stories about diabetes control from Sri Lankans who were my distant relatives and friends that I met during the funeral and after, made me juxtapose their experiences of diabetes with those of the Sri Lankan migrants in Melbourne, whom I met during my fieldwork in Australia. This story of the death of my aunty and the memories of diabetes in my extended family in Sri Lanka, provide a background and a prelude for the stories of diabetes of the Sri Lankans that I met in Australia, a background for the life that they left behind years ago when migrating to a new land.

11th of February 2012, Kuliyapitiya

The February sun in Sri Lanka was intense. I might have felt it more strongly as I was there for the first time after more than three years. The big house and the vast shaded compound with cashew trees were full of relatives, friends and neighbors dressed in white. My aunty who had suffered from uncontrolled diabetes for a very long time lay in the coffin that was placed in the middle of the living room, with two traditional brass lamps kept burning on both sides of the bottom of the coffin. The atmosphere was laden with sadness and low whispers among people who had come to pay respects to my aunty. It was an expected end to her life at an unexpected time. She had uncontrolled diabetes for over 25 years and was in hospital for months, almost having to undergo amputations and even experiencing near death numerous times. However she managed to escape any dire consequences thanks to the private medical facilities that our family could afford - something that an average wage earning Sri Lankan could not have fancied. Along with my uncle,
my aunty owned a very successful catering business and a line of restaurants that was originally passed on to them by my aunt’s parents. Her whole family was engaged in the restaurant industry and was known among friends, relatives and people in the area as extremely generous. Their kitchen always cooked lavishly prepared food for ten extra people for every meal. Although food was not usually wasted, the house always had food in great abundance, something that was not very typical of an average kitchen of a normal wage earning family. Known as great connoisseurs of rich traditional dishes (and later also of western food), the family cooked rice and curry meals and served them to people with great generosity. The whole family was overweight and had diabetes.

Despite being able to afford the best medical facilities on the island, I found it incomprehensible that my aunty did not manage her diabetes and take on a more responsible attitude and role towards her condition without letting it get out of control. She had an ever fluctuating blood glucose level for a long time. She suffered from several complications for a number of years and even came very close to the amputation of a foot twice. She was unwilling to restrain her diet and engage in any sort of physical exercise. Friends and relatives thought the sudden and early death of my aunt was just a continuation of the family’s pattern of dying at a young age. Several of the doctors who treated her also attended the funeral. In contrast, they thought her long standing refusal to seek proper and timely medical help and advice, and her lack of consciousness of healthy foods and a balanced diet, brought about her untimely death. She was only fifty six years old. Could this stubbornness and resistance have been a manifestation of the denial of possible diabetes complications or could it have been an expression of the difficulty she faced for most of her life to reject habits that were nurtured from an early age? Was this stubbornness caused only by the exhaustion of having spent much of a lifetime seeking medical care and spending weeks and months in hospitals? Or was it an expression of giving up on a so-called healthy life? Would a change of a familiar environment that was not conducive to a healthy lifestyle, do any good in changing habits that can have a negative impact on the management of a chronic illness like diabetes, or would it help in instilling better lifestyle habits regarding eating? Listening and participating in these conversations in Sri Lanka only instigated and raised more questions about my research findings at that time about living with diabetes of Sri Lankans in Australia. I had left my fieldwork abruptly to attend this funeral in Sri Lanka. Subconsciously I was also attempting to relate this very personal story of diabetes to those stories of Sri Lankans with diabetes living in
Australia; for it was mostly people belonging to the same generation as my aunt that I was studying in Melbourne.

I made a sudden decision to go to Sri Lanka with my son, who was then only four years old. On a cold Thursday morning in February 2012 while driving to the university in Parkville, Melbourne we received a call on my mobile phone from my father in Sri Lanka who informed us that my aunty had suddenly died in a hospital in their village. I listened with equal measures of shock and despair, as this was an unexpected death in the family. On the same day, I decided that I should go to Sri Lanka and join my family at this sad time. At hearing the news of the death I felt desolate and wanted to reunite with my family back in Sri Lanka. It was with this purpose that I went to Sri Lanka. However the trip also gave me the opportunity to listen to several other stories related to diabetes from relatives and friends that later prompted me to talk with Sri Lankan health professionals involved in diabetes care in my hometown, Kandy, which I believe added more depth to this ethnography.

The topic of diabetes was not very far from many conversations I had with friends and relatives at the funeral. A distant relative that I met there was very vocal and open about her life and diabetes. She lived with her husband and her son, and the son too joined in the conversation. She started talking about her diabetes management, which involved western medicine along with many other alternative herbal medicines recommended to her by neighbors, obtained from the village’s Ayurvedic practitioner. Apart from her medicines, whenever she felt that her blood sugar was too high she would consume a lot of greens with her three main meals. Only after that would she check her sugar using the meter. She noticed that the reading of the meter was always low after consuming a lot of fresh greens with her rice meals. Without exception people with diabetes that I had the opportunity to talk with took alternative, mainly Ayurvedic, medicines along with their regular western medicines.

I inquired whether she also did any physical exercise as a way of controlling diabetes. Instead of a reply she only smirked and waited for a few seconds before answering, “Oh I would not go and run around like the city ladies”, as if exercising and jogging were something to be ashamed of. She was from a rural area in the south of the island. The thought occurred to me that would this be a common perception among people who come from Sri Lankan rural areas with a similar educational background and socio economic class, including some of my participants in
Melbourne. She stressed that the physical work that is necessary in their coconut and banana estate gives her enough “moving about”.

Everyone who comes to a Sri Lankan funeral is served with a meal – breakfast, lunch or dinner. Usually people who are close to the family in which the death has occurred bring food, mainly rice and curry, to the house where the funeral is to be held. When a death occurs in a Sri Lankan Buddhist household, the funeral lasts for about three to four days before the body is cremated or buried. Customarily, except on the last day of the funeral, food is also cooked at the house. Something that was very noticeable to me at my aunt’s funeral was that most meals that were brought, as well as those cooked at the family home, were fried. Palm oil and coconut oil had been profusely used in the cooking. I had been away from my native island for seven years, and had lived those seven years in a social and educational environment that prioritizes health and healthy eating. This meant I now viewed my traditional food, which I enjoyed with my friends and relatives, through fresh eyes. The deliciously strong taste of tropical spices, coconut milk and coconut oil in my mouth brought back memories of the past years at home and also of elaborately cooked meals we used to have whenever we spent a few days at my aunt’s place. When reflecting on this memory it was apparent that unless one has a great amount of self control or an ability to dissociate from the pleasurable memories of growing up, it would be a challenge to anyone with diabetes to change the ways of cooking and eating that are deeply imbedded in their way of living. This was an occasion out of the ordinary to observe and recall traditional Sri Lankan ways of cooking and eating. However the constellation of memories I had of food and ways of cooking and eating on the island, that were revived on this one occasion, was enough to make me realize that this was not a very conducive environment for the effective management of a lifestyle related chronic illness such as diabetes. I was well aware too that food consumption in this context was dramatically at odds with the instructions concerning life style modifications given to the Sri Lankan diabetes patients living in Australia by their health professionals.

The stories of diabetes and controlling blood sugar that I heard at the funeral, and the food that was laid out on tables, inadvertently evoked memories of stories of diabetes control that I was trying to comprehend and analyze from my fieldwork at this time in Melbourne. The stories and images that I encountered in Sri Lanka helped me identify similarities as well as departures from these traditional ways, that I noted and observed among the stories and ways of life of Sri Lankans.
in Australia. Listening to the personal stories of diabetes of people in Sri Lanka prompted me to set out on a search for more information on the issues and challenges that they face managing the disease. To do so I sought to understand these challenges from the perspective of a few health professionals who are directly involved in delivering diabetes care services in the government and private health care sectors in Sri Lanka. I expected that receiving information about the challenges health professionals faced in Sri Lanka, from their perspective, would provide me with a balanced and a more enriched view of those challenges. I also expected that this information from Sri Lanka would enrich and add more depth to the analysis of the data that I was gathering in Melbourne in relation to migrant Sri Lankans’ diabetes management.

Actually the problem is two-fold. The main problem with patients here is that they don’t know the seriousness of diabetes. On one hand they lack information about their condition and most who come here (a public facility) are financially struggling. On the other hand health professionals are over burdened with too many patients and they know that if they spend longer than five minutes even with one patient then their day is going to be a very long one and it would be very late to go home that night (laughing). Everyone likes to go home early, don’t we?\(^1\)

This is what Prof. Anthony – the consultant endocrinologist of the Kandy General Hospital – had to say in a frank assessment of the doctor-patient relationship at a Sri Lankan public hospital diabetes clinic.

Paskins (2001) states that although health services have improved considerably in Sri Lanka, in recent years, overcrowding in health services and lack of resources are major problems that limit effective care. This is especially the case for chronically ill patients. He specifically mentions that in Sri Lanka the problem of diabetes in patients is further compounded by the culture. However he does not specify what features of Sri Lankan culture complicate the problem of diabetes management for these patients.

\(^1\) He noted that in a diabetes clinic in a public hospital, a doctor would have to see around one hundred patients per day. As the service and drugs are free in public hospitals, these facilities are particularly overcrowded.
Prof. Anthony observed that poverty was often a barrier to management:

Sometimes we think patients do not take the insulin tablets regularly because they are non-compliant. For example I have a patient who comes from a very rural area and his blood glucose level is very high despite all the prescriptions or drugs that I have given him. I assumed that he must have taken all the recommended tablets and could not figure out why he still had very high blood sugar. I asked more questions and then only he told me that he only takes tablets once in two days, as he can’t afford to take a tablet a day.

A diabetes educator who worked in a private diabetes clinic was also concerned about the practical problems in life that patients faced that pose a challenge to effective diabetes management. This educator had travelled to Australia several times, and had some understanding of the Australian health care system through her sister who works as a nurse at the Dandenong hospital. She compared the situations in the two countries:

Everyone is over taxed here as they have to overwork to make the ends meet. It’s the urban middle class who come here (the private diabetes clinic) that find life the hardest. Still they do not get the money to have a comfortable life. Even if they come to the private sector to see the doctor for their diabetes, many often cannot afford to buy all the prescribed drugs².

Financial pressures and stresses were commonly thought to be a more worrying priority than diabetes for the patients the staff saw at these diabetes clinics in Sri Lanka, and one that negatively affected their diabetes management regimens. According to Prof. Anthony, it was common that a majority of the patients with chronic illnesses found medications unaffordable, especially in public hospitals. This perception is confirmed in the literature, with researchers stating that a majority of diabetes patients who visited a public hospital in Sri Lanka could not afford the maintenance therapy (Paskins, 2001). The Sri Lankan who earns an average wage

² In Sri Lanka those who can afford to, can go and see a doctor in the private sector. For this, one does not necessarily have to have private health insurance. Patients expect that going to a private clinic would save time, even though one has to spend more money on the doctor’s fee, as in government hospitals there are long queues and long waits.
struggles to sustain and secure at least a reasonable standard of living in their mother country, and therefore some start looking for greener pastures and envisage migrating to a more economically prosperous developed country such as Australia to overcome their financial struggles.

Yet another important concern which both Prof Anthony and the diabetes educator raised, is the lack of resources with regards to information about diabetes for patients. They concluded that this lack of informative and educational material about diabetes management obstructed gaining of knowledge about diabetes and efficient diabetes management of many patients who came to see them especially from rural and semi-rural areas. These views of health professionals in Sri Lanka about their patients’ lack of knowledge about diabetes and their lack of adherence to clinical guidelines of diabetes management, urge us to establish the assumption that Sri Lankans would adhere better to those clinical guidelines of diabetes management, if they are supported in a better funded diabetes care and health care environment. In the proceeding chapters we shall find out if this is the case with Sri Lankans with diabetes who receive care in the better funded health care system in Australia.

However the health professionals in Sri Lanka did not raise the issue of the level of health consciousness and understanding of diabetes of the patients they saw. This was of particular interest to me, as many health professionals that I talked with in Australia who saw Sri Lankan people with diabetes, expressed their belief that this group had low awareness of health. One general practitioner from a medical clinic in St. Albans stated that Sri Lankans are generally not health conscious because of the lack of health education they receive during their school years. This GP had gone through all his years of primary, secondary and university education in Sri Lanka and perceived that the education system in Sri Lanka did not give much priority to health education among school children.

These conversations with Sri Lankan health professionals in Australia about their patients’ lack of health consciousness due to lack of exposure to health education evoked in me a very palpable memory from Sri Lanka fourteen years ago in my family. In fact it was this memory that had originally provided the impetus to my subsequent studies of understanding the experiences of diabetes.
The story of my interest in diabetes

My first memory of a premature death caused by the complications of diabetes dates from 2000, when my grandmother died. I used to visit my grandparents’ home regularly and can recall it vividly now – their small house, set under lush tropical mango, papaya and pomegranate trees was a haven and a place full of treats. Inside, the smell of sweet wafers and soft drinks permeated the hot, steamy air. My grandmother always seemed to have a store of such treats in her cupboards and she’d sip tea with us, joining us in the indulgence of biscuits and sweets.

The tall leafy trees were interspersed with beds of yellow and orange marigolds and in the shade there were makeshift benches fashioned from wooden planks where we would seek shelter on the days after the monsoon, when the sun beat down and the heat in the interior of the house became unbearable. The garden was a convivial place, with neighbors and members of my uncles’ households often joining us there to get some respite from the heat and to enjoy my grandparents’ hospitality, sharing sweets and cool drinks. Such memories are in many respects typical for Sri Lankan migrants – the evocation of another home, where family and friends now distant enjoyed familiar food and drinks, and relaxed together in the hazy heat of the tropics.

Thinking now of my grandmother’s health, her diet and her illness, I am struck by how unaware we all were of her condition and its implications. Twenty years ago, when she first became aware of her illness, there was little in the way of diabetic health education and diabetes management services available in Sri Lanka. In retrospect I can understand that she lacked reliable information and her attempts to improve her health were really more about groping in the dark. My mother recalls how my grandmother kept on changing doctors until her passing away. She says that there was no-one in the family or among her friends who knew enough to give her correct advice regarding diabetes care. My mother also recalls how her mother tried ‘dodgy’ alternative treatments of chronic illnesses from the popular Sri Lankan traditional medicines that were advertised in newspapers. Even today one notices an abundance of advertisements by various people who call themselves ‘local medicine-men’, claiming to be able to ‘permanently cure’ diabetes among various other chronic illnesses and ailments at the back pages of Sinhalese newspapers. My grandmother was entirely credulous and put her faith in many of these nostrums.
Her lifestyle was similarly not conducive to improving her diabetes. It was known in the family that she did not stick to any special diet or regimen. They thought that she had too many sweets (as, unlike many Sri Lankan elders, my grandfather could afford a variety of comfort foods that his wife liked, which were believed to be bad for diabetes). My grandfather would indulge her love of sweets, often buying rich confectionary such as dodol – a traditional Sri Lankan sweet made from a boiled mixture of palm sugar and rice flour – from a famous shop called Gilbert Brothers in Kandy town. Neither did she engage much in the house chores that could have given some ‘physical exercise’ according to my mother, aunties and uncles. In retrospect her indulgence was completely inconsistent with contemporary guidelines which suggest that an imbalanced diet and lack of physical exercise would engender a consistent high blood glucose level, leading to various other health complications. According to diabetes management guidelines, the intake of high concentrated energy foods such as sweet foods and drinks, and high calorie foods rich in carbohydrates such as rice and bread, have to be limited and carefully controlled by a person with diabetes because of the impaired ability of the body to absorb sugar in the blood stream (Diabetes Australia, 2012).

Questions still remain in my mind concerning the degree to which my grandmother suffered physically and emotionally from diabetes and the extent to which my grandfather and her children understood her accounts of living with the disease. As an adolescent during this time, I remember how my grandmother often complained of pains in her body, problems that were not taken very seriously by her children, even though they cared for and supported her in many ways. The family knew that she did not adhere to any strict diabetes regimen. In hindsight I can see why she ended up at the hospital with a myriad of complications associated with the disease. She died from a cardiac arrest in a coma at a hospital after admission for extremely high blood sugar. But what is most powerfully embedded in my memory is the perception that she suffered from diabetes silently, as she was surrounded by people who were not able to understand it well.

It was only years after, when I was conducting my undergraduate final year project in Sociology on the experiences of suburban and rural Sri Lankans with type 2 diabetes in a diabetes nephropathy clinic in Kandy, that I discovered that diabetes is a disease that goes hand-in-hand with depression. In fact diabetes and depression are two diseases that are said to have a bi-directional relationship (Campayo, Gomez-Biel and Lobo, 2011; Mezuk, Albrecht, Eaton and Golden, 2008). It was then
that I was able to comprehend her silent suffering and the emotions underlying her complaints. Reading and listening to my elderly participants' stories of their diabetes opened my eyes to what it would have been like for my grandmother to live the last fifteen years of her life with diabetes. For me, conducting my undergraduate research in Sri Lanka felt like coming to terms with our misunderstanding, or lack of understanding, of her suffering.

About five years after her death I migrated to Australia with my husband. Less than one year after migration I began my postgraduate studies in medical anthropology, which gave me the opportunity to conduct a minor study in the area of migrant health. As questions and issues raised by my earlier undergraduate research and from the story of my grandmother were still lurking in my mind, my curiosity inevitably turned towards this important chronic illness in Australia when I decided to prepare a PhD research proposal.

The journey that unfolds

In the following chapters of the thesis I reveal how complex socio-cultural and personal aspects of the Sri Lankan lay participants interact to give rise to a situation where they see diabetes management as not just a simple adjustment to life, but as a major change that interferes with their life ambitions. Participants demonstrated that caring for one's health and managing this lifestyle disease could be easily forgotten due to the complexities of life associated with migrant status, initial goals of migration, personal history and the socio-cultural baggage that one brings to the host society. When referring to my participants I will be using pseudonyms to protect their identity and confidentiality of the information they provided me.

The above prologue of my country and culture of origin, background and some important events in my life that generated my interest in the topic of diabetes management also provide an apt start to the next chapter. In this Chapter I also describe some of the socio economic and cultural barriers that diabetes patients in Sri Lanka encountered, which in turn provide the general social background of the lay participants of my study prior to migrating to Australia.

In Chapter Two, I will foreground and problematize my personal joys and challenges experienced in the process of researching my own people; the epistemological position that I took as the
researcher to approach my participants and to analyze the data; the nature of the participants and their experiences; and the methodology that I employed in the study. In other words, Chapter 2 will concentrate on the relational dimensions of fieldwork in a community where I was simultaneously an ‘insider’ with shared identity and an ‘outsider’ – whose working milieu and academic interests were decidedly Australian. I elucidate some nuances of my Sri Lankan/Australian hybrid identity that facilitated access and enabled an empathetic understanding of people. I describe people that I met in the field and the nature of the relationships that I developed with them, observing similarities and differences that I noticed between myself and some of the participants, which I elaborate in the following chapters.

In Chapter 3, I set out the historical background of Sri Lankans in Australia and discuss the changed socio cultural and demographics of the recent waves of Sri Lankans to Australia. The characteristics of Sri Lankan migrants, according to published literature, provide a valuable background profile for the people that I write about in this thesis. I also explore their original intentions of migration to Australia. In this chapter I also discuss about the myriad of tribulations that they had to face settling in Australia. I also demonstrate how Sri Lankans are socially and culturally flexible and welcome most changes that they come across in Australia, challenging commonly held ideas about the difficulties migrants have adapting to their new environment.

In Chapter 4, I discuss the diabetes epidemic in the South Asian region and in Sri Lanka in particular, while also drawing on the literature about the epidemic in South Asian migrants living in western countries. In this chapter while discussing about the perceptions of the nature of chronic illness, its causation and its management, I address two important tendencies that most participants regressed into when managing diabetes: the externalization of responsibility and biographical reinforcement. These two tendencies have significant implications for diabetes management, an issue that is considered in greater detail later in the thesis.

In Chapter 5, I present the ways in which the changes and continuities of eating patterns after migrating are enmeshed with dynamics of identity and social class in the lives of this group of Sri Lankans. They were flexible and open minded about changing food habits in many contexts after migration and had willingly embraced new food habits. However their changed circumstances after migration made it difficult and sometimes even impractical to adhere to strict dietary regimes. Neither changes nor continuities were explicitly or deliberately directed towards efficient
management of the disease. In fact those changes appeared to stem more from the need to develop and maintain concepts of self and identity that also incorporated aspirations for social mobility.

Chapter 6 will illustrate the paradoxical nature of perceptions and expectations of doctors and Sri Lankan patients. I will show how erroneous assumptions and lack of open communication—compounded by certain socio cultural traits specific to most in this group—present significant challenges to satisfactory diabetes management, both from the point of view of the health professional and of the person with diabetes. This chapter will also show how certain perceptions and preconceptions about Sri Lankan patients by the Sri Lankan health professionals reflect on their treatment plans, and are based on class divisions and associations that prevail in their country of origin.

Chapter 7 captures first, what it means to be Sri Lankan in Australia and how Sri Lankanness is reconstructed and represented in the Australian environment. In this chapter I will argue that even though the Sri Lankan community in Australia appears to be quite cohesive and united, this solidarity is illusory. In fact, there are distinct (and unified) sub-groups of the migrant population. The segregations were subtle and were based broadly along the lines of levels of education and social class. It was clear that this ‘segregated’ solidarity meant that some people experienced feelings of alienation and estrangement in different public contexts, such as at Buddhist temples and other cultural events in their own community.

Chapter 8 argues that the unexpected experiences of diminished social status for some members, and other challenges of settling in the country, combined with the internally-created competition for achievement of material success that were linked to the original migration goals, generated significant stress in the lives of some participants. This caused them to engage in paid work to an extent that they did not have time for leisure, nor did they pay close attention to their health. Health care was not a priority in the daily life of the average person in the study even if they were aware of the importance of the adherence to a daily regimen of diabetes management. I argue in this chapter that the undeniable element of uncertainty in many aspects of life as migrants fuelled their deliberate disregard for the importance of health care in everyday life.
In the concluding chapter I argue that a conglomeration of socio cultural and personal factors cause decreased motivation to employ agency, and relegate the goal of diabetes management to the bottom of participants’ priority list. In this chapter I also argue that, in contrast to what has been previously demonstrated in the literature, level of education and the ability to understand health related information are not the most important determinants of effective diabetes management for this group. Rather, the idiosyncratic social and cultural phenomena that characterize the Australian Sri Lankan community, in combination with participants’ long held migration goals, mould lifestyles that are not conducive to health, including effective diabetes control.
Chapter 2: Locating Myself and the Ethnography

In this thesis I provide an ethnographic account of the lives of a particular group of Sri Lankans now living in Melbourne, Australia. My research describes how their experience of migration intersects with their experience of living with diabetes, a chronic illness which results in progressive deterioration of health. In this chapter I situate myself as the researcher, by discussing my position as ‘an outsider within’ the Sri Lankan migrant community. I will also discuss my own identity as a Sri Lankan, explaining my socio economic, cultural and ethnic background. While reflecting on my position as a researcher with a ‘hybrid identity’ in this community, I discuss the complexities that this gave rise to in the research and in the relationships between my participants and me. I continue to examine the complexity and intricacies involved in the process of entering the field and how the strategies I used, combined with my position as a researcher inside my own migrant community in Australia, elicited nuance-laden information that has informed the ethnography. These layers of understanding of the community then lead to reflections on the complex variations within the Sri Lankan migrant community in Australia. The range of views expressed by people in the community then guided me to discuss how these complexities affected their experiences as migrants.

In order to gain an in-depth understanding about my participants’ lives in Australia, and to bring the intrinsic and deeply embedded social and cultural characteristics of the people that negatively affect disease management into light, comprehension of their experiences as migrants was crucial in the research as an initial step. In fact, comprehension of their experiences as migrants at the start of the research was more important than delving immediately into their experiences as migrants with a chronic illness. While describing these aspects, throughout the research, I will attempt to interpret in detail the ethnographic importance of important sociocultural phenomena that seemed to be intertwined with participants’ perceptions and understandings of the disease and its management.
Researching one’s own

Hall (1996) argues that all writers speak from a particular position and place, and it is important for them to identify this positioning through the acknowledgement in their writing of their culture and experiences that impinge on the research they undertake. In conducting this research, on one hand I am a Sri Lankan migrant researcher who explored the experiences, social interactions and interactions with health professionals of a group of other Sri Lankan migrants with type two diabetes. On the other hand, I am a Sri Lankan migrant mingling in the Sri Lankan migrant community, taking part in events as just another participant or an observer. My ethnicity and migrant status meant I have many things in common with the people who were participants.

Much has been written and debated in anthropology about researching one’s own community as an insider (Clifford, 1986; Spradley, 1979). There are clear advantages and disadvantages of this type of research. As Clifford observes ‘insiders studying their own cultures offer new angles of vision and depths of understanding. Their accounts are empowered and restricted in unique ways’ (1986, p.9). De Souza (2004) maintains that the ‘binary categories’ (such as exclusion and inclusion, center and periphery, norm and deviance, powerful and powerless) of most dominant discourses of the development of knowledge and representations of migrants in the health care system are unwittingly involved in a process of ‘othering’ these ethnic groups (2004, p.466). This ‘othering’ obscures the complexities that characterize minority groups, while homogenizing the whole group in ways that potentially distort the reality. She contends that the problems migrants face in the health care system are often related to issues such as racism, assimilation, ethnocentricism and cultural hegemony that result in the pathologising of minority groups. While writing about the motherhood experiences of migrant women in the New Zealand health care system, she states that the research frameworks based on the dominant worldviews of western knowledge systems are inadequate for the study of ethnic minorities in developed societies. She argues that dominant western knowledge systems have limited ability to see the intricate complexities of ethnic minority communities. De Souza contends that studies in these communities by researchers of color and of minority ethnic group identity are desirable, as the researcher has the opportunity to delve into areas worthy of research with a stance of ‘an outsider within’. She maintains that it enables us to see through the health-related issues of these communities without locating them in the dominant world views of western paradigms.
approach implies that for researchers of color, when studying about any community (in this case my own community living in Australia), there is a need to be bi-cultural in terms of epistemology (Scheurich and Young, 1997). Referring to the ‘outsider within’ approach Collins (1990) states that researchers belonging to minority groups need to be fluent both in the dominant culture of academia and that of their own community; thus fluent and knowledgeable about both cultural contexts in which they operate. Collins (1990) contends that the ‘outsider within’ position provides opportunity and space for the expression of the range of subject knowledge of the researcher and it also acknowledges the limits of the multiple identities of the researcher. For example in this research, my identity and prior experience of and perceptions about my participants as another Sri Lankan migrant, gave rise to many opportunities as well as challenges that I had to make use of as well as overcome. These instances specifically included accessing the community and the interpretation and analysis of participant observation sessions and of information about experiences of being migrants.

The ‘outsider within’ approach also provides structure for how to use the complex interplay of the researcher’s multiple identities in understanding the experiences and worldview of the research participants and the dynamics of the research project. The ‘outsider within’ stance provides the researcher with the flexibility and ability to be both inside and outside the lives of the research participants. This facilitates an understanding of both what it is like to be a member of the community that is being researched, and a member of the dominant culture. Collins also emphasizes that the ‘outsider within’ stance particularly facilitates the understandings of the limits and restrictions of dominant approaches and hegemony in understanding the experiences of ethnic minorities. Theorists who uphold the ‘outsider within’ position contend that the reconciliation of the friction and the tension that is brought about by the stance can produce new knowledge about ethnic minorities and the marginalized. It provides a voice for the complexities and intricacies of the lives of the people who belong to ethnic minority and marginalized groups in developed societies, and brings to light their worries and concerns that have been so far hidden from the mainstream society. An important advantage of this type of research, especially in a minority ethnic community, is that the researcher who is an insider is able to identify nuances and connotations in the language participants use. The down side of this important advantage is that at the same time, the indigenous anthropologist can overlook or take such understanding for granted and might even misinterpret the nuances of language and linguistic peculiarities.
In discussing the knowledge generated by this approach, Bailey (1998, P.30), maintains that it has two important advantages: it develops a new perspective on ethnic minorities that have been neglected in dominant epistemologies and it also provides knowledge for those who are in positions of authority and power to develop new understandings of the relationship that the dominant society has with these minority communities.

**My stance as an outsider within my own community**

In this research I position myself primarily as an outsider within the Sri Lankan community for three reasons. First, because the questions I pursue arise from the literature in medical anthropology and sociology on migrants and health. Second, because there is an implicit comparison with the broader Australian population, including other ethnic groups, that is based on my training and interests and align me with academic colleagues rather than the people who were the subjects in my study. Third, the discipline and the language of my research both locate me ‘outside’ the Sri Lankan community in Melbourne.

I obtained my secondary and higher education in the medium of English both in Sri Lanka and in Australia. I have an academic background primarily in the medium of English, within a Western educational framework. However, I remain identifiably Sri Lankan – and was recognized as such by those who participated in the study. I speak Sinhalese fluently, as it is the main language I speak at home, and I am able to discern nuances of meaning and cultural references in Sinhalese conversation. I have strong cultural roots that I acquired from my traditional Sri Lankan Buddhist parents. I consider the influence of these cultural roots as strong as that of the Western education that I received in Sri Lanka and Australia. However, with exposure to a western value system and culture that I received from my education and through living in Australia for close to ten years, I also observe myself questioning the traditional cultural and political ideologies that are strongly held by my parents in Sri Lanka. In this respect I am positioned ‘outside’ the community, as someone who questions and problematises the ‘taken-for-granted’ aspects of a Sri Lankan worldview. Perhaps even more than other anthropological positions that lack the insider-outsider duality, such an interstitial position ensures that ‘participant observation’ is simultaneously a self-conscious activity and, for me as a migrant, a familiar ‘naturalized’ condition.
Another element of this mixed identity is my experience in Australia as a Sri Lankan migrant. As Jhumpa Lahiri in her novel *The Namesake*\(^3\) observes:

“Being a foreigner... is a sort of lifelong pregnancy – a constant burden and a continuous feeling out of sorts...” (2003, p.49)

Even though this quotation from Lahiri’s novel resonates with the experiences of a majority of participants living as migrants in Australia whom I got to know in the field, my experience in settling in and living in Australia, I believe, has been smoother and has not altogether made me feel “out of sorts”. While claiming this, I admit to moments where I wished I were back in Sri Lanka. Feeling out of sorts or not, I habitually make comparisons of things between Australia and Sri Lanka internally. Just as for me, for many other participants, migration permits perennial subjective analysis and comparison and contrasting of the lives in two worlds, the one that one lives in the present time and the one left behind. It is with the interplay with this dual identity as a researcher that I conducted my research among the Sri Lankan Australian migrant community in Melbourne.

Another important aspect of my identity is the social class that I belonged to in Sri Lanka – I am immediately identifiable as middle class. Social class categorization in Sri Lanka is quite complex and takes several sociocultural aspects that are ‘uniquely colonial’ into consideration. Some of the sociocultural markers of my being middle-class are the ability to speak fluent English and having formal education from an urban elite school. The age of English language acquisition and the ability to speak English fluently are important indicators of class in Sri Lanka, a characteristic observed by previous sociologists (Karunaratne, 2003). Apart from English fluency and high income, membership of the middle class is also determined by the level of formal education. In Sri Lanka great importance is attributed to formal education, as it is considered the main means of social mobility (Little and Sabates, 2008). Thus the possession of university education also functions as an important category in the formation of social class in Sri Lanka. English fluency, high parental income and the possession of university education in Sri Lanka are limited to relatively few people.

\(^3\) *The Namesake* is a novel that observes the nuances that are involved in the struggle in the life of an Indian migrant during his experiences of the differences between two different cultures, the two cultures being those of New York City and Calcutta.
My parents spoke only a little English, as their higher and tertiary education was in the vernacular, and they both came from rural areas around the hill capital. Our residence in the urban sector, my attendance at an elite girls’ school in Kandy, having parents working in administrative positions in the government sectors, and the exposure to the medium of English through education, meant that I was unequivocally identified as middle class. In short, my siblings and I embodied the experience of social mobility to which many people in Sri Lanka aspired. My world, and that of my brother and sister, were shaped by the acquisition of English and French languages from a young age and mingling with friends who belonged to the English speaking upper middle class through the school and tertiary education environments. Therefore, even though I describe myself as middle class because of the social origins of my parents, in fact, specific socioeconomic and cultural characteristics about me as an individual can even be associated with more of the upper middle class in the Sri Lankan environment. Identifying myself as belonging to these two social classes offered me a specific advantage when it came to fieldwork. During fieldwork I was comfortable mingling with participants from both middle and upper middle classes. It is my experience in all occasions that, perhaps due to my familiarity of ways of speech and mannerisms of both social classes, participants, irrespective of which social class they belonged to in Sri Lanka, did not view myself as very different to them. During initial rapport building with participants, to facilitate and not to disrupt the established ease of communication, first I tried to downplay the characteristics of my upper middle social class (such as my ability to switch between Sinhalese and English language easily and my educational background) if the participant did not come from the same social class. However during the second or third visits to them, it is possible some participants belonging to middle class identified myself as someone with an upper middle class background after learning more details of my sociocultural origins in Sri Lanka.

Social class is an important marker of a person’s status in Sri Lankan society. It determines a person’s way of life that includes what they choose to eat, their leisure activities (if there are any at all), their aspirations for their children, and their wishes and hopes for the future. Pierre Bourdieu states that a person’s taste and way of life are products of his/her level of education and upbringing, which reflect his/her social origin (Bourdieu, 1979, p.1). Social class was important in my research as it influenced the ways that people perceived diabetes management and how they expressed their thoughts about it. The social class they belonged to in Sri Lanka had a strong influence on their way of life in Australia too. However the question arises whether social class
was a direct or indirect determinant of how they managed diabetes or whether it affected the way they sought the regular medical advice and assistance that is needed for diabetes management. These are topics taken up in chapters 7 and 8.

**Personal dilemmas of being an outsider within**

When operating in the field I encountered numerous situations in which I found myself questioning and doubting the balance I should strike between my position as a researcher and my position as a fellow migrant in the Sri Lankan community, in deciding how to represent in the thesis what my participants told me in the field. For example, often I became acutely aware of the class of particular participants and by implication, their education (or lack of it) when they were expressing their opinions and experiences of the illness.

Participants’ different understandings of the onset of diabetes were indicative of their access to education and socioeconomic class in Sri Lanka. Their interpretations about the migrant experience and identity too had associations with the class and status they had in Sri Lanka. Having that ‘insider knowledge’ of intricate and subtle references to different classes in the Sri Lankan society, I was often able to detect people’s reference to others in the community, or their own or others’ ways of living in Australia, as ‘lower’ or ‘higher’ status. These intricacies of class and status, and the matters that people deemed significant about their own position, require careful negotiation on the part of a researcher. Many of the intricacies could be easily overlooked by an outsider. For example when some participants were recalling the reasons they thought they had become diabetic, they made strong reference to the drastic change of foods eaten upon migration from Sri Lanka. Participants described their new consumption of meat products, sweets such as chocolates, and dairy food such as cheese, foods that were actually restricted to upper or elite class lifestyle in Sri Lanka as reasons for the onset of their diabetes. In the following chapters, to rationalise their perceptions of these drastic changes in foods as reasons for becoming diabetic, I would be also referring to the desires of lower middle classes to emulate the lifestyles of upper middle classes that were expressed by specific Sinhalese idioms and expressions during interviews. An outsider to Sri Lankan culture would have easily missed such fine detailed and subtle Sri Lankan expressions in conversations. For these Sri Lankans, including more meat in the diet did not only
signify a change of eating patterns due to migration and the new culture, but also an upward mobility in the Sri Lankan class structure and in the associated lifestyles too.

Nira Wickramasinghe, writing about the contested identities in contemporary Sri Lanka, explains how complex class strata and identity is among Sri Lankans (Wickramasinghe, 2006). Wickramasinghe examines the factors that have a determining effect on modern Sri Lankan identity. She notes that the Sri Lankan social strata are distinctly demarcated according to class and caste divisions, despite the wholehearted embracing of modernity by the average Sri Lankan citizen. She contends that this social stratification has in turn led to subtle class and caste based marginalization and discrimination in the society (2006, p.330). Wickramasinghe attributes discrimination and marginalization of certain semi urban and rural segments of the population, to the nation’s uneven development (2006, p.331). She even goes on to make a bold observation that equal and non-discriminatory treatment still remains unattainable for many segments of the population (Wickramasinghe, 2006, p.332). Certainly among my research participants now living in Australia, there were many who came from the marginalized semi urban and rural areas in Sri Lanka that Wickramasinghe refers to. For example, many of my participants who were less educated fell into this group.

Class is an important determinant of the formal and informal groups in the Sri Lankan community in Australia too. For among the many elements of their ‘cultural baggage’ that migrants bring to their new social environment, their class values and pre-migration status and history are crucial and enduring. Many critiques of literary works on migrants in western societies view this endurance as a struggle between progression, or survival and regression to the past (Rushdie, 1983; Akhtar, 2008). With the process of upbringing – which Bourdieu sees as having social origins and formal education – social class becomes a deeply embedded phenomenon in one’s personality and determines one’s lifestyle (Bourdieu, 1979). It was evident in the research how class position determined patterns of responses in relation to the identity and experiences of the participant as a migrant and their style of living, that had a direct impact on participants’ diabetes management.

All except one male participant were Sinhala speaking and were educated mainly in Sinhala. Except with this participant, I conducted all the other twenty-four interviews with lay participants in Sinhalese, as they were more comfortable in expressing themselves in their mother tongue. Twenty-one had functional English skills; they had sufficient English skills to be employed and
perform day-to-day activities such as shopping etc. Proficiency and competence in English was very high for four participants. These four participants used both English and Sinhalese at home. The one male participant with whom I conducted the whole interview in English had English as his medium of education and it was also the language that he used at home. It was clear that the way of thinking, the style of living and the experiences of adaptation to the Australian culture and its way of life were significantly different between those participants who predominantly spoke Sinhalese and those who were more comfortable expressing themselves in English.

I also noticed a significant difference regarding the experience and perceptions of the initial settling experience in Australia and of acculturating to Australian culture, between a majority of my participants who spoke predominantly Sinhalese, and myself. It is my contention that this difference could be partially due to my prior exposure to western culture and values through my western-oriented education, and my attitude to life in general that has been moulded from this education. Except for three participants, none of the other participants had a comparable western oriented education. This difference of perception, not only as a researcher but also as another Sri Lankan migrant, enabled me to examine and analyze experiences of migrant life and the challenges in managing diabetes in Australia, from an empathetic outsider’s point of view.

Migrancy and Diaspora have been topics of many literary works in the past and present. One such literary work is Stephen Gill’s *Immigrant*, which relates the story of the hopes, fears and struggles of a newcomer from India to a Canada. Critiquing Gill’s novel, Akhtar argues that migrancy is associated with history and culture and the immigrant goes through a process of inhabiting two historically and culturally specific spheres which present him with ‘a subtle tension of dislocation and alienation’ (Akhtar, 2008, p.69). The themes of dislocation and alienation were reflected to various extents in the stories of my participants too. The experience of listening to the stories of this group of people about their various internal conflicts and dilemmas as migrants, also shed light on aspects of my own life as a migrant. Their stories were symbolic of a continuing engagement in a constant internal conflict; a conflict that most migrants who are living away from their homeland face. Therefore it is my understanding that this special positioning as a researcher in the community warranted me to provide a representation of their perceptions as migrants that is as close and truthful as possible to the realities of their lives. This very positioning of myself as a researcher may also have been one of the main reasons why many people contacted me.
voluntarily through the participant recruitment advertisements that were displayed in Sri Lankan community shops and why they invited me to their homes to listen to their stories. In retrospect, I think an interview gave them a moment to reflect on their lives and express their experiences as Sri Lankan migrants. According to some of them, as ‘brown skinned, easy going and friendly South Asian migrants’ (Quoting participant’s words that were used to identify and differentiate themselves from the ‘White’ majority) who have made Australia their home, they also found themselves alienated and distanced in this land from time to time. So as a fellow ‘brown skinned’ migrant, I was able to connect with them and build a friendly rapport with them throughout my fieldwork.

**Entering the Field**

For most anthropologists conducting ethnographic research, entering the field is marked with specific dates and or significant (or not so significant) events. However in the strictest sense of the word, my entering the field was not marked with any significant event. My field in the ethnography was the Sri Lankan community in Melbourne’s suburbia. The community is dispersed across Melbourne. Many community hubs such as Sri Lankan shops and Buddhist temples are located in areas where there is a significant Sri Lankan community, and I was already familiar with them during my time of living in Melbourne.

Even before conducting this research, I had been living in the Australian Sri Lankan community as another Sri Lankan migrant interacting with my compatriots on a regular basis for four years. I had been attending Sri Lankan cultural and religious events held in Melbourne ever since I migrated to Australia in 2006. Therefore my ‘entering’ the field and establishing relationships with my participants had its own complexities as we shared the same migrant identity, participating in many similar activities. In fact, my research provided the opportunity to forge new relationships within my community, some of which have continued.

Obtaining approval from the Melbourne University ethics committee was crucial to me being able to start the research in 2010. It took an unusually lengthy time to gain the ethics committee’s approval due to the then committee’s doubts about ethnographic methodology. After changing
the wording several times to ensure the committee understood what would be involved in undertaking participant observations of communal day-to-day activities in a South Asian migrant community, I finally gained ethics approval and began the research in March 2011. The field work continued until February 2012.

While I had strong pre-existing relationships in the Sri Lankan community in my home and neighbouring suburbs, I wanted to enter the field from somewhere unfamiliar to me and have my first encounter with someone that I did not know previously. This is because I wanted to disengage from my own community and because I wanted my participants to have minimal assumptions about me as another Sri Lankan. I thought it would enable me to observe them and their surroundings with fresh eyes. Therefore I conducted my early interviews and participant observations in locations that I was less familiar with.

At social gatherings such as celebrations of children’s birthday parties of distant relatives and friends, it is a very common question to be asked by anyone “What do you do?” Back in Sri Lanka this was not a common question posed at such events (as such gatherings mainly consisted of close friends and family so such ‘getting-to-know’ questions were unnecessary). At such gatherings in the Melbourne Sri Lankan community where one meets new people, asking about one’s occupation in Australia is a way of opening up a relationship and establishing rapport with the other person by the sharing of experiences. Connections made this way at celebratory or social gatherings sometimes went a long way in providing assistance in settling, by helping people find odd jobs or “good” child care services where there were Sri Lankan child care workers. The process of introduction sometimes provided the foundation for lasting friendships.

On such occasions when this question was thrown at me, I explained that I was studying at university and that I was doing research about Sri Lankans with diabetes and I was looking for people with diabetes who would like to talk to me. On the basis of this information some very generous and thoughtful people that I met at the houses of friends and family put me in touch with several key people through whom I could get to know people with diabetes. They also informed me about cultural and religious events organized around traditional food. Some of these key people functioned in the community as community leaders. One of the most important people was Ravindra Tisera (I addressed him using a fictive kinship term, Ravindra Ayya, meaning brother) who is the JVP (Janatha Vimukthi Peramuna, a Marxist-Leninist communist and revolutionary
political party that is now in the mainstream democratic Sri Lankan politics) party’s chief organizer in Melbourne. It was after an initial telephone conversation with Ravindra that I was able to contact several people with diabetes in the community.

JVP membership is associated with a certain social class in Sri Lanka. The JVP represented Sinhala-educated and Sinhala-speaking youth who came from middle and lower middle classes in Sri Lanka (Wickramasinghe, 2006). From its origins in the mid sixties to early seventies, the JVP developed as a political party that reflected the frustrations and discontent of educated Sinhala rural youth. Wickramasinghe (2006) found that the composition of JVP leadership and membership was in stark contrast to Sri Lanka’s other main political parties, in which the leadership was comprised of English educated English speaking elites, and membership consisted of men from non elite Sinhalese backgrounds. Most people that I met through Ravindra Ayya represented the predominantly Sinhalese speaking Sri Lankans who belonged to the middle class in Sri Lanka. The JVP is a very tightly organized political party in Sri Lanka which was subjected to much government curtail in the 1980s and 90s, due to the party’s revolutionary nature and Marxist ideology. More trust in an outsider was established especially if that person was introduced by a well-known member of the party. Therefore Ravindra’s introduction immediately established me as someone who could be trusted. From the initial stage of the research, I was interested in exploring how certain sociocultural characteristics that are entailed by the membership to particular social classes would impact on the health seeking behavior of the Sri Lankan migrants. Although contacting Ravindra through one of his friends took place for reasons of convenience, unexpectedly, it led me to a group of Sri Lankans who shared similar sociocultural characteristics. As JVP membership reflected the membership of a particular social class in Sri Lanka, interviewing members of this political party provided an understanding off the everyday life of a particular group of Sri Lankan migrants belonging to one particular social class.

Members of the Melbourne Sri Lankan community who were members of the JVP, were actively engaged in the community and in political activities such as fund-raising for JVP’s activities in Sri Lanka. One important characteristic that I noticed was that there was a generally acknowledged solidarity and commitment to their organization and a strong camaraderie among themselves. Following the tradition of the party, on most occasions when I addressed participants I had met through Ravindra, I used fictive kinship terms (‘brother’ etc). The implications of their affiliation to
the political party and what is symbolic of the participants’ social class membership through this affiliation, is important here as a determinant of their expectations and aspirations for life in Australia. This will be further discussed in the next chapter.

Almost all the people that I met through contacts like Ravindra Ayya and those who voluntarily contacted me for participation in my research, opened their doors to me and welcomed me warmly. Sri Lankans are well known for their hospitality and friendly nature. There was no one in the houses that I went to, who did not offer me a plate of biscuits or cakes with a cup of tea. When offering these sweets they invariably made jokes about diabetes and sweets, because the participants too enjoyed these sweets while sipping a cup of English breakfast tea. If there was another person in the family present in the house, or if some other visitor arrived, they too joined the conversation. Encounters were very warm and friendly and conversations were relaxed, as most of them acknowledged me as “one of them”. During this time of field work there were also many dinner parties that my whole family was invited to and meals that I gave them back after inviting their families to my house in Melbourne. These occasions gave me ample opportunity to talk with the participants and their families further about diabetes, and about many other aspects of life that were unrelated to diabetes but which enriched my analysis in the end.

**Participants**

In an ethnographic study, unlike in many other types of qualitative studies, communication and observation is not confined to the specific group of participants who are interviewed in-depth. I talked to many people who acted as key informants about the community. There were many whom I talked to about my study to gain knowledge, learn more about context and also to test my knowledge about the Sri Lankan community and culture in Australia. So, many people from the Sri Lankan community who contributed to my research did not necessarily have diabetes. While giving due recognition to them in the realization of this project and expressing my deep gratitude to their invaluable contributions, in the interest of rendering clarity to the term, the word ‘participants’ signifies two groups in this thesis. They are the lay persons with type two diabetes and the health professionals with whom I conducted in-depth interviews and observation sessions of clinical encounters (see the appendix attached for information about my participants).
All participants are from the Sri Lankan Buddhist and Catholic communities. The homes of the participants were spread across Melbourne and its suburbs. Sri Lankans are more concentrated in the Dandenong area in Melbourne’s east, and in Melbourne’s rapidly growing northern and western suburbs. None of my participants were from the Sri Lankan Tamil community in Melbourne due to the difficulty I would have had in accessing and engaging with this community (I don’t speak Tamil).

In this study, there were nine female and sixteen male participants with diabetes. Two of my participants were aged over sixty years, with the other twenty three being between the ages thirty and sixty. Fifteen of them had lived in Australia for more than twenty years. Ten had lived in the country for ten years or less.

Of the twenty five participants, only five were diagnosed with diabetes before migrating to Australia. Two of these participants previously diagnosed in Sri Lanka (both aged over fifty years) had attended regular diabetes clinics before they migrated to Australia to stay with their children under a parental visa. From the rest of the three remaining participants, one person had managed his diabetes only through herbal medications and other alternative methods. He had never consulted a doctor of western medicine for diabetes before migrating to Australia. The other two younger participants (in their thirties) had never taken any type of medication for diabetes when they were in Sri Lanka as they did not think it was essential. The remaining twenty participants either did not know that they had diabetes when they were in Sri Lanka or experienced the onset of diabetes after migrating. This is significant in the research, because whether participants did or did not have diabetes in Sri Lanka prior to migration strongly affected their perceptions of the reasons for the onset of diabetes. It also affected their perceptions of their health condition and the strategies of management. This will be discussed later in the thesis.

All but two of the twenty-five participants with whom I conducted in-depth interviews were at least high school educated, middle class migrants. Five participants had completed university education and nineteen participants had a diploma qualification. One participant had a PhD qualification. Overall they all could read, write and understand Sinhalese very well and they all had at least functional level skills in English. The high level of literacy in this group of participants distinguishes this research from other studies on the lived experiences of diabetes among South Asian migrants, conducted in countries such as the UK, Denmark and Netherlands. In most of
these projects participants did not have a high literacy level or level of fluency in English (or the host country language). Nor did they come from the same social class as this group of Sri Lankans living in Australia (Chowdhury, Helman and Greenhalgh, 2000; Greenhalgh et. al, 2011; Lawton et. al, 2008). Findings from these studies often attributed problems in diabetes management to lack of fluency in the host country language and disadvantage due to lower socioeconomic status. In this regard, the Sri Lankan participants in my research strongly contrast to the participants of many of these studies.

The current literature argues that self management of diabetes and adherence to medical advice are better among patients from higher socio economic strata and with higher education levels (Chaturvedi et al. 1998; Goldman and Smith, 2002; Schillinger et al. 2006). It has also been identified that cultural diversity and linguistic barriers among ethnic communities in Australia prevent people born overseas from obtaining effective health care (Jowsey, Gillespie and Aspin, 2011). Given the relatively high socio-economic status of Sri Lankan migrants in Australia and their greater fluency in English (ABS, 2011) this research project was in part inspired by the desire to see whether these factors led to improved engagement in diabetes management regimes.

The next group of participants with whom I conducted in depth interviews was health professionals, most of whom I met through sessions of clinical observations with lay participants who gave me consent to accompany them. I formally interviewed seven health professionals who were treating Sri Lankan patients with diabetes. From this group of health professionals, six were general practitioners (GPs) and one was a diabetes educator. I also had informal conversations with other health professionals, such as nutritionists and podiatrists, on several other occasions when I visited them with my participants on their regular appointment days. Five of the seven formal interviews I conducted with GPs were with doctors of Sri Lankan origin. The GPs were contacted using the contact details given to me by the lay participants. The predominance of Sri Lankan GPs in the study demonstrates that many of the Sri Lankan migrants that I interviewed chose to see a Sri Lankan general practitioner. Even though the number of GPs from an ethnicity other than Sri Lankan is limited, they added a different dimension to the information that was provided by the Sri Lankan health professionals about their Sri Lankan diabetes patients. One of the most challenging tasks that I faced in fieldwork was to find time and opportunity to meet with these health professionals because of their extremely busy schedules. Apart from these health
professionals in Australia, I also interviewed three health professionals (two endocrinologists and a diabetes educator) while I was in Sri Lanka at the time of my aunt’s funeral. Out of the seven interviews with health professionals, four were conducted in English and the other three were conducted in Sinhalese.

**Methodology**

In addition to the numerous formal and informal conversations that I had with members of the Melbourne Sri Lankan community, and observations made at social occasions and community events, the bulk of the information I gathered in my research was derived from in-depth interviews with twenty five lay people with diabetes and seven health professionals who treated them. All these sources of information were interpolated in the research, to achieve the research goal of uncovering the experiences of and challenges for managing diabetes of this group of Sri Lankan migrants.

Ravindra Ayya, who I described earlier as holding the leadership of the JVP political party in Melbourne, was an invaluable asset in my research as it was through him that I gained access to most of the participants. During my research I met him several times at friends’ and distant relatives’ homes, and at dinner parties for various celebratory events such as birthday parties and wedding anniversaries. He operated a small scale catering business with his wife as a part-time job. At social occasions he often attended as a guest as well as the caterer. These informal meetings over traditional Sri Lankan spicy dinners facilitated the development of a relationship of trust and friendship as well as introductions to people with diabetes. They in turn directed me to others who they thought would be interested in talking with me. Thus, as in many other ethnographic studies, gaining access to the lives of my participants was entirely based on their generosity and hospitality, coupled with their confidence in me as a researcher.

Participants were also recruited through advertisements posted on the walls of two Sri Lankan community shops and circulated online through the network of Sri Lankans connected to the Victor Meldor Sri Lankan library in Broadmeadows. Victor Meldor has been living in Australia for more than forty years and he voluntarily maintains a library of resources about Sri Lanka and
anything that is written about Sri Lankans in Australia. The library is a small extension that has been built in his backyard and it sticks in one’s mind long after the visit because of its congenial atmosphere and beauty. Victor had grown an evergreen creeper and a jasmine creeper to cover a good part of the library roof. On warm spring and summer days he keeps the French doors open so as you read in the library, the lovely fragrance of jasmine scents the air. Over the years his neatly kept tiny house and the library have been frequented by many Sri Lankan scholars visiting Australia, as well as those who are now living in Australia. Victor has kept many theses on the topic of Sri Lankans in Australia that have been produced over time, including my Masters thesis. The network of Sri Lankans that Victor maintained in the library was mainly comprised of highly educated, English speaking more affluent Sri Lankans who were in their middle age or older, and who had migrated to Australia in the 1970s as professionals. Snowballing participants from these two channels of recruitment reflected a clear distinction in the social classes they came from in Sri Lanka, and their perceptions of and general attitude to life and diabetes management.

The health professionals were mainly contacted through the details given to me by the lay participants of my study. I also collected the names of all the clinics that the lay participants went to and provided the health professionals with an information sheet about the study that included my contact details if they would like to participate and contribute their experiences to the study. On occasion health professionals would direct me to another colleague, who they thought would be interested in talking to me about their experience in diabetes health care delivery. All the interviews with health care professionals were conducted in their respective clinics, usually after hours or during lunch breaks. Sometimes I conducted these in depth interviews over two different days when the health professional I was interviewing had to stop in the middle of the interview on the first day because of an unforeseen emergency at the clinic. Although the snowballing sampling method is accompanied by some disadvantages, such as limiting the sample to a homogenized one (Liamputtong and Ezzy, 2008, p48), it was useful in this research because it was a strategic way to access this well-networked yet very heterogeneous group of people, a characteristic which I discuss in detail in Chapter 7.

All in-depth interviews with persons living with diabetes were held at the participants’ houses. Most houses were newly built and were decorated with a combination of traditional Sri Lankan or expensive looking Australian furniture. It was common to see artificial plastic flower arrangements
on table tops and other pieces of furniture. Some participants owned two or more houses, sometimes in different suburbs. Only two families lived in rented apartments during the time of field work. All interviews took at least two hours.

I also made numerous visits to three Buddhist temples in Melbourne to have informal chats with the monks, as temples are places that are frequented regularly by Sri Lankan Buddhists. Quite to my surprise even the head monk of the Yuroke Buddhist temple made a cup of tea for me while we were chatting in the temple kitchen. It is not the tradition in Sri Lanka for a monk to serve tea, especially to a female. However this unexpected generosity of the monk was a reflection of the closer and more secular ties that the temple has developed with the migrant population over time.

Anthropologists who have conducted studies in Sri Lankan Buddhism show how it has transformed over time and traditions are recreated in Buddhist temples (Gombrich and Obeyesekere, 1988). They demonstrate that in Sri Lanka, temples are modernized with the introduction of public address systems and holding of vocational training courses for youth, and also the appearance of popular monks on public media. This secularization was also very noticeable in temples in Australia. It was important to communicate with the Buddhist monks as they granted me with permission to observe several food oriented religious rituals and festivals throughout the year.

Sri Lankan shops are unique places that cater to many needs of the migrant community. During my fieldwork I visited these shops several times, in order to converse with the shopkeeper informally. These informal conversations with the shopkeepers and with their wives, who were sometimes there at the shop helping with the work, shed light on many aspects of the community that were not known to me. These shopkeepers had daily interactions with many Sri Lankans who came to the shop and had many valuable insights about their compatriots. The Sri Lankan shops were usually full of foods, Ayurvedic medicines, soaps, creams and lotions that have been imported from Sri Lanka. The moment you enter the shop the strong smell of a mixture of Sri Lankan made soap, biscuits and dried fish is unmistakable and every time I entered into the shops this smell was powerful enough to transport my mind to a distant memory of entering inside a little ‘supermarket’ called Dhanasiri in Kandy, my home town. People did not just come to the

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4 Supermarkets that one finds in Sri Lanka are perhaps one tenth the size of a normal Coles or Woolworths supermarket that one finds in Melbourne suburbs. But these shops were still called supermarkets because of its relatively large size compared with the other little local grocery shops.
local Sri Lankan shop to get products and foods from Sri Lanka. They also came there to socialize, hear and gossip about the others in the community, and also to get information about services that are provided by other Sri Lankans, such as driving lessons, catering services, cake baking and decorating services, dress makers, and even private tuition classes for their children. On the display boards at these shops there are usually several advertisements for these types of services. So, buying Sri Lankan products was only one of many reasons that many Sri Lankans frequented such shops. Apart from enabling conversations with a range of people, participating in these community places also led to valuable observations of the community.

Apart from in-depth interviews and such informal conversations, the study included a number of different types of observations. Following the interviews of invitations with some of the lay participants with whom I had good rapport, I conducted numerous participant observations that included events such as cooking main meals; meal times; attending cultural events such as the Sri Lankan new year celebration; monthly gatherings of senior citizens; and birthday and age-attaining parties where food and eating were central. These participant observations were immensely helpful in setting the background to which this group of South Asian migrants is living in Melbourne and forming my perceptions of their everyday life.

A crucial component of my research was the observation of clinical encounters between my participants with diabetes and their health professionals. In this study I conducted six sessions of observations of clinical encounters. Permission was first requested for the researcher to sit and do an observation during the in-depth interview or an observation of a daily activity from the lay participant. The next step was to contact the health care provider and request permission for the observation well prior to the actual appointment date of the lay participant. The observation of these clinical encounters added another dimension to the story of this group of Sri Lankans, while also providing a lens through which to view the nature of their communication with the health care provider in the management of diabetes. This also provided the opportunity to observe the communication and the nature of the relationship between the health care provider and the lay person with diabetes. It enabled me to unearth important contradictions in the stories from patients and health professionals that had significant effects on diabetes management.

To set the background for the stories of my participants, in the next chapter I will discuss the historical backdrop to Sri Lankan migrants in Australia and the dynamics of the Sri Lankan
community in Australian society in the present time. To provide more color to this picture about Sri Lankans in Australia, I will also discuss other complexities that exist in the Sri Lankan community such as social class while referring to the reasons for migration and the experiences of settling in of my participants. This discussion of social class, migration goals and experiences of settling in of participants provides an apt backdrop to the complex nature of the Sri Lankan community that I present in this thesis.
Chapter 3: Background and the historical context of Sri Lankans in Australia

Roughly the size of Tasmania, Sri Lanka, formerly known as Ceylon, is located in the Indian Ocean east of the southern tip of the Indian continent. The island is home to twenty-two million people. Historically colonized by the Dutch, Portuguese and the British, Ceylon was under foreign powers for more than three centuries before it gained independence in 1948. These three centuries of foreign government have left powerful and important Dutch, Portuguese and particularly British characteristics on the island’s systems of government, education, health, and many other sectors including transportation and architecture. Some of these colonial remnants continue to be powerful and influential factors on the way of life and the patterns of thinking of many Sri Lankans. Today, Sri Lanka is a developing South Asian nation state that prides itself on its very high literacy rate (91%) that is actually close to, or equivalent to that of a developed industrial nation (UNICEF, 2011). Sri Lankans also have a high life expectancy for a developing nation, which is again close to that of a developed country: the life expectancy of males is 70.7 years and for females is 75.4 (WHO, 2012) compared with the life expectancy in Australia, which is 78.7 for males at birth and for 83.5 females (AIWH, 2012). Since the gaining of independence, Sinhalese and Tamil have been Sri Lanka’s official languages, although English too is spoken fluently by ten percent of the population.

Sri Lanka has one of the most inclusive health care systems in the whole Asian region (Rannan-Eliya and Sikurajapathy, 2009). In relation to many other developing countries with similarly low per capita income (in 2012 Sri Lanka’s per capita income was $6100, whereas in the same year that of Australia was $42, 000) Sri Lanka shows very high health indicators. This favorable situation in national health is often attributed to the country’s health policies – which emphasize universalism – that have made it possible for all populations to access health care easily across the country. Free state mass education based on the principle of equality was introduced to the island by the Kannangara report in 1943 that recommended free education from kindergarten to university education for all (Wickramasinghe, 2006). Along with this, it is noted that the combined

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effects of mass female education and significant behavioral changes that were brought about by the country’s health policy have made Sri Lankans highly sensitive to illness and proactive in taking precautions for any illness (Caldwell, 1986; Caldwell et al. 1989; De Silva et al. 2001; Rannan- Eliya, 2001). A combination of these social factors has given rise to high health indicators in Sri Lanka.

Sri Lanka has three major ethnic groups: the Sinhalese, who account for nearly three quarters of the total population (75%); the Tamil group, which is comprised of Sri Lankan Tamils (11%) and Indian Tamils (4%); and the Muslims (9%) whose origins go back to the Arab traders who came to Sri Lanka for trade from the Middle East (Encyclopedia Britannica; Sri Lanka Department of Census and Statistics, 2001). There is also a very small Burgher population that accounts for about 0.01% of the population (Sri Lanka Department of Census and Statistics, 2001). Burghers are the descendants of the Portuguese, Dutch and English colonizers.

An account of the early Sri Lankan migrants in Australia

Some historians maintain that links between modern Australia and Sri Lanka began in the eighteenth century. While addressing the annual celebration of the formation of the Sri Lankan club of Victoria on April 28th 1982, the Commissioner for Community Relations stated:

“It is recorded that in the first fleet which signified the birth of modern Australia on January 26, 1788, there was a sailor from Sri Lanka. So, the links between Sri Lanka and Australia go back to the very birth of the nation.” (A.J. Grassby, 1982)

Mass migration to Australia from Sri Lanka took place mainly after the Second World War, however there are several texts that describe Sri Lankans in Australia in earlier times. The history of a significant number of Sri Lankans arriving in Australia runs back to the late nineteenth century when a group of over five hundred Cingalese (as Sri Lankans were referred to at that time) arrived in North Queensland in November 1882 to work in the sugar plantations. The earliest Sri Lankan migrants settled mainly in North Queensland and Thursday Island (Weerasooriya, 1988). The Sri Lankan historian and researcher, Pandula Andagama (1985) notes that Sri Lankans migrated to Australia even prior to 1882. Weerasooriya’s research found that in the 1870 (or perhaps even earlier) there was a group of Cingalese who were employed at the top of Cape York in the pearl
fisheries. Weerasooriya mentions that Andagama estimates that a total of seven hundred Cingalese were employed in the sugar cane industry between the years 1877 and 1879 (Weerasooriya, 1988). He maintains that these Cingalese were unemployed at home, and were trying to escape from a period of depression in Sri Lanka. He cites an observation by the editor of the Mackay Mercury who saw the arrival of one of the first groups of Cingalese as an ‘invasion’ at that time. The editor notes:

“The class of Cingalese who have honoured us with their presence are dangerous (since) there is a great fluency in the use of the English language and a competent knowledge of mental arithmetic. In fact they appear to be intelligent, well trained artisans, whom it is as reasons to restrict to the shovel and the hoe, as it would be to yoke, a high bred and spirited horse to a bullock dray. Some of them were very well educated... ” (Weerasooriya, 1988, p.137).

Recent Sri Lankan immigrants

Authors divide the recent migration of Sri Lankans to Australia into several periods. Weerasooriya reports that Sri Lankan migrants arrived in Australia in three waves. In the 1960s the main category of Sri Lankans who migrated to Australia was Burghers. During the 1970s it was predominantly the Sinhalese, and in the 1980s it was mainly Tamils (1988, p.34). However these ‘waves’ are not exclusive – my participants were Sinhalese Sri Lankans, and many of them had been in Australia more than ten years.

Weerasooriya suggests that the periods of migration of Sri Lankans to Australia always mark distinct events that are politically, socially or economically significant in Sri Lanka (1988, p.33). Striking changes, especially in the Sri Lankan political arena throughout recent history evoked many feelings of insecurity among the different ethnic groups (Weerasooriya, 1988).

The first wave of migration to Australia took place in response to drastic political and legislative changes in Sri Lanka in the 1950s, after the then prime minister S.W.R.D. Bandaranayake brought about the “Sinhala Only Act” which changed the official language of the country from English to Sinhalese, ushering in profound changes in Sri Lankan society. The change in official language reflected the shift of political power and it proceeded with the introduction of mass education in
the mother tongue (Sinhalese). The main language used by the Burghers had been English and they were educated also in English. At this time, because of the advantage of fluency in English, it was the urban dwelling Burghers who occupied more high status government positions than any other ethnic group. Through these political and social advantages under, and immediately after the colonial government, Burghers constituted an elite class in urban Colombo. With the change of the official language to Sinhalese, Burghers lost their educational and linguistic advantage and associated privileges. Their loss of status was reinforced at this time when a nationalist movement and a Sinhalese Buddhist revival emerged in the country, constituting a concerted opposition to the Western cultural and political domination that had previously prevailed. This drastic change made many Burghers – the descendants of former colonizers – disconcerted and disappointed in the Sri Lankan government as they felt increasingly marginalized in Sri Lanka during this period. These social and political changes provided the impetus for many Burghers to migrate to other countries, including Australia.

The decades of the 1950s, 1960s and 1970s were also periods that saw many social and economic reforms. These included the spread of nationalization, measures for private corporations and services when many private corporations were brought under the control of the government, and land reform that caused a lot of unrest, even among the English-educated urban Sinhalese. These reforms and the change of the official language into Sinhalese made a minority of English educated Sinhala elite and professionals disaffected with the country’s social and cultural environment, which led them to leave the motherland in search of greener pastures.

Under Australia’s “White Australia Policy”, which remained till 1972 through the Immigration Restrictive Act, Burghers were the only category of Sri Lankans who were acceptable as migrants. Burghers possessed Caucasian physical characteristics, in contrast to most other Sri Lankans who were dark in complexion, and their British descent meant that they had cultural and linguistic characteristics that were acceptable to mainstream Australians. Weerasooriya (1988) maintains that the settlement of Burghers was much smoother in Australia than for other groups who migrated from Sri Lanka because they shared very similar cultural, religious and linguistic characteristics with the Australian population (Weerasooriya, 1988, p.60).

The next main wave of migration from Sri Lanka took place in the 1970s following the imposition of strict restrictions on foreign imports during the government of the Sri Lanka Freedom Party
At this time the Sri Lankan economy was faced with an economic shock due to the world oil crisis and food and fertiliser shortages (Lakshman and Tidsell, 2000). This instigated restrictions in the economy that drove many professionals away from the country in search of better lives in Western countries. Australia was one of the countries that saw an influx of professionally qualified Sri Lankans in the 1970s under the category called “distinguished and highly qualified Asians” (Weerasooriya, 1988, p.30). According to Weerasooriya (1988) the settlement of this group of professionals was also relatively easy due to their good English language skills and their prior exposure to ‘Western’ cultural values.

The Sinhalese and Tamil insurgencies in the 1980s gave rise to a third wave of Sri Lankan migration to Australia, mainly comprised of Tamil Sri Lankans seeking asylum. There was a further significant influx of Sri Lankans to Australia in the 1990s, when many skilled people migrated in search of financial stability and success. Many who came to Australia under this migrant category in and after the 1990s were Sri Lankans who belonged to Sinhalese ethnic group with skilled professional qualifications. However their levels of education varied from diploma qualifications in technical and mechanical professions to degree qualifications. It is this category of Sri Lankans who migrated to Australia in and after the 1990s whose stories I will be relating in this thesis.

Pinnawala (1984) categorizes the majority of Sri Lankans in Melbourne as middle class. He further states that it is this middle class position that has made the Sri Lankan community a geographically scattered community. Writing about the factors that affect identity in the Sri Lankan community in Melbourne, he divides the community into three groups. Pinnawala’s categorization sheds light on the sociocultural background of Sri Lankan migrants and their adherence to the sociocultural values they bring with them to Australia.

Pinnawala’s first category is ethnic assimilationists, into which he puts the earliest Burgher migrants who consider themselves Europeans and who have been fully absorbed into Australian society. They would reject the label “Asian”, considering themselves direct descendants of the Europeans. According to Weerasooriya’s grouping most migrants from Sri Lanka who arrived in Australia during the 1950s and 1960s belong to this category.

However it is important to note here that the majority of participants in this study arrived in Australia in the first half of 1990s, i.e. almost a decade after Pinnawala’s PhD thesis.
Pinnawala’s second category is ‘ethnic integrationists’ into which he puts Sinhalese and Tamil Christians who arrived in Australia during the 1970s. Pinnawala also contends that most who migrated during this time were Anglophiles (those who were admirers of English language and English culture) and had a prior exposure to a Western lifestyle and culture. This is a group that Weerasooriya suggested found assimilating and integrating to the Australian society easy (1988).

The third category of Sri Lankan migrants Pinnawala labels is ‘ethnic traditionalists’. Unlike the two earlier migrant groups, ethnic traditionalists have strong bonds with their native country. The process of immigration of this third group of migrants is different from the other two groups. They would migrate to Australia initially having no clear-cut intention of permanently living in Australia. Their decision whether to stay in Australia or not was dependent on the circumstances that they encountered after settling in Australia. As Pinnawala explains, even though this group of people is physically living here, they retain a very strong social existence in Sri Lanka. He says that this is the group of Sri Lankans “who bring the problems of Sri Lanka to Australia” (1984, p.112). By this, Pinnawala means that these Sri Lankans constantly dealt with the issues and problems their extended families and friends encountered in Sri Lanka and often tried to intervene by providing monetary help whenever necessary. They were inclined to cherish a dream of returning to Sri Lanka one day. Pinnawala further observes that because of this tendency to maintain the dream of returning to the motherland, and because they do not consider their stay in Australia to be a permanent one, these Sri Lankan migrants do not make a conscious effort to integrate completely into the Australian society.

This is an important categorization of Sri Lankan migrants in Australia, as in retrospect I consider that most of the participants I interviewed in the study fall into this category of ethnic traditionalists who have only a half existence in Australia and who maintain an active presence in Sri Lanka. During interviews, for example, one theme that recurred was the intention to return permanently to Sri Lanka, one day in the future. Even if they were aware of how complex the process of returning would be, they seemed to relish the thought of it; they seemed to enjoy thinking about and envisaging it.

My husband and I don’t really have the intention of staying in Australia for a long time. Australia is a good country but we cannot live here forever. Our plan is to stay here until we get the citizenship (Australian). All our relatives, connections and
friends live in Sri Lanka. And Prabhathi, we are living a life like this (referring to her old and dilapidating apartment and to her life without many friends and connections in Australia) only after having left a beautiful life in Sri Lanka... (Anula, 33)

Sometimes we feel, “What’s this life we are having here?” We are just busy all the time and do not have a time to breathe. In a way this ‘busyness’ is also good as we deliberately keep ourselves busy. Otherwise one would get just bored. All our relatives and friends are over there (in Sri Lanka). Even as you were walking towards the house I was on a phone call with a friend from my old work place, Sri Lanka Customs, in Sri Lanka. (Denver, 50)

This desire to return to Sri Lanka was shared equally among participants who had spent twenty years or more in Australia and those who had arrived less than five years ago. The number of years spent in Australia did not appear to make a difference to the intensity of this desire. There have been many literary works on migration and migrancy which discuss the tendency for migrants to clutch on to a re-imagined illusion of the past in their home which is far from the present reality of the ‘home’ (Arasanayagam, 2002; Rushdie, 1995; Sarvan, 2011). Although not all, there were many participants in the study who relished the aspiration of returning to an idealised home one day.

Some other authors categorize Sri Lankan migrants into two general groups based on the sociocultural characteristics of their pre-migration periods (Liyanaratchi, 2006). Liyanaratchi contends that there are two large distinct groups of Sri Lankan migrants. The first category is mainly English-speaking, English-educated migrants from the Sri Lankan urban and elite sectors who were accustomed to the Western way of life and who migrated mainly in the early 1970s. The second category is bilingual and bicultural Sinhala Buddhists, Tamil Hindus and Muslims who were mainly educated in the mother tongue and who later acquired English as a second language through professional training (2006, p. 31).

Sri Lankan society and social class

The Sri Lankan community in Australia is far from homogenous, as demonstrated above. When interpreting perceptions, attitudes and ways of life, it was conspicuous in this ethnography that
one’s social class in Sri Lanka seeped into the participants’ ways of being and personal milieu in Australia too. In this section I examine the cleavages of social class and its myriad nuances and shades that affect people’s lives in Sri Lanka.

Social class in Sri Lanka is, as elsewhere, largely determined by economic factors that are complicated by historical, cultural and political determinants of status. Kapferer calls Sri Lanka a very hierarchical society and ‘a highly complex cultural universe that is complicated by doubtless numerous factors’ (1988, p. 102). British colonization in the early 19th century deposed the feudal aristocracy that had ruled over numerous small kingdoms for centuries. However, many of these aristocrats were able to retain or reclaim some of their lands and their descendants today often have large landholdings, plantations and control over primary industry. British rule introduced a new class system that included government bureaucrats, bankers, and professionals such as lawyers, doctors and university teachers as well as a large bourgeoisie that controlled commerce in urban areas. Within Sri Lanka today, class divisions are marked by rural and urban distinctions, as well as these divisions in terms of relations of production.

The wealthy elite comprise landowning families whose business interests encompass not only their rural estates but also large commercial enterprises and urban development. Scions of these extremely wealthy families or lineages may enter professions and so become part of the urban upper class, many gaining tertiary qualifications in Britain or the United States; but few emigrate.

The upper middle class is best characterized by its origins in the merchant, government bureaucracy and professional classes that flourished during the late colonial period and came into their own at Independence. Some come from families who owned land, who employed numerous rural laborers, and whose wealth was in many respects classically middle class. They are secure in their prosperity and social status and provide the standard for those who aspire to social mobility.

A much larger proportion of the population constitutes the lower middle class and working class in both rural and urban areas. Upward social mobility through means of education, foreign employment and immigration are characteristics shared by middle and lower middle classes in Sri Lanka.

Social class is a very complex phenomenon in Sri Lanka and it entails various sociocultural, economic, political and geographical categories. According to many authors who have written
about class divisions in Sri Lanka, the use of English language in social interactions is an important feature that functions as a clear demarcation between classes (Fernando, 1977; Kapferer, 1988, p.96; Obeysekara, 1974). Writing about different types of English that are spoken by Sri Lankans, Fernando divides them into three groups and this categorization has strong socioeconomic connotations. For example she defines the first group as bilinguals who can belong to any ethnic group, show a highly anglicized lifestyle, speak a uniform variety of English and who typically belong to the elite and upper middle class and are members of the legal, medical and educational professions, civil service and commercial executives. These Sri Lankans would use English as the language of home and other social interactions. Fernando classifies average peasants, lower middle and working class groups, who do not speak English and would regard it as foreign and alien, as a second social group. The third group according to Fernando is middle, lower middle and working class who speak English, but with limited fluency. She states that this is the group that gets exposure to English from the school curriculum, where English is taught as a second language. Only a very small percentage from this group would acquire fluency in the language later in life, as university and higher education institute students (Fernando, 1977, p.348-356)

In previous works on social class and acquisition of English as a second language in Sri Lanka, categories such as income, parental education, father’s occupation, language spoken at home and age at which English learning commenced have been examined by social researchers (Karunaratne, 2003, p.3). Karunaratne conducted a study of English language acquisition among school students of prestigious and elite government schools, and demonstrated that only students from upper class backgrounds, delineated by having English speaking parents and large family incomes, showed higher levels of English acquisition.

Obeyesekara (1974) has also demonstrated how the children of the English-speaking elite went to the privileged schools mainly located in Colombo and Kandy, and how the local school system marks one’s social status in the class hierarchy in Sri Lankan society. Added to this, until the 1970s, having a higher education from The University of Ceylon or an English university was a mark of one’s social status. According to Obeyesekere, village youth, in contrast to the elite, generally went to schools that are known as Maha Vidyalayas and Madya Maha Vidyalayas (Central high schools located in the rural areas of Sri Lanka).
With the introduction of the open economy in 1977, many new private education centers and technical colleges were established by the government and privately owned organizations, to cater for those who could not go to the preferred public universities. Despite these changes to the education system, my experience living in Sri Lanka for twenty-five years before I migrated, suggests that the hierarchy among schools and universities described by Obeyesekere persists, and that what school one attended and the ability to converse in English continue to function as markers of social class in contemporary Sri Lankan society. It is common to ask about which school one attended when mingling in the Sri Lankan migrant community in Australia, especially among people who came from middle and upper middle classes. It usually enables the listener to place the other person in this social class hierarchy.

Within Sri Lanka, class origins and attainments are understood in terms of their complex historical formation. People’s consciousness of their own position is similarly grounded in a range of material and symbolic components of social status. Upon immigration, many of these markers become irrelevant or are superseded by class distinctions in the host country. But for the migrant, whose aspirations have been formed in Sri Lanka, ideas about social status are manifested in the material possessions, educational attainments and way of life that they envisaged for themselves in their homeland. It is for this reason that Bourdieu’s theoretical writings on distinction are most useful in exploring the meanings of class and status for Sri Lankan migrants. Bourdieu states that a social class is characterized by many other subsidiary features, that include or exclude others who do not belong to that class (1979).

“The individuals grouped in a class that is constructed in a particular respect... always bring with them, in addition to the pertinent properties by which they are classified, secondary properties which are thus smuggled into the explanatory model. This means that a class or class fraction is defined not only by its position in the relations of production, as identified through indices such as occupation income or even educational level but also by ... a whole set of subsidiary characteristics which may function ... as real principles of selection or exclusion without ever being formally stated... A number of official criteria in fact serve as a mask for hidden criteria...” (Bourdieu, 1979, p. 102).
Social class of Sri Lankans in Australia and its implications on the nature of the community

Sri Lankans living in Australia have been generally depicted as middle class (Pinnawala, 1984; Sherrard, 1994; Weerasooriya, 1988). These accounts drew more on the Sri Lankans’ ability to integrate into the Australian society and lifestyle than on any other social determinants of their life in Australia. Other recent accounts of Sri Lankans however, contest this idea of their predominant middle class status. For example Gamage (1998), writing on the class structure of Australia and using class models proposed by Western and Western (Western and Western, 1998, P.86) and neo-Weberians such as Wild (1978), maintains that a class analysis of the Sri Lankan migrant community is problematic.

At this point it is useful to examine how sociologists explain class in Australia. Authors who have written about the Australian class structure describe it as fourfold and they base divisions on income and occupation (Encel, 1970, p.39; McGregor, 1997, p.12-13). According to McGregor the underclass is the lowest class that is comprised of welfare recipients, the unemployed and the homeless (McGregor, 1997, p.261). The second category is the working class, which is comprised of unskilled and skilled blue-collar workers that include trades people and factory workers. Above the working class there is the middle class, which is again divided into three. Lower middle class which is made up of people with working class incomes but who work in non manual occupations, central middle class which is comprised of professionals working in non-manual occupations with significantly higher incomes, and the upper middle class that is comprised of people with particularly high incomes. The last strata is the upper class which is made up of people with great wealth attained by professional and commercial incomes, or by inheritance.

The statistics draw a positive picture of Sri Lankans in Australia. For example, according to the Australian Bureau of Statistics, Sri Lankans have a socioeconomic status that is much higher than that of other south Asian migrant groups (ABS, 2006). Their median weekly income is $553 and it is higher than that of all overseas born populations ($431) and the Australian-born population ($488). However it is important to note that in these sociological works the possible socio economic aspects that are unique to minority groups like migrants are not taken into account. Nevertheless it provides us a general idea about where the Sri Lankan migrant group is in the Australian class structure.
According to the Community Information Summary produced by the 2006 ABS census, 64.8% of Sri Lankan-born people had some form of higher qualification (ABS, 2006). ABS census data also reports that 93.6% of Sri Lankans living in Australia spoke English very well or well. When considering this relatively high level of English fluency and high median weekly income, one can surmise that most Sri Lankans perhaps belong to a social class that is closer to the central middle class in Australian society, using McGregor’s class classification. Even though McGregor maintains that one’s income functions as an indicator of social class, this does not account for the fact that a person’s income does not always reflect the type of occupation that they are involved in. For example many Sri Lankans that I met in the study were employed in blue-collar jobs in factories. However they were also engaged in other paid part-time and shift work to supplement their main income. Some of them had even bought investment properties over time with this hard-earned money, from which they were getting a regular income. Thus McGregor’s categorization based on income seems too simplistic to explain the complex aspects of the social class of Sri Lankan migrants.

This complexity is compounded by another phenomenon. Gamage (1998) and Liyanaratchi (2006) argue that the social class of many Sri Lankans now living in Australia is difficult to determine drawing on such markers as education and professional qualification. Many highly educated and experienced Sri Lankans enter lower paid occupations such as factory workers, tram and bus drivers, aged and child care workers after migration to Australia. Both Gamage and Liyanaratchi found that many Sri Lankans were over-qualified for the jobs that they were engaged in and that many of them who held middle class jobs in the mother country are now engaged in working class jobs in Australia. Liyanaratchi states that many Sri Lankans encounter problems in the job market, where there are the mismatches between their qualifications and experiences and the employment opportunities (2006, p. 102).

Liyanaratchi (2006) also found that there were numerous factors contributing to Sri Lankans’ downward class mobility in Australia. These include: Sri Lankan migrants’ lack of exposure to and difficulty in understanding the Australian accent, phraseology and idioms; lack of the English communication skills that are required for work; racial prejudices of some employers; inability to understand Australian humor, phrases and colloquialism; feelings of inferiority due to lack of understanding of the Australian culture; and reluctant employment in jobs that they consider as
low status on the part of educationally qualified workers. Therefore Gamage notes that it is with much caution that one should use social class categories that are based exclusively on occupational qualification to describe the Sri Lankan community in Australia (1998). He emphasizes that occupation can only be used as a crude measure to determine a person’s class status in the Sri Lankan migrant community in Australia (2006, p.54).

Nevertheless previous literature also point out that Sri Lankans face crucial employment problems in Australia (Liyanaratchi, 2006, p.150; Richardson, Frances and Diana, 2001) which can lead us to the reasonable assumption that many Sri Lankans encounter downward class mobility after migration. This view stands in opposition to the dominant characterization of the community as middle class, fluent in English communication skills and easily integrated into Australian society. Liyanaratchi is of the view that social integration and adaptation to Australian society and culture by most of the more recent migrants – migrants who arrived in Australia after 1970s, who were educated in Sinhalese or Tamil with or without English as a second language at school – was not as smooth as it was for early migrants, whose adaptation was facilitated by their prior exposure to Western culture and values. It is in this context that the more recent immigrants have established cultural and religious associations and organizations that represent the interests of Sri Lankans who identified as middle class when they were in Sri Lanka.

These subtle differences in the socioeconomic characteristics of Sri Lankan immigrants are an important dynamic in this thesis, as the presence of differences within the community means that education and occupation are not clear determinants of the health related practices and life style of Sri Lankans in Melbourne. This is one of the reasons why an ethnographic methodology was chosen for the study. Establishing on-going relationships and rapport with participants was crucial to gaining a nuanced understanding of the rich and complex elements that affect people’s behaviors, their views of their own status, and their attitudes towards health.

Gamage comes to the conclusion that due to significant changes in the demographics of recent Sri Lankan migrants, the community is now more internally cohesive and there is rather less mixing, integrating, or assimilating into the wider Australian culture and community. Gamage states that the establishment and blossoming of many Sri Lankan Sinhalese and Tamil cultural and welfare organizations, especially in Melbourne, implicitly demonstrates this internal cohesion and segregation from the rest of society in recent times (1998, p. 46).
The example he offers to demonstrate this shift in Sri Lankan migrant demographics is the transfer of the organizing body of the well-known Sri Lankan cultural festival held in April on the Sri Lankan Sinhalese and Tamil New Year. Historically this festival had been organized by an upper middle class cultural organization, the members of which were predominantly English speaking Sri Lankan professionals (Sinhala Cultural and Community Services Foundation, Victoria). Recently control has passed to the so-called ‘working class’ Sri Lankan welfare and cultural organization that is run by the Sri Lankan German Technical College Old Boys Association. One reason for this shift of organizational power was the criticism raised by the latter that the former did not play any active role in assisting recently-migrated families in settling in the country (Gamage, 1998, p.46).

In my research, several people that I interviewed were directly or indirectly connected to the Sri Lankan and German Technical College Old Boys Association (German Tech) in Victoria. Throughout the year they organized several cultural and religious functions across Melbourne, especially in the northern suburbs where there is a large Sri Lankan population, that bring together many in the community.

The aspirations of migration

At least for most recent migrants (I can certainly say this for a large majority of the participants in my study), there were two significant issues that motivated their migration to Australia: to achieve a better standard of living and more financial security than they had in Sri Lanka, and to gain a better education for their children and therefore secure their children’s future.

Denver’s case illustrates this clearly:

Denver was fifty years old and he had three children who had all gone to university. He held quite a high status job in Sri Lanka, as an Airport Customs officer. It was out of paternal love and responsibility that he chose to come to Australia rather than out of reasons of self-interest. This was accentuated in his account where he said that he had to give up the hope of completing an accountancy degree in Australia as he thought his children needed him at home more than he needed his degree.
...So what I am saying is that when having left a good job like that and having to do an “odd job” in a factory like this is surely a stress. For most, an experience like that could be very challenging and stressful, (but) for me it has been ok. The reason is that my intention of migrating and living here is different from them. No matter how high my position would have been there in Sri Lanka, there would have been no way that I could have sent four children here (Australia) for education. I think I could achieve seventy five per cent of my goals. It was my dream to see my daughter becoming a doctor and I could realize that dream. And my youngest son is very weak in his studies. I don’t think he could have ever gone to a university if he was in Sri Lanka... It is because he was here from the beginning that he could go to the university. And my youngest daughter just wants to get a basic degree. She is not too keen on studying hard. But she still could go to the university...

Reasons for migration slightly and subtly differed based on the socioeconomic class and the education level of these migrants. For example for most of my participants who had migrated to Australia as skilled migrants (based on diplomas and experience in technical and mechanical fields), attaining financial security and children’s education were top priorities. However for others who already had a degree or other higher education qualifications, providing children with a better education was not emphasized as a top priority. The latter group had prior experience of higher education in Sri Lanka and seemed more relaxed about their children receiving education either in Sri Lanka or Australia. These differentiations of reasons for migration too were subtly made use of, especially by those more educated when they were in Sri Lanka, to distinguish themselves from less educated migrants who came to Australia as skilled workers in the 1990s.

Views about differences in migration aspirations functioned as a trope for the more educated to be critical about the pursuit of material successes in Australia by ‘most other Sri Lankans’. Here the more educated participants typically referred to the less educated and those who they believed did not originate from a social class as high as they have now in Australia. While the more educated people were ‘othering’ their less educated compatriots, referring to their pursuit of material success, they thought the latter’s lifestyle contributed to adverse health outcomes. In short, what the highly educated participants indicated was that unlike them, their less educated compatriots had migrated in the hope of achieving upward social mobility. According to the highly
educated participants, the achievement of a higher quality of life was their main goal. This group usually talked about the valuable assets that they had left behind in the home country and indicated that before migration they had a higher social status back home.

For example Anula says:

Even though we live in a small apartment like this in Australia we had to leave behind the newly built house in Sri Lanka. I have never stayed in a place like this before. Living in this apartment is like living in a fish tank.

I will be discussing in-depth later in the thesis how these criticisms made of each other in one’s own community regarding the pursuit of material success and upward social mobility, contribute to adverse health effects. Nevertheless with the intention of differentiating themselves from the less educated participants, those who were highly educated consistently represented or projected that their goals for migration differed from the former.

Navin (50), who had a very high status job in the private sector as well as very powerful political connections in Sri Lanka, migrated to Australia ten years ago with his son from his first marriage to reunite with his second wife who was already living in Australia. Anula, a graduate teacher in Sri Lanka and whose husband was a successful architect, had a very financially secure life back in Sri Lanka but wanted to migrate because of the political insecurity (due to terrorist threats to Sri Lanka’s capital city) that they felt in Colombo where they lived and worked. Children’s education was important, even for these people who came from a higher socioeconomic class in Sri Lanka, but it was not the primary reason for migration.

The less educated migrants I interviewed, clearly expressed their reasons for migration, complaining about the ever increasing cost of living in Sri Lanka and their inability to cope with it. Amanda was Ruwan’s (the participant with diabetes) wife and she too eagerly joined in our conversation several times. She did not have diabetes. During one of my visits to their place Amanda mentioned that

…it would have been just a dream for us to build a house such as this one (built in Craigieburn), had we stayed in Sri Lanka. The rising cost of living made saving too difficult to do anything...
Tribulations during settlement

Many Sri Lankan migrants to Australia soon realized that their aspirations are not as easily achieved as they expected. Having talked to many Sri Lankans about the first few years after their arrival in Australia before, during and after my field work, it was evident that for many their new life was a struggle, with more burdens in life than when they were in Sri Lanka, where they usually had help and assistance from family and friends. For many, finding employment and having to start life ‘from scratch’ were difficult and understandably very stressful. Most had to confront disillusionment about finding jobs that were in keeping with their Sri Lankan educational qualifications, training and work experience. Most had to accept positions that gave them lower status; many had to take jobs that were menial and made no use at all of their professional qualifications. For some, these tribulations were exacerbated by loneliness in the new country.

Even though data about the socioeconomic status and the early accounts of Sri Lankan migrants and their ability to integrate are positive, recent research demonstrates that it is often difficult for many migrants to start their life in Australia. Issues such as unemployment, especially among new migrants for whom English is not the mother tongue, have been written about at length (Healy, 1997; Leser, 1998; Liyanaratchi, 2006). Leser found that many skilled migrants suffer from depression, high blood pressure and heart conditions that may be linked to unemployment and underemployment (Leser, 1998). Whether this is statistically true or not regarding the participants in my study, I observed that many felt deep regret and unhappiness that was related to their employment status. These emotional responses were especially expressed by the more educated migrants with diabetes. In describing the employment experiences of Sri Lankan skilled migrants to Victoria, Liyanaratchi (2006) writes that many who migrate under the skilled category faced difficulties in finding employment that matched their skill levels and earlier qualifications, despite these qualifications being accepted as formal qualifications by the Australian government prior to migration (2006,p.81). Liyanaratchi emphasizes the fact that although these people possess paper qualifications and good English skills, their lack of colloquial and cultural fluency and familiarity function as barriers and inhibits their personal and professional growth, which may lead to feelings of inferiority (2006, p. 103).
Unlike the earlier Sri Lankan migrants who arrived in Australia during the 1960s, the more recently arrived migrants, especially those who came after the 1990s, represent a generation of Sri Lankans who have different experiences from those of the earlier cohort. The latter settled down in Australia after challenges and tribulations and it is against this backdrop of settlement experience that my participants, at least most of them, built their lives in Australia.

**Openness, receptivity and genuine interest to ‘fit in’**

It was clear that my participants had risen above all trials and ordeals by grabbing any chance that came their way to get back on their feet. During my observations of several cultural events, as well as in my conversations with some participants and their families, it was obvious that while proudly retaining some core characteristics of their ‘Sri Lankanness’, they were also very accepting of aspects of Australian culture.

Many deliberately changed established habits if they regarded these changes as ways of ‘fitting in’ that were appropriate and as ways of managing their new situation.

Dayan (49), a father of three daughters said that he spoke in English to his daughters when they were in public because he considered it was rude to speak in Sinhalese in this situation. He explained that they always spoke in Sinhalese at home. This demonstrates that not only was Dayan receptive to and flexible in the new ways of living that he found in Australia, but that he also took an active interest in adapting to the Australian society. Although not to the same extent as Dayan, none of the participants adhered strictly to their own cultural ways; for example participants such as Anula, Ruwan and Amanda (Ruwan’s wife who did not have diabetes) who were not fluent in the English language were keen to learn it and to get to know their new environment better.

Unlike the depiction of many South Asian migrant groups in the health literature, Sri Lankans have been portrayed as a people that have been exposed to modernity, irrespective of their location on the island, urban or rural, educated or uneducated. Wickramasinghe depicts Sri Lankans, using
Partha Chatterjee’s expression, as ‘willing consumers of modernity’ whose lives and subjectivities as an island nation are affected by many ‘electronic mediations’ irrespective of urban or rural dwelling (Wickramasinghe, 2006). She further says

...they straddle cultures with remarkable ease as a new *imaginaire*, a constructed landscape of collective aspirations, is being created...(2006, p.330).

This flexibility might also be attributable to the historical phenomenon of being a colonized nation for more than three hundred years. People were exposed to and required to adapt to many Western cultural, social, economic and political changes introduced by successive foreign powers. When health services and Western medical knowledge were introduced, they were quickly embraced by the colonized. Caldwell observes how, like Japan and Kerala in South India, Sri Lanka was eagerly receptive of Western medicine during the colonial period and after (Caldwell et al. 1989). These historical accounts show the openness and receptive side of the average Sri Lankan to change of culture, life and environment. However they are generalizations that do not take account adequately of the range of attitudes that exist within and between communities; nor can they be usefully ascribed to particular individuals.

Gamage and Mahon (1993) argue that especially bilingual migrants go through a dual identity formation and this dual identity formation is a fluid and a continuous process. It is formed by the core values of the two different groups that the migrant identifies with; in this case the Sri Lankan migrant community and the dominant Australian culture. According to Edwards (1986), ethnic group members lie in a continuum between submersion and segregation in terms of their relations with the dominant Australian culture. At one end of the continuum there are migrants who attempt to adhere strictly to their native culture. Gamage and Mahon state that first generation migrants and those who identify themselves with orthodox religious groups often belong to this group. At the other end of the continuum there would be some migrants who try their best to identify with the host culture and neglect their own cultural elements. This may be either due to external pressure or due to the desire to build a new life in the new land. In the middle of the continuum there are those who try to negotiate between their ethnic identity and the identity of the new home. It could be construed that many Sri Lankans described in this thesis belong to the

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middle of this continuum. Explaining this dynamic process of identity formation in the host culture further, Gamage and Mahon claim that a person may never lose a primordial and elemental identity even though he/she goes through a behavioral assimilation; the process of assimilating the norms and values of the host society by a newcomer to that society (1993, p. 119).

Creation of a sense of community

However flexible and open they were with the Australian culture, my participants also tried to retain what is valuable to them from their culture of origin to maintain consistency in their lives (Bottomley 1976). In this section I describe community events in which I participated, to illustrate the ways in which a sense of belonging and community, feelings of nostalgia and identity were evoked within the host country among Sri Lankan migrants in Melbourne.

The Sinhalese and Tamil New Year festival organized by the German Tech Old Boys Association in April is an important community cultural event in Victoria. This cultural event is the one that would see the largest Sri Lankan gathering in the whole of Melbourne. It is held annually in the show grounds in the outer suburb of Dandenong. On this day the celebration resembles a typical New Year festival held in Sri Lanka. It begins early in the morning, around half past eight. As the festival starts everyone present is served a very traditional Sri Lankan breakfast, which typically consists of milk rice (rice cooked with coconut milk and cut into squares after being cooked), traditional sweets and banana. Hundreds of families with young children usually come, especially to enable their children to participate in the traditional games that start in the morning. The games continue till the evening and finish with the competition for the New Year Princess who is selected from among the young girls who are clad in Sri Lankan traditional costume, a long floral designed cloth draped like a long skirt to ankle length and a short, tight top. Sinhalese pop music as well as classical songs play in the background. Around the ground there are various stalls that sell items with a traditional value such as paintings and brassware that have traditional Sri Lankan designs.
Figure 1: A stall with traditional Batik artworks with images from the famous procession of the Temple of the Tooth Relic of Buddha in Kandy, Sri Lankan wild life and Buddhist mythology.

Figure 2: Another stall with traditional Batik designed clothes and wall hangers.
An inexpensive lunch is provided for everyone who comes to the ground. One gets a choice between rice or koththu, a Sri Lankan dish probably influenced by Indian cuisine, which is made with finely chopped up roti and fried vegetables mixed with a spicy meat, or fish curry. Koththu is a very popular dish among Sri Lankans in Australia.

In the background, groups of boys and men play cricket. The event is an occasion for renewing ties with friends. According to Anula, a female participant with whom I established close rapport throughout my field work, it is at this festival that they get to meet and talk with some of their friends who live far away in other areas of Victoria, whom they otherwise do not see during the year. The Sri Lankan New Year festival thus has other functions for the community beyond those of simply joining in celebration. It serves to maintain some traditional aspects of the culture, instilling them in children by showing them what and how things are done at the festival, and also reaffirming the sense of community and a collective consciousness among its people. In this scenario, cultural identity, as Kapferer argues, has served as a strong principle of association within collectivities of people with similar identity (Kapferer, 1988, p.114).

The Sri Lankan Buddhist temple is another very important place where this sense of collective consciousness is revived on a more regular basis throughout the year. Sri Lankan Buddhist temples are very well organized religious institutions in Melbourne, with hundreds of Sri Lankan donors and sponsors. They hold several religious functions around the year, usually every month. One such important religious function that I attended was the Katina function at the Daham Niketanaya Sri Lankan Buddhist temple in Yuroke, in Melbourne’s outer north west. Whereas at the New Year festival people are dressed in colorful costumes, at the Katina ceremony everyone is clad in white. It is customary for Sri Lankans to dress in white or other light colors for the temple, where simplicity is appreciated. White in Sri Lankan culture and religion symbolizes purity,

Katina is a religious ceremony held at Buddhist temples to celebrate the termination of the rainy season retreat. At the Katina function the main event that takes place is the offering by the laity of the traditionally unsown special robe called the Katina civara to the monks, who in turn present it to those particular monks who observed the retreat. The Katina ceremony is usually accompanied with many religious celebrations by the laity and it is celebrated with a keen interest and devotion. It is also mentioned in the mahawamsa (a historical poem written in Pali language about the kings of Sri Lanka) that Katina ceremony was celebrated by the past kings with a lot of grandeur (A.G.S. Kariyawasam, http://www.accesstoinsight.org/lib/authors/kariyawasam/wheel402.html#ch6 Accessed on the 11th January 2013)
tranquility, peace, auspicious events, and the diminution of worldly desires. The usual serene and calm environment in the temple is taken over by the hustle and bustle of children and people preparing for the procession that leads from the bodhi tree (pipal tree: *ficus religiosa*) to the temple hall at the start of the ceremony in mid morning. Months of careful preparation by donors and supporters precede this important religious event in the Buddhist calendar. It is celebrated extravagantly in every temple in Sri Lanka, to mark the end of the rainy season. In Buddhist temples in Australia too Katina is celebrated ostentatiously so that the grandeur of the occasion is stressed.

The procession that starts from the bodhi tree is made up of several groups of dancers who are children from a Sri Lankan traditional dancing academy. While the dancers head the procession, in the middle there is a group of traditional ceremonial drummers clad in exquisite traditional drummer costumes who lead a group of those Buddhist monks who observed the retreat. The journey of the procession starts when the drummers start the beating of the traditional *dawul* and *thammattam* drums.

![Figure 3: Drummers getting ready to lead the monks who walk behind them.](image)
Figure 4: Children who are dressed in traditional costumes in a group dance that leads the procession.

Figure 5: People gathered start to trail behind the monks to the hall to listen to the sermon.
Different groups of dancers dance to the rhythm of folk songs sung by their dancing teacher, who rhythmically steps with them towards the hall alongside the procession. Everyone else who is watching the dancing groups also joins the procession behind the monks to go and sit inside the hall for the rituals that precede the serving of dhana (lunch) to the monks. When the monks finish lunch they give a sermon to the gathered, about the meritorious consequences of serving meals to monks, and the official rituals finish. After this, it is time for everyone else that is gathered to eat their lunch. At the Yuroke temple they served lunch to the laity in plastic boxes. My participant, Damayanti said that this meal was prepared by a group of families who were a part of the organizing committee, of which she was also a member. Damayanti had brought white Basmati rice cooked at her house to put in the boxes. Another group of people had carefully packed the rice with curries early in the morning at the temple. At lunch time one could see how groups of people enjoy the vegetarian lunch talking to each other. The lunch was comprised of a salad made of carrots, a traditional fried onion salad, a fried dhal and a deep fried eggplant. The spicy and sour taste of the curries was immensely enjoyable. I sat with Damayanti and her family and had my lunch while they reminisced about their lives in Sri Lanka.

Figure 6: People start having lunch seated on the benches placed under trees on the temple ground.
Figure 7: Katina meal served to everyone at the temple in a disposable box.

It is notable that at community places such as temples where people gather regularly and spend considerable time taking part in rituals they, especially relatively recent migrants, are introduced to others in the community by people they know already. Anthropologists have noted in works on Sri Lanka, that in these conversations, information such as one’s village of origin in Sri Lanka, where one worked or information about one’s family and relatives are usually shared among people, to seek for common links amongst themselves (Kapferer, 1988, p.114). An important but covert function of an instance where such information is shared is that, apart from widening the social network of the person, this sharing of information also situates the person in a particular social background and class. An idea about the social background of the person could be conjured from information such as where one’s native village is in Sri Lanka, one’s school or university, and where one worked in Sri Lanka, as well as what one’s parents are doing in the home country. Information on one’s social background in Sri Lanka could be a determinant of one’s formation of networks of friends and acquaintance in the community in Australia too. Sitting on the stone benches behind the temple over lunch, Damayanti, the female participant with whose family I attended the Katina function, asked me which school and university I attended in Kandy, Sri Lanka.
Her husband was interested in asking where my parents worked in Sri Lanka. Having participated in numerous gatherings in the Sri Lankan community in Melbourne since the time we migrated to Australia, I was very familiar with this type of friendly and chatty interrogation. As in many societies, information about where one studied in Sri Lanka and about the family background would give a fair indication of one’s social class. It was clear to me at this instance that Damayanti and Palitha (57), her husband, both having attended so-called Sinhalese elitist Buddhist schools in Colombo, were trying to determine my Sri Lankan social and cultural background. Compared to the conversations that I had with people from social backgrounds that were quite different from mine, it appeared to me that between Damayanti, Palitha and myself, there was a sense of closer affinity that was built, because of this sharing of similar social backgrounds. In the community this identification of important social signifiers of people gives rise to the emergence of long lasting friendships.

While having lunch, Damayanti’s husband nostalgically talked about how many elements in the procession have undergone ‘necessary’ changes from those of Sri Lanka. A Katina procession in Sri Lanka was much longer, with more components. The procession at his village temple always featured a decorated elephant amongst the dancers. This opened up a conversation between us, about how things have changed significantly in the temples in Australia. A significant difference that I noticed throughout my fieldwork at temples was the absence of the oil burning smell from the lit-up little clay lamps around the bodhi tree and the dagaba\textsuperscript{10} and the smell of incense, because of the restrictions of lighting fires in Australia. There were notices around the bodhi tree and other places in the temple not to light any oil lamps. At another occasion one participant related to me how the monk in their temple does not allow the performance of the bodhi puja\textsuperscript{11} ritual at the temple as it was causing damage to the tree as well as due to the high water bill it

\textsuperscript{10} The white structure that is situated usually in the middle of the temple compound of the shape of a pile of rice.

\textsuperscript{11} Bodhi puja is the veneration ritual of the Bodhi tree under which the Buddha attained Enlightenment. Bodhi tree is an essential element in every Buddhist temple on the island. The ritual is performed by reciting poems of praise of qualities of Buddha while circumambulating around the tree and bathing tree with three pots of water. It is said that the veneration of the Bodhi tree fulfills the emotional and devotional needs of the person in the same way he worships an image of the Buddha (Kariyawasam, 1996).
would impose on the temple. People resented this stricture on their performance of these important symbolic rituals.

At the temple, people, even those who are strangers, greeted each other with broad smiles. The atmosphere was one of conviviality. From the volunteers who were directing traffic into the temple to those who were engaged in performing religious duties inside, there was a markedly well-planned organization of duties and responsibilities. An ethos of communal harmony pervaded. Kapferer argues that in Sri Lanka there has been a generalization and the decontextualization of local and folk traditions over decades. Following Anderson, he ascribes the way that ‘print capitalism’ created an ‘imagined’ community whereby restricted and constricted folk knowledge became widespread, enabling the emergence of a unifying Sinhalese Buddhist consciousness that surpassed all class and caste barriers, enveloping people in bonds of kinship and solidarity (Kapferer, 1988, p.90-103). This unity that Kapferer refers to is observable also at the New Year festival and at the temple in Australia.

However in Australia one important factor that was noteworthy at this occasion was that a large majority of people who were engaged in the organization of this event were older, middle-aged and established migrants rather than new or young migrants, with or without young children. An aura of inclusion and social confidence was apparent from the older group in their comportment in the temple. The monks too appeared to be communicating more with this group of established migrants than with the young ones. One occasion that young and new migrants with young children actively took part in this occasion was the procession. Apart from this, it was evident that they were more spectators of the event rather than active participants. Behind the façade of this sense of community, togetherness and conviviality, there were also hidden nuanced divisions that one could see only if one looked at it with a critical and analytical eye. During in-depth interviews themes such as loneliness and feelings of foreignness in one’s own community were often raised as an aspect of life that contributed to the sense of absence or lack of fulfillment felt by more recent as well as more established migrants. This theme of segregations in the community will be discussed at length in Chapter 7.

In this chapter I argue that the contemporary Sri Lankan migrant community in Australia is characterized by complex inflections of class identities and diverse migration goals. In spite of their receptivity to change, the initial migration goals of Sri Lankans play an important role in their lives.
Later in the thesis I discuss how these goals shaped participants’ lives in Australia, at times impacting negatively on their disease management regimens. In the next chapter I shall discuss how the participants viewed diabetes and its management in Australia. I describe how education, combined with the values instilled in them while growing up in a South Asian culture, gave rise to a complex and layered conceptualization of the illness and its control regimens.
Chapter 4: Diabetes and illness perceptions

This is a chapter about diabetes as an illness and the perceptions of this illness held by Sri Lankans. In this chapter I discuss the nature of diabetes among Sri Lankans in Australia in detail. I shall also delve into the disease management strategies of Sri Lankans. I argue that lay perceptions of the illness and management strategies bring into view the many ways in which people attempted to reconcile advice from health professionals with the meanings they had attached to the disease in their lives. This provides a backdrop to the following chapters in the thesis that discuss the social, cultural and personal factors that affected participants’ management of their diabetes.

Diabetes – The Medical Perception

Diabetes is a metabolic disease that results in high blood sugar because the body does not produce enough insulin or because the cells do not respond adequately to the insulin that is produced by the pancreas (Shaw, 2012, p.3). As it can progress in the body asymptptomatically for several years before developing any complications, it is called a ‘silent pandemic’ in Australia (Shaw, 2012, p.15). Over time if poorly managed, it can lead to a plethora of long-term health complications and co-morbidities in the eye, kidney, and the nervous and circulatory systems (AusDiab, 2005). In addition, many recent studies about diabetes, identify loss of mental health and well-being as a common side effect of diabetes (Goldney, Philips, Fisher and Wilson, 2004; Rock, 2003).

At diagnosis in Australia a person is usually provided with a complete medical evaluation to determine the category of diabetes\(^{12}\) and also to identify possible diabetic complications that have already developed. After diagnosis, the patient is initially assisted by the health professional to develop a care plan. In this management plan, dietary and exercise guidelines are provided for the patient by a health professional, along with recommendations to measure blood glucose regularly.

\(^{12}\) The three types of diabetes are type 1 diabetes (also known as the insulin dependent diabetes), type 2 diabetes (the most common form of diabetes which is also known as the non-insulin dependent diabetes), and gestational diabetes (which is diagnosed in the middle of a pregnancy and predisposes women to the development of type two diabetes later in life).
and information about metformin\textsuperscript{13} therapy (Diabetes Care, Position Statement, 2012). According to the progression of the disease, the health professional may continue to increase the drugs given to the patient until he/she approaches the stage where one or more daily insulin injections have to be taken to manage blood glucose.

It is a disease that can be viewed as posing a constant threat to the health and wellbeing of the patient and potentially that of the family too, if not managed properly. In diabetes care a high emphasis is placed on self management, in which the patient is required to incorporate several lifestyle modifications related to healthy diet and exercise and to adhere to a strict regimen of medications if necessary (Van den Arend, Stolk, Krans, Grobee and Schrijvers, 2000). In this regimen the patient is also expected to check and monitor blood glucose once or several times a day, using an apparatus called the glucometer (Lawton, Peel, Douglas and Parry 2004; Peel, Parry, Douglas and Lawton, 2004). In Australia, it is usual for the diabetes patient to receive care from a team of health professionals that may include a diabetes educator, nutritionist, podiatrist, nurse, dietitian and a mental health professional. This team is usually coordinated by a general practitioner. Diabetes care involves lifelong, regular blood tests, and investigations to check for complications, and a continuous process of education at every stage of the disease and its progression (Diabetes Care, Position Statement, 2012).

However, despite support from a large team of health professionals and receiving extensive education and information about diabetes management, many patients with diabetes are reported to be struggling to follow professional advice (Nagelkirk, Reick and Meengs, 2006; Sullivan and Joseph, 1998). There is also research which states that many patients’ commitment to disease management decreases over time (Lawrence and Cheely, 1980).

\section*{Diabetes in Sri Lankans}

The whole of the South Asian region has been identified as a hotspot for diabetes and the countries in it have some of the highest diabetes prevalence in the world. Studies show that in the

\textsuperscript{13} Metformin is the medication that is usually recommended at the initial diagnosis. It is usually in tablet form.
South Asian region it is estimated that prevalence of diabetes will increase by over 151% between the years 2000 and 2030. For the same period of time the estimated increase of diabetes globally is 40% (Wild, Roglic, Green, Sicree and King, 2004). Studies also demonstrate that South Asians are at a much higher risk of developing diabetes than other races and ethnicities (Mckeigue, Shah and Marmot, 1991; Yajnik, 2004). Some of the reasons for this high vulnerability are thought to be related to the specific genetic disposition of South Asians, culturally determined ways of food and eating patterns, lack of physical activity and increasing body weight, and age of this group of people (Mohan, Sandeep, Deepa, Shah and Varghese, 2007; Menon et al. 2006). Many studies have demonstrated that South Asians also have a higher risk of developing diabetes at a younger age (Mukhopadyay, Forouhi, Fisher, Kesson, Sattar, 2006).

Sri Lanka is one of the countries in South Asia with a high prevalence of diabetes. Studies have found that in Sri Lanka, one in five adults has either diabetes or pre-diabetes and one third of this pre-diabetes group is still undiagnosed (Katulanda et. al. 2008). It is possible to surmise that even if a Sri Lankan has not been diagnosed with diabetes at the time of migration, there is an elevated chance of him/her developing diabetes at any time after migration simply because of the high prevalence in the home country.

Even though the prevalence of diabetes is high in Sri Lanka, there are substantial problems that Sri Lankans with diabetes have to confront in the health care system. From my experience of field work in Sri Lanka, the inequality in care and attention that patients received between public and private hospitals was a significant issue. Those who cannot afford the services of private health care were usually unable to spend more than three minutes with the doctor. According to three health professionals that I interviewed in Sri Lanka, the general hospital was always short of metformin and other medicines prescribed for diabetes and therefore they could not provide the patients with the necessary diabetes medicines. It was also the experience of the health

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14 Pre-diabetes is also called Impaired Glucose Tolerance (Diabetes Australia, 2013) and this condition in the body at a young age, may lead to type 2 diabetes later in life.

15 Medicines were free for patients who attended clinics in general hospitals in Sri Lanka. Apart from clinics for such as cardiovascular diseases, since they were more trusted than those in private hospitals, it was mostly poor working class, lower middle class and rural peasantry who visited diabetes clinics in Kandy general hospital more often.
professionals that for many patients in rural areas who could often only afford the cost of travelling to the Kandy General Hospital, the prescribed medicines and further tests were unaffordable. One endocrinologist further commented,

... added to the difficulty to manage diabetes, due to the financial costs attached to it, there is also another big problem that I see in the health care system regarding diabetes care in Sri Lanka, i.e. the lack of education materials for these patients. Especially due to the low budgets of public and government hospitals and also the ministry of health, even though it is a big problem in the country we have very few materials to give away to patients who come to these hospitals, as a means of educating them about the disease...

It was difficult to find any published articles about the anthropological and sociological importance of the disease and the sociocultural and economic burden it places on the community in Sri Lanka. However, interviews with health professionals in the public and private sector suggest dire problems in diabetes management, especially for patients from low economic and rural backgrounds. Drawbacks associated with the Sri Lankan health care services for diabetes patients were reflected clearly in the stories of participants who had received care in Sri Lanka before migration. Most participants in Australia acknowledged that they would not have access to similar services had they remained in Sri Lanka.

Diabetes and South Asian migrants in Western society

Many studies conducted in affluent Western societies demonstrate that there is a higher prevalence of diabetes among South Asian immigrants than among migrants from other parts of the world. Studies also suggest that there has been a dramatic increase in diabetes among South Asian ethnic groups living in Western and developed countries (D’Costa et al., 2000; Riste, Khan and Cruickshank, 2001). An important explanation of this tendency to develop diabetes among migrants to more Westernized societies, is their exposure to new cultures and the effects of acculturation (Greenhalgh, 1997; Ness, 1977). This is called the ‘acculturation hypothesis’, which is defined as the experience of deteriorating health conditions by migrants from cultures that have
inculcated protective health practices (Franzini and Fernandez-Esquer, 2004). Other researchers have attributed this health deterioration to a variety of other factors, including lifestyle and living conditions, the lack of social support networks, cultural and language barriers, experiences with racism and lack of awareness of the harmful effects of cultural health beliefs and practices (Lassetter and Callister, 2008). Concerning South Asians, there is also the hypothesis that they are genetically predisposed to the onset of diabetes (Yajnik, 2004). A combination of these factors gives rise to higher diabetes prevalence among South Asian communities in many Western affluent societies, including Australia (Abate and Chandalia, 2001; Venkataraman, Nanda, Bewaja, Parikh and Bhatia, 2004). Two studies by Thow and Waters (2008) and Colaguiri, Thomas and Buckley (2007) identify Sri Lankan migrants in Victoria and New South Wales, as communities with very high diabetes prevalence.

When settling in a new society, immigrants go through many stressors that sometimes they view as causing various illnesses (Schoenberg, Drew, Stoller and Kart, 2005). In the migration process, after the physical relocation, migrants experience life transitions such as socioeconomic changes, family role modifications and sociocultural network changes (Messias and Rubio, 2004). This physical, social and cultural relocation is thought to have positive as well as negative impacts on the health of voluntary migrants (Hull, 1979; Messias and Rubio, 2004). These changes in health are believed to be related to stress, feelings of disorientation, alienation, exposure to racism, changes in lifestyle and sociocultural environment (Elliott and Gillie, 1998; Frisbie, Cho, and Hummer, 2001; Lassetter and Callister, 2009; Robertson, Iglesias, Johansson and Sundquist, 2003; Sharareh, Carina and Sarah, 2007; Steffen and Bowden, 2006; Steffen, Smith, Larson and Butler, 2006; Williams and Hampton, 2005). Research suggests that it is fair to surmise that immigrants to Western developed countries encounter significant social, cultural and psychological barriers and challenges for the effective and efficient management of diabetes.

According to Messias (1997), there is no identifiable marker that signifies the conclusion of the migration process. Migration and settling are prolonged processes that do not have a clear conclusion. Given this, how can we look in to the different stages of settlement and understand the challenges migrants face in managing a chronic illness like diabetes? Ethnographic research exploring the range of perceptions about management of diabetes held by migrants to Western
societies, provides insights into the diversity and complexity of experiences that migrants have in managing diabetes.

**Exploration of lay perceptions of chronic illness**

Although people’s beliefs about illnesses have been extensively explored in anthropology, there has been less emphasis on exploring lay perceptions of the causation of chronic illnesses (Blaxter, 1983; Mercado-Martinez and Ramos-Herrera, 2002; Pill and Stott, 1985). Many researchers demonstrate the importance of investigating lay perceptions of illnesses, as a way of gaining a comprehensive understanding of the elements that shape people’s health care and chronic conditions, not only in industrialized, Western developed societies but also in developing societies (Mercado-Martinez and Ramos-Herrera, 2002; Shcoenberg, Amey and Coward, 1998). People’s subjective accounts of illness causation and management are also important when attempting to facilitate change in behavior in health related matters (Parry, Peel, Douglas and Lawton, 2006). More importantly, an ethnographic inquiry that takes place into lay perceptions about diabetes can provide an in-depth understanding of the socioeconomic conditions that have shaped the perceptions and understandings of diabetes, health seeking behavior and management strategies of this group of Sri Lankan migrants living in Australia.

When interpreting the understandings of diabetes of the Sri Lankan participants it can be seen that their explanatory models include a mélange of commonalities in their experiences – some related to migration, others to their lives in Sri Lanka. Bury argues that when “lay people construct and present narratives of their experiences, they do so within cultural settings which provide specific forms of language, clichés, motifs, references…which allows and constrains what is said and expressed” (Bury, 2001, p.278). Crawford too is of the view that to understand the reality of a society one has to examine what he calls ‘core- narratives’ that stem from the dominant social and cultural values and categories (Craword, 1984, p.61-62). Crawford contends that these core narratives shape – and are reflected through – the narratives of a people in a society. On this basis I contend that this group of stories of diabetes reflect the core narratives of a specific time and place; they are being produced within their particular use of language, clichés, motifs and references that are specific and intrinsic to this group of Sri Lankan migrants in Australia.
Perceptions about causation of diabetes

Unarguably a complexity that is added to the challenges of providing health care for migrants in any health care system, is the health beliefs that migrants bring with them to their land of settlement. Among these beliefs, which could fall into the categories of cultural, social and personal, beliefs of disease causation take an important place for several reasons.

Lay people’s views of illness causation are important in health service delivery as these perceptions form a basis for subsequent care-seeking behavior and their treatment of the illness in everyday life (Furnham, 1988). Hunt, Valenzuela and Pugh (1998) maintain, while looking at the relationship between the causal stories of diabetes and treatment behaviors of Mexican migrants in American society, that “consideration of causal reasoning of patients opens up a window onto the understanding and interpretations of their illness” (1998, p.960). Hunt et al. found that in their study, the group of Mexican Americans tended to relate their treatment behavior to their perception about the cause of diabetes through their personal stories (1998).

Participants in my study had different perceptions and levels of understandings of the disease. In this section I examine their subjective perceptions of diabetes causation in order to shed light on challenges that are faced by the Sri Lankans in diabetes management. The Sri Lankans’ perceptions of diabetes causation also elucidate reasons why some people do not take active responsibility in effective disease management.

Strong family history, acceptance and fatalism

Apart from five participants (Anula [33], Chandra[49], Dayani [71], Ruwan [34] and Amarawathi [72]) all others claimed that they were diagnosed with diabetes after migrating to Australia. When discussing the perceptions and understandings of the etiology of diabetes, most of them offered candid explanations in terms of family history. Nine participants claimed that the reason for their diabetes was familial. All nine of these participants had either one parent or both with diabetes. Therefore their perception of the cause of diabetes in this case was on par with the bio medical explanatory model of the disease that draws links to the disease from one’s family history.
However, only one participant, Edward (51) related his own condition to the physiological causes of the disease. Edward referred to the impairment of insulin or pancreas to respond effectively to the glucose level of the blood as the cause of diabetes. Edward said that he became diabetic because his father has passed on that gene to him and he had a genetic makeup that did ‘not allow his sugar level to go down’ below fourteen in the glucometer.

Among the nine participants who referred to family history as the main cause, there was greater acceptance of the disease than for other participants. For these nine participants there was a stronger sense of embodiment of diabetes in their lives as they considered it a part of their bodily makeup. The association between the family history might also be viewed as having a compelling liaison with the view of karma as the cause of the ‘suffering’; in my view both perceptions about diabetes combined to accentuate the attitude of acceptance of the disease.

Most participants, as they started to feel relaxed with me, were more honest about how diabetes had affected their lives. Participants who considered themselves to have high blood sugar levels – such as Denver (50), Athula (51), Champaka (47), Edward (51) and Sunimal (53) – often described diabetes as a “karuma lede”. This refers to the Buddhist concept karma with its connotations of unavoidability and inevitability and the effects of past deeds, good or bad, a person has committed in his previous lives. In referring to diabetes as a “karuma lede” they expressed fatalism, acceptance of suffering and their destined succumbing to diabetes.

**Effect of lifestyle as compounding cause of onset**

When talking about family history as the cause, self-criticism was inevitable in most of the nine participants with a strong family history of the disease. For example Dayan (49) said:

...compared to how my uncle, who was a teacher at the St. Thomas College in Colombo, who always had a flat stomach and a very fit body always until he died at

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16 *Karma* and suffering were concurrently used to refer to diabetes by participants.

17 “karuma lede” can be translated directly as the illness that has afflicted someone from one’s own bad karma.
an old age, no one in my family was careful about healthy eating. There was no concept those days called healthy eating in the first place. There were five of us in the family and my mother always cooked a lot of rice and curries at home for all three meals most of the days. And unlike now we were all used to eat a lot more rice and not many vegetables. That was how we were used to eat. So there is no wonder that my father got diabetes early...

Anula too, when talking about her father’s diabetes as a cause of her own diabetes, referred to the ways of familial cooking and eating in Sri Lanka. Similarly, Nalani (54) also referred to her mother’s diabetes as a cause for her own diabetes. However the explanation of family history was often coupled with descriptions of cooking and eating in the family in Sri Lanka, to the extent that they could not exactly explain which came first. Nalani said, gesturing to her mother (who was present at the interview and who is also diabetic):

...I think it’s because it runs in the family. My mother has it and now my brothers too have it. And of course it was not a surprise that we all got diabetes because of the way of her excellent cooking (She was not at all blaming her mother here. But it was meant to be a compliment to her cooking skills). And even now it is the same reason why I find it very challenging to keep it (blood sugar measurement) under a certain count because when she cooks rice or other sweets the most difficult thing is to resist them (both laughing)...

Athula (51) mentioned an unexpected benefit his extended family received after he was diagnosed with diabetes in an early age of forty one just two years after migrating to Australia.

When the doctor said that I was diabetic he asked me whether I have any siblings in Sri Lanka. And when I said yes he asked me to advise them to get a blood check done. I have five siblings and when they did it after I asked them to go to the doctor they found that my older brother too had high blood sugar. Then only recently my two sisters too found out that they have it.

These causal explanations which were tangential and blended with biomedical explanations of diabetes are not unique to this South Asian group of migrants. Other studies have recorded similar perceptions of causes of diabetes and its management among different groups of people. For
example Hornsten, Sandstrom and Lundman, while exploring the personal models of illness among a group of people in Sweden state that heredity was claimed to be a significantly acknowledged reason for the onset of diabetes among most groups. In a study conducted among Latino migrants and European Americans, both groups referred to heredity as a main cause of their diabetes (Chesla, Skaff, Bartz,, Mullan and Fisher, 2000). However this research also found that the European Americans were more medically oriented in their explanations than the Latino migrants. In another study of Yugoslavian migrant women and Swedish women, the former referred to social reasons as well as supernatural causes for the onset of diabetes while the latter referred to more medically oriented explanations that included impaired insulin production and distribution in the body (Hjelm, Nyberg, Isacsson and Apelkvist, 1999).

**Stress from issues in Sri Lanka**

Many of my participants attributed their diabetes to social causes, appealing to their migration experiences for the onset of diabetes. They spoke of the stress stemming from work and familial responsibilities towards the extended family in Sri Lanka. For example for Anoja (47), a forty six year old woman who worked in a sewing workshop owned by another Sri Lankan, the main worry was her ailing elderly mother in Sri Lanka. She said she does everything to help her mother by visiting her as frequently as she can and by sending her money to help. But as the eldest in the family she felt it was her responsibility to look after her mother and she worried that her assistance was inadequate. To obtain some relief from this stress she meditated every night. She thought that every time she worried about her mother’s health in Sri Lanka her blood sugar level increased significantly. Navin too said his diabetes must have been caused because of the stress and emotional upheaval he had to undergo during the period of his first divorce back in Sri Lanka.

**Migration as the cause**

Participants also referred to the sudden change of lifestyle associated with migration as a cause for their diabetes. They talked mainly about the change in diet, as the cause for onset. For
example, Ranil (50), Athula, Tissa (53), Sunimal (53) and Athil (53) stated that migration was associated with the start of consumption of too much processed meat in Australia (Athil, Athula) and too much chocolate, fruit drinks and cheese in the Middle East (Ranil, Tissa), and they attributed their diabetes to these changes in consumption patterns.

Athil had a host of explanations and reasons for the onset of diabetes that derived from his experiences of being a migrant.

When we came here we became very busy. When we were in Sri Lanka we did not have such a busy life. I worked for the Brown’s group in Sri Lanka. We really had a more relaxed and happier life there. Even there I went to work sites and used to come home in the evening. And there I felt more relaxed and free when I came home in the evening. I had my first two children when we were there. I didn’t have any servants there. But we lived close to all our family. My sisters, brothers and my parents we all lived close by. So it was like one big land (watta) that we had built our houses and lived in. There were four houses in there. So when we lived in Sri Lanka we had more joy in life…. Now it’s not to say that we have a lot of problems here. It is all OK here and we do have a good life in Australia. But life has become so very busy… It could be because of the increase of oily food that we started eating after coming here that I got it. In Sri Lanka we didn’t eat as much oily food like this. Did we? (The interrogative directed at me for my approval of his experience and understanding). And we started eating a lot of meat too. I think that can be considered as one reason…However sometimes I think this could be a reason too. When I came here ten years ago I smoked. And I had to go to the city for work. What I did was I drank a lot of tea and had very few meals… and also because it was a very stressful job that I used to do then… the nature of my job was to go out and make the (computer) network work again. So what happens is when those networks go messy the network inside your head also goes wrong. To get rid of that stress what I did was to smoke. Then later I quit it by myself…

Quitting smoking would have only added a benefit to his health and to his diabetes management regimen, but he clearly associated smoking with stress.
Athil speculates that stress and lack of mental relaxation he experienced in Australia as a migrant caused the onset of diabetes. Similarly, Sunimal appealed to the drastic change in his life upon migrating to Australia. He thought that the change of eating patterns because of demands of the lifestyle they had to lead as new migrants was one of the major causes that affected their health in their first years.

I never thought I would get diabetes because no one in my family has diabetes. My mother is still living and she is ninety four years. And she has no diabetes... So when I came here if I got thirsty I only drank a Pepsi or a Solo (brands of soft drink). But when you are in Sri Lanka you only drink water isn't it. And I never thought anything dangerous or bad about eating a lot of sweets because of that family history. In the past when I ate chocolates I didn’t stop from one or two little squares but I had it in whole big blocks. If I was in Sri Lanka I don’t think I would have done it. In the early days during the night shift at the factory we used to get pizza and a big Coke bottle around eleven in the night and I would come home within half an hour after eating and fall on the bed. Those days I emptied one and half liter bottle every night with a big pizza...

Thus from the perceptions of Sri Lankans, coming to Australia was a salient factor that contributed to the change of lifestyle that resulted in the onset of their diabetes. Nevertheless none of them believed that coming to Australia was the sole cause for their diabetes. Everyone thought diabetes was inevitable no matter where they lived. But they also thought that had they remained in Sri Lanka then their onset would have been delayed because the ‘environmental support’ in Sri Lanka would delay onset. According to Ranil

..And I think the weather here has an effect on us that makes us not feel like doing any activity, it makes you feel like staying in one place. There is nothing you could do during winter. You feel like sleeping all the time. I went and had a nap just before you came here. In Sri Lanka you can't do that. It is hot in Sri Lanka so you cannot sleep like that whenever... If this was a day in Sri Lanka we would at least go to the neighbor’s house or else we would do something in the garden. Things like that we did not really appreciate in Sri Lanka are lost to us here. The short walk to and from the bus halt are things that we take for granted but which really have a
positive impact on our health. But here you don’t get them. The only place you walk to is to the garage (Laughing). Maybe that’s one reason that diabetes is delayed in people because you get the support of the environment to delay it in your body...

He contrasts the two environments, Sri Lankan and that of Australia, along the lines of these inadvertent positioning of controls over the individual behavior that ultimately impacts on one’s blood sugar.

...when living in Sri Lanka we do things that are good for our health unintentionally... Foods like pizza are unaffordable to ordinary people in Sri Lanka. Here a pizza is 5 dollars. And to a family of two buying a pizza is much cheaper than cooking a meal... so in Sri Lanka you are controlled naturally. And in Australia you are naturally pushed to have the unhealthy choices. It was the same in Dubai too. Here you can eat to your heart’s content. But until it (diabetes) is fully there in your body you wouldn’t even know. If I stayed in Sri Lanka I could have delayed it in at least ten years. This is because of (inadvertent) physical activity and the lack of affordability of very rich food...

In the aforementioned study by Lawton et al., Indian and Pakistani respondents referred to migrating to Britain as the main event that gave rise to circumstances in their life that caused their diabetes (Lawton et al. 2007, p.901). For them these circumstances included not having the right kinds of foods and medications available for diabetes, having to work hard for the family and the stress arising from that work. However, Sri Lankan participants in my study did not particularly complain about the lack of availability of particular foods or medication for diabetes in Australia. As a matter of fact, unlike the South Asian participants in the British diabetes research, except for five participants (Anula, Eresha, Dineth, Chandra and Champaka) none used any alternative medication for diabetes. To my surprise they even tended to disparage the use of alternative diabetes medicines from Sri Lanka. They had deeper faith in Western medicine and also believed that a mix of medications from two systems could even be hazardous to health and disease management. This could well be due to their prior exposure to Western medicine in Sri Lanka and the reinforcement of this image of the superiority of the Western medical system in Australia too.
Even though the Sri Lankans viewed migration as an aspect that had a negative aspect on health, they were accepting and appreciative of the elements of lifestyle that they encountered in Australia in relation to diabetes management.

**Appreciation of life in Australia**

The participants were satisfied and appreciative of the services and care they received from the health care sector in Australia after being diagnosed as diabetic. Eresha was a medical doctor with diabetes and she had experience in a diabetes clinic in a general hospital in Sri Lanka. She compared the qualities of services she received in Sri Lanka and Australia. She said that diabetes services in Australia offered very comprehensive, regular and organized care for the patient.

Ranil was receiving social security from the government at this time as he was unable to be employed because of a physical injury that took place a few years ago. Ranil articulated his appreciation of living in Australia for a peculiar reason, which did not resonate with the perspectives of other participants.

This country is million times better than Sri Lanka. They don’t go to pick on other people’s business and would only mind about their own affairs. And at the same time we are on a very low level of status here. *Api leda godak age dara gena inna minissu.*

Even though in his eyes, ‘living off the dole’ conferred a low social status, Ranil was very grateful for living in Australia because, in his view, Australian society looked after him and his family like the Sri Lankan society would not have done at a time of financial difficulty. Thus even though they were simply stressing on the inadvertent aspects of the lifestyle in Australia that they thought may have precipitated the onset of the disease, they understood equally that life in Australia had a

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18 Ranil was unemployed at this time because he had to resign from his previous job due to a work place injury that caused a permanent impairment of his right hand. Due to this situation he could not work long term and physically strenuous work.

19 *Api leda godak ange dara gena inna minissu* means we are people who are bearing a lot of illnesses.
positive impact on the management of diabetes especially in relation to the care and health services that they received.

Perceptions about diabetes and management strategies

In this section I will discuss about the participants’ perceptions about diabetes, its consequences on their life and briefly, about their management strategies. The meanings that people attach to an illness condition and the interpretations that they develop about the condition are considered as intricately connected with how people cope with the illness and manage everyday life (Carricaburu and Pierret, 1995).

The participants’ understandings and attitudes about diabetes varied. They ranged from the expression of a very negative to a careless attitude towards the disease. Most of the participants in the study made some effort to control what they cooked and ate, to varying levels. If the participants felt that their adherence to a management regimen was not adequate, regardless of whether they had a fatalistic attitude towards diabetes or not, they expressed this negligence of management in a tone of guilty conscience. Athula and Tissa for example looked embarrassed about not being able to keep a lower blood sugar level. It is significant that despite their fatalistic attitude towards the disease, they were aware of the possibility of maintaining a healthy blood glucose level had they managed diet and engaged in physical exercise. Hence is my rationalization of their guilty conscience and embarrassment about not adhering to these management guidelines.

However participants such as Navin and Denver were not reluctant to express how they honestly felt about diabetes management. Navin said that he does not do anything other than walking around the block as exercise. He did not do any regular tests of blood glucose or control what he ate. He did not even have a glucometer at home. He was honest about this style of living, not only with me but also with his doctor with whom he candidly expressed his reluctance to change his way of life. Denver too had a very laissez faire attitude towards following specific strategies to manage diabetes. He did not engage in any regular exercise, was frank about it and did not seem to be embarrassed about it unlike others. And although he was not very open with his health care
professionals about the issues that he was facing in diabetes management and its side effects such as impotence, he was very frank and truthful with me about his genuine lack of interest in management. For Denver, his life was far more complex than ‘having to manage diabetes’. He felt that he had come to a turning point in his life after having seen most of his five children excelling in life, achieving what he expected them to be\(^{20}\). After ‘helping’ them to achieve a good education, he felt that his life tasks were over. His story about his daughter’s recent visit reveals his attitude to life.

...she was really scared when I called her and asked her to get ready for a funeral (laughing), because over two days there was a subtle pain in my chest. Because she is a doctor I thought of calling her about it. She came here with her husband at that instance from the city where she lives with her husband and was admonishing me to go to the GP as soon as possible. (Lightheartedly) I just told her that if it is meant to happen and if it’s my time I will have to go and that I’m not one bit sad to go as they all can look after themselves and can get on their feet independently now...

His point was that he was not scared of death and thus was not interested in taking care of himself, so diabetes management was ‘not worth the effort’. And he made no effort to hide about it to his family or to me.

For Anula too the necessity to manage diabetes did not pose a threat to the way she was always used to eat. She said

... when I go shopping I don’t just select what is good for diabetes. There are other people too in the house. Anyway I don’t restrict what I would like to eat because of diabetes. Diabetes \(\text{thiyenawa kiyala bala bala inne ne}\)\(^{21}\). If there is something that I like to eat I would eat it. What’s the point in having a life like this (she was referring to her new restricted life in Australia in an old apartment at the time of the interview) if we don’t even get to eat what we like.

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\(^{20}\) The impact of the sense of completion and contentment in life is discussed in a later chapter

\(^{21}\) I just don’t weigh and measure everything to see whether it is good or bad for diabetes.
Many participants were very resistant to the idea of making the drastic changes to food, cooking and eating that were advised by health professionals. Sri Lankan participants’ views regarding cooking and eating differed significantly from those of many other South Asian migrants with diabetes, in countries like the UK. The study by Lawton et al (2008) examined the views of Pakistani and Indian migrants and White British diabetes patients about diabetes and food. While the latter group referred to discourses of ‘gluttony’, ‘excess’ and ‘guilt’, the former referred to discourses of ‘restraint’ and ‘cutting down’ what they saw as ‘risky foods’ such as the rotis, rice and curries (Lawton et al. 2008). Contrary to these findings, several respondents in my study were strongly resistant to change of eating habits despite their responsibility to manage diabetes and no one, except one female participant during only one occasion, referred to any food as risky.

The need to engage in physical exercise too did not weigh much in daily life. Despite knowing the importance of exercise and diet modification in the management of diabetes, all participants acknowledged that it was impractical to think about managing sugar, at times such as when they were socializing; and most participants felt that it was just too difficult to go for physical exercise within their daily schedule. However this is not a uniquely Sri Lankan challenge to diabetes management. A lack of physical activity was also seen particularly among Pakistani and Indian migrants living in the UK, to which researchers have attributed lack of time and opportunity, social rules and cultural expectations and lack of socialization into sporting and outdoor activities (Lawton, Ahmad, Hanna, Douglas and Hallowell, 2006,p.51).

One important pattern that emerged clearly in these interviews was that except for a few participants whose blood sugar readings were often too high, the others were not too concerned about the consequences and the impact of diabetes on their everyday life. This lack of concern for disease management can be perhaps understood by the lack of physical consequences experienced from diabetes by these participants. While observing and listening to the stories of the participants and sometimes even those of the family members of the participants, it appeared that several of them were neglecting the control of food and exercise despite their awareness of the nature of the disease. Many of them also did not elaborate on the consequences and impact of diabetes in their life as much as they did so about their beliefs of the causation of the disease. This emphasis on the causes rather than the consequences and impact on life in their stories of diabetes, appear to be linked strongly with their equally relaxed attitude towards diabetes
management. For several participants, management of diabetes by the control of food and exercise usually was deemed important just before they had to go for the doctor’s appointment, as they felt that they would be reproached by the doctor if the doctor noticed a high average reading record in the glucometer. For example, Denver was waiting till Friday\textsuperscript{22} until he could control his alcohol and food for few more days before going to make an appointment to see the doctor. Athil, Champaka and Ruwan all became most concerned about regulating their diet and exercise before seeing the doctor. Thus it was near the medical surveillance dates that people became more concerned about management. I will discuss the dynamics of doctors and the lay participants with diabetes during the medical encounter in more detail in Chapter 6.

However not everyone had this laissez faire attitude towards health and diabetes management. For example, Anil and Kanchana attempted to be meticulous about their regimens that included healthy eating as well as exercise. Even though Anil was mostly doing sedentary work, based in one position, he had to often go to other positions in the large factory. He said that when he had to walk to other work stations he made it a point to walk briskly so his daily routine involved some form of physical exercise. He also tried to swim a lap or two whenever possible as he had a pool in his newly bought house. Kanchana also said that when she was going to a Vietnamese doctor just after migrating to Australia she too was very particular about getting some exercise whenever possible during her daily life. But with time and especially due to change of doctors, her enthusiasm to be mindful about controlling food and exercise had started to wane. These perceptions towards diabetes as an illness and its management played an important role in their motivation to adhere to a diabetes management regimen. These perceptions were significantly affected by the life circumstances that they encountered in Australia.

**Life circumstances shaping attitudes towards life and diabetes**

Of note, only Anil was carefully striving to manage his condition effectively through both exercise and diet at the time of my field work. However Anil suffered from a pain in his right arm at this time.\textsuperscript{22} It was a Monday that I went to see him at his house for our interview during which he was experiencing some aches and pains that he thought were related to too much blood sugar.
time and he had strong suspicions that it could be related to his diabetes as he had experienced pains and aches in body previously too. He was very keen to go to all the appointments with the health professionals in that year to ‘fix this pain’. He worked in a factory and he was paying a mortgage and his children were still very young. Therefore he could not be resting and not working. One could surmise here that his vigilance of adhering to strict management regimens could also be attributed to the immediate pain in his arm that he wanted to get rid of, as it was interfering with his work at the factory.

If we suspect that a person would only be more inclined to manage their diabetes, if they face a ‘tangible’ symptom such as a pain in the arm (whereas the knowledge of probable long term complications are easily ignored), then Denver’s case undermines this assumption. On the day of our interview he was getting started with an exercise regimen to lower his blood sugar not because of the chest pain but because his three monthly doctor’s appointment was nearing and he was scared of being reproached by the doctor.

One other participant, Navin, made sure he performed a substantial amount of exercise as he did not want to control his eating pattern at all. Kanchana tried to stick to strict regimen of exercise and diet during one phase before she changed to a different doctor. All others, regardless of whether they had a high blood sugar level or not, tended to ‘relax and lighten up’ about the necessity for self responsibility towards diabetes management. These stories show that only a few people in the group of 25 participants were genuinely motivated to follow the set guidelines of diabetes management. The participants’ motivations for adhering to a management regimen were not straightforward. The variations in motivation sprang from diverse factors including their attitudes to life in general and their life circumstances. But overall participants lacked commitment for the importance of adhering to a management regimen in a regular and consistent manner. Most tended to be reactive, changing diet or taking exercise only when they were conscious of symptoms or had to.

Conversely what can be also seen in this perception is the deliberate reduction of agency and personal responsibility regarding the onset of diabetes and its management. This reduction of agency was sometimes engendered by Buddhist beliefs of karma, fate, and destiny and at other times it sprang from their deliberate suppression of the importance of management by placing more emphasis on their business of their routine life. For example they often blamed ‘lack of time’
for their inability to engage in exercise. Without a doubt, this regressive attitude towards the illness can have a significant impact on one’s sense of motivation to control diabetes too.

**Externalization of responsibility**

While participants attributed many reasons for the onset of diabetes, a pattern that emerged significantly during in-depth interviews was their tendency to externalize reasons for this affliction. This can be conspicuously seen in the stories of Navin, Ranil, Anula and Anoja, as described above. What I mean by externalization is the participants’ strong inclination to treat the causes of diabetes as external to the individual and body, and the tendency to extend these reasons to the wider social networks and life circumstances that they encounter.

Lawton, Ahmed, Peel, and Hallowell (2007) also note this externalization of reasons for diabetes onset among their South Asian participants now living in a British town. According to these authors, the reasons the Indian and Pakistani migrants gave for diabetes onset were often drawn from their idiosyncratic life circumstances. For example, they often attributed their diabetes to severed social networks and to the psychological strains that stemmed from the disruptions to social and cultural relationships. But in contrast to these groups of migrants, the Caucasian diabetes participants attributed their diabetes to personal failings such as their own inability to eat a healthy diet and to exercise (Lawton et al, 2007, p.895). According to the authors, there was an internalization of reasons for diabetes (referring to one’s own lack of responsibility in lifestyle and the individual choice) in the second group of white patients.

This externalization of reasons for diabetes has been observed in other studies. Thomson and Gifford’s research into diabetes among an Australian urban Aboriginal population found that the respondents referred to external factors rather than to internal and self imposed factors when describing the onset of the disease. The authors note that this could be symbolically attributed to their sense of disenfranchisement that stems from their historically specific circumstances that are related to the Australian white settlement (Thomson and Gifford, 2000). Moreover Mercado-Martinez and Ramos-Herrera note how their Mexican participants attribute diabetes to negative emotions of anger and fear that are evoked by circumstances in the outside world (2002). Similarly
for Sri Lankans, the reasons for onset derived often from aspects related to the changes experienced upon migration, hereditary diabetes, and the Sri Lankan diet at their parental home. They blamed diabetes onset on the sweets they got to eat in their childhood, or for getting to eat too many pizzas and chocolates, or drinking too much Coke because of their affordability in the new society. They referred to this type of eating as “a lot of sweets are being eaten (by me)”: “(panirasa kawenawa wediy)”. The passive tense of this phrase itself denotes their involuntary tendency to externalize responsibility for their consumption, and their inclination to attribute lack of agency to their own actions. Several believed that they had contracted diabetes because of stressful life circumstances, such as a divorce or facing problems finding employment in the new country. It is my contention that this type of externalization of causes of disease resonates with the resigned, passive or taken-for-granted attitude towards diabetes management and with reluctance to take any active measures to reduce blood sugar levels. Diabetes was not a problem that they created for themselves. It came from external sources that were beyond their control. It was considered an inevitable problem, and one that could have occurred at any time.

This tendency to externalize responsibility for illness in these societies (including that of the Sri Lankan community) is perhaps, as Lawton et al. (2007) surmise, due to a common sociocultural aspect that exists in these societies. Anthropologists such as Dumont (1970) called these “holistic” cultures. According to Dumont (1970), Mauss (1985) and La Fontaine (1985), in societies with holistic cultures, individuals live a life that is strongly interlinked and enmeshed with others and other social, cultural, kinship and political networks. The concept of “the individual” in these societies does not exist as a moral or conceptual category that entails a capacity for complete autonomy. In holistic societies, the role and status of the individual are decided by kinship, political, religious and social networks. Marilyn Strathern, examining the notions of the individual and the initiation rituals of males and females on the Melanesian islands argues that in such societies the person is “not axiomatically an individual, who as in Western formulations, derives an integrity from its position as somehow prior to society” (Strathern, 1985 p. 93). Strathern calls this positioning ‘relational sociality’ whereby an individual’s identity is construed as being ‘constructed’

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23 The direct translation of “panirasa kawenawa wediy” is “a lot of sweets are being eaten (by me)” as opposed to “I eat a lot of sweets”. In the first translation the power of the agent is diminished by the passive tense in the phrase than the second translation.
by others in the society, particularly the immediate family. Importantly however, we have to acknowledge here that throughout history, these holistic cultures too, particularly in this case the Sri Lankan society, have undergone change and have been exposed to modernization and Westernization and therefore to Western ideas such as ‘individualism’ and the imperatives of ‘progress’. Nevertheless I argue that even though holistic societies have undergone many changes throughout the years, the individuals who have grown up and who have spent their formative years in such cultures, are inculcated with values of holistic cultures from different avenues such as family, school and religious institutions even in the present day. This presents as a reason for the Sri Lankans’ inclination to externalize the causes of their diabetes.

The relative lack of emphasis placed on the notions of individualism, self and personal responsibility in these societies, compared to the emphasis on moral independence in more industrial, Western and developed societies, is also closely related to Kleinman’s idea about the “body self” which he defines as “an open system linking social relations to self, a vital balance between the interrelated elements in a holistic cosmos” (Kleinman, 1988, p.11). In this way, the group of Sri Lankans’ notions about the onset of diabetes might be seen as originating from a consciousness that is derived in, and set against, a holistic social value system. As with Lawton et al (2007)’s group of Indian and Pakistani migrants with diabetes living in the UK, Sri Lankans too tended to refer to causes outside their domain of self that were related to outside circumstances, when expressing their understandings about the disease causes.

**Externalization of responsibility of disease management**

Unlike Lawton’s et al (2007)’s Indian and Pakistani migrant participants, individuals in this study tended to externalize the responsibility of disease management too. Participants like Nalani, Anoja, Anula, Athil, Ranil and Ruwan had specific reasons that did not ‘allow’ them to engage in efficient management.

For example, Nalani said that she could not control diabetes because her mother always made delectable delicacies. When she comes home from work very hungry, she could not be more appreciative of her mother having prepared something sweet to “quickly gobble”, in order to gain
some strength to do the rest of the day’s work at home, such as preparing dinner for the family. Anula and Ruwan said it was difficult to think about controlling diabetes first when they migrated to Australia because they were more worried about looking for a job and starting life from scratch in an unfamiliar society. Athil and Ranil commented that it is because of the cold weather and short days, especially in winter, that they do not get to walk around the block as a form of physical exercise. Even though Navin did not directly externalize the responsibility of managing diabetes, he implied that his passion for cooking would not be compromised by attempts to manage diabetes, as he held cooking the food he liked and tasting them closer to his heart than managing diabetes. Navin said that apart from trying to walk around the block to manage diabetes, he does not even try to think of placing dietary constraints on himself. Cooking the food that he liked in traditional Sri Lankan ways was his passion. He found solace in the activity of cooking even though most of the time he only cooked for himself. Taking conscientious and meticulous care and effort in cooking was how his leisure was spent and thus it was an integral part of his life that he valued greatly. When I visited his house he had dhal, a mixture of fried dried fish and caramelized onions, polos ambula\textsuperscript{24}, a gotukola salad with freshly grated coconut, and fried eggplant curry, all homemade. Even though these curries in and of themselves in smaller portions are probably not particularly unhealthy for maintaining a healthy blood glucose level, the large portion of rice and the fried curries clearly were not measured according to the ‘cup’ recommended by the nutritionists and diabetes educators. This was rather unusual for a main meal for an average Sri Lankan household, where one would normally see rice with three other curries. Navin clearly did not want to compromise his passion for cooking in order to manage his chronic illness. He took the risk of eating to his heart’s content\textsuperscript{25} and did not regret it or feel or look guilty about it, like others. Cooking was a major source of joy in life that he did not want to disturb by bringing in changes that were recommended by doctors. For him, cooking and eating had deeply emotional,

\textsuperscript{24} Polos ambula is a typical traditional Sri Lankan dish that is made with green jackfruit and cooked in a special spice mix in a wooden oven (in Sri Lanka) commonly for five or six hours with a weak flame, for the green jackfruit pieces to absorb the spice flavor slowly. It is considered a delicacy in rural as well as in urban sectors.

\textsuperscript{25} Except for the fact that, unlike other participants, he made a genuine effort to walk around the block for physical exercise, to manage diabetes.
pleasurable meanings as activities. Diet (or the control of food) in diabetes management was quite alien to the real meaning of food and cooking in his life.

**Creation of niches and reinforcing biography**

A significant aspect of my study that was noticeable in many Sri Lankans’ perceptions and understandings of diabetes management was that management was sporadic. Except when they had to get a routine blood test done or had to attend to a check up by the doctor, they all attempted to continue their life with a minimal level of change or disruption by diabetes management in their everyday life. It is my contention that in such a scenario, we cannot understand this relatively relaxed perception of disease management through a concept such as biographical disruption (Bury, 1982). Bury’s work on rheumatoid arthritis, that is heavily cited in literature on the sociocultural aspects of chronic illness, perceives chronic illness as a major disruptive event in the person’s life. Informed by Bury’s conceptualization of chronic illness as a biographical disruption, many authors who have studied the everyday experiences of chronic illness in communities have referred to biographical disruption (Bury, 1982; Wilson, 2007) a useful way of conceptualizing the experience of chronic illness. However it is evident in my research that this model is not entirely correct and justifiable in describing the impact of diabetes on my participants. For much of the time, the Sri Lankan participants conducted their lives without reference to their illness. Visits to the doctor provided the main ‘disruptive’ event, forcing people to constitute themselves a diabetic.

Participants were more concerned about the continuity of the way of life as it used to be pre-diabetes, and were attentive to their recommended management regimen only when they had to ‘succumb’ to medical surveillance. We could also understand these reactions to diabetes management as a mental defense some people exercised as a response against the need for change. Carricaburu and Pierre’s concept of biological reinforcement becomes a more appropriate and helpful concept to understand this attempt to retrieve the normality of pre-diabetes life by the group of Sri Lankans (Carricaburu and Pierret, 1995). In their research the authors note how hemophilic men who were later infected by HIV did not see HIV as a biographical disruption. Instead HIV infection only reinforced their pre-existing self perception and identity as hemophilic
patients (p.81). In my study too, although they perceived that they had become diabetic for various reasons, and although it warranted taking ‘responsibility’ for management, by changing food patterns and eating habits and engaging in physical exercise, most attempted to create niches; niches in which they could retreat to ‘normality’ by blocking away or ‘suspending reality’ for a period of time and by externalizing the responsibility of disease management (Balcou-Debussche and Deussche, 2009, p.1112).

In the next chapter I turn to an examination of how practices surrounding food contributed to this creation of normality and continuity in their lives. I will explore how food was conceptualized and treated by this group of people, showing how the meanings attached to diet went beyond and were far more complex than the nutritional meanings advocated by health professionals.
Chapter 5: Food ways and Sri Lankanness

In the medical literature, diabetes is referred to as a ‘diet related disease’\(^{26}\) (Tapsell, Breminger and Barnard, 2000). The high incidence of diabetes in some populations has lead to scrutiny of the sociocultural factors that influence food choices and difficulties in maintaining a dietary regimen (Lawton et. al. 2008). In this chapter, I draw on my interviews with participants and my observations in the community to examine the range, variation and types of cultural factors that were influential in the dietary habits of Sri Lankan migrants in Melbourne. Ways of cooking and preparing food and the types of food consumed are bound strongly to culture. Food ways, a term used commonly in anthropological literature, in this chapter refers to the ways in which food functions as a means of understanding social relations, identity construction and the identification of cultural boundaries in the Sri Lankan community. When people migrate to a new land, the types of food consumed and the ways of cooking appear to be aspects of their culture that are maintained, even after years of living away from their country of origin.

Ray and Srinivas state that local gastronomy and activities surrounding cookery “make inhabitancy in a distant locale viable, while illuminating poetics and politics of place-making through diet and desire” (2012, p.7). There is evidence that the migration experience itself reinforces a conservative attitude to food, as foods become markers of distinct ethnic identities in multicultural societies such as Australia. In other words, knowledge of and the ability to cook foods that are culturally significant have the capacity to become an essential part of one’s identity in “an uprooted world” (Ray and Srinivas, 2012, p.5).

The processes and experiences of migration initiate a continuous process of questioning and reforming a person’s identity. Thus Ray and Srinivas suggest that food practices that are transported from one society to another through migrants, connect and challenge the notions of

\(^{26}\) The general dietary guidelines for people with type 1 and 2 diabetes consists of three main rules according to Diabetes Australia; meals that are regular and spread evenly throughout the day, lower particularly in saturated fat and meals that are based on high fibre carbohydrate foods. It particularly advises people to avoid too much fat in food, saturated fat (which is contained in fast food, butter, precooked meats, sweets such as chocolates and cakes), carbohydrates with high glycemic index and foods with added sugar (Diabetes Australia- http://www.diabetesaustralia.com.au/Living-with-Diabetes/Eating-Well/Food-What-Should-I-Eat/).
‘self’ and ‘other’ by making them indexical of concepts of ‘home and abroad’ and ‘private and public’ (Ray and Srinivas, 2012. P.7). Activities such as shopping for food, making choices of food, cooking and preparation, serving and consumption of food among South Asian middle classes have deep connections with aspects of identity such as ethnic affiliation; gender constructs; notions of social hierarchies and nationality. Moreover, as Herzfeld argues, food is a cultural attribute that can function as a signifier of traditionalism, localism, nationalism, and also cosmopolitanism (Herzfeld, 2004).

This chapter will identify the themes that arose in the discussions and observations that took place in the context of food purchasing, preparation and consumption. I draw on my extensive observations, made over a twelve month period, of domestic meal preparations and meal times at the participants’ houses; special functions at houses such as birthday parties and attaining age parties; community gatherings such as Sri Lankan New Year festival; and my observation of ritual functions at Sri Lankan Buddhist temples. This chapter is also informed by my personal experience and knowledge, as another Sri Lankan migrant living in Melbourne.

In this chapter I first present the different functions of food at home at an individual level and then at the level of the community. I argue that the making of food choices in the domestic and public arenas of Sri Lankans provides us with a deep understanding of the subtle and nuanced tensions and cultural meanings of food ways in the community. These food ways would show us how people maintained and held on to their traditional ways of life and habits and the ways in which they (either deliberately or subconsciously) made an effort to interact with the Australian culture through gastronomy. I will then discuss how the metamorphosed food ways, when they are combined with habits practiced throughout the years spent in Sri Lanka, corresponded to the notions of “health” and “effective or good diabetes management” and whether they potentially obstructed effective management of diabetes.

27 A girl attaining age is considered as an auspicious event in the Sri Lankan culture where the rituals associated with puberty symbolize the girl’s transformation from dirtiness (the dirty female body) to female purity (Winslow, 1980). Like many other cultures, this very domestic and private occasion is celebrated with family and friends in the community, after a seven day confinement of the girl from the first day of her first period.
Food consumed at the home kitchen

Maternal origins of cooking

Most participants connected their patterns and methods of cooking as adults with their mothers’ patterns and methods of cooking. The maternal origins of their cuisine were consistently presented as a reason, an excuse, and even as an escape from having to explain their food habits, especially if these methods of cooking and food patterns departed from those advised by their health professionals and were believed to be bad for effective diabetes management.

The thoughts and practices related to food and cooking were intricately intertwined with memories of food from the participants’ childhoods and youth in Sri Lanka. There is a double layer of attachment here regarding food, as it is strongly associated with mother’s love and nurturance and also with the motherland. Roy (2002) provides a review of the autobiographical cookbooks of the well-known native Indian cookery writer, Madhur Jaffrey, who lives in Great Britain and whose main audience is the Indian Diaspora living in America and Britain. Writing about the culinary communities in the South Asian diasporas, Roy explains how nostalgically evocative was Jaffrey’s description of how her mother’s letters from India contained long recipes of the Indian local dishes. Roy further notes how Jaffrey’s texts on Indian cuisine “on one hand evoke, especially in the Indian reader in the South Asian Diaspora, a mutual substitutability of food and words and on the other, a reciprocity of the shedding of tears (of homesickness) and the watering of the mouth” (Roy, 2002. P.482). Thus the patterns of consumption can be interpreted as a means of nostalgically conjuring the comforts of both mother and motherland in an alien environment. This is further illustrated by the following cases extracted from my fieldwork observations.

Anula recalled that her mother never failed to cook for extra people for every meal because neighbors and friends always used to visit them. At home they never ran out of food. Her mother always made traditional Sri Lankan sweetmeats such as kawum (oil cake), aluwa, dodol and walithalapa28. Elaborating upon this characteristic of her household in Sri Lanka, she said that when she got gestational diabetes during pregnancy her friends said that it was not a surprise

28 These are traditional sweetmeats prepared for special occasions, and usually made with great amounts of sugar/treacle and oil.
because her place always had homemade sweetmeats. Every time I visited her old rented apartment in Reservoir, Melbourne, Anula always had something sweet, usually a traditional Sri Lankan sweet, which she had made the previous day and she kept in a big plastic box placed on her simple table in the kitchen. Unlike many others that I came across during my fieldwork in Melbourne, who only made traditional sweetmeats during the New Year time in April, Anula said that the practice came to her from her mother and it is a necessity that she makes and serves these sweetmeats to visitors whenever she could. She was critical of those who served visitors a packet of commercially manufactured biscuits. She was clearly proud of her hospitality and her knowledge and ability to make these traditional sweetmeats, now a rare skill among Sri Lankan women of her age.

Change of division of labor and woman’s changed role at home

In Sri Lankan culture, cooking is mainly a responsibility of women. Thus the kitchen can be considered as the arena of female authority. This is typical of many South Asian cultures that were originally agrarian, where in the processes of production to the final step of consumption, the division of labor was conspicuously based on gender (Wandel and Holmboe-Ottesen, 2010). Although many men know how to cook, cooking remains mainly the responsibility of the women in the household in Sri Lankan culture (2010; p 123).

This gendered division of labor persists to a great extent in Sri Lankan households in Melbourne. During my fieldwork, in most of the households I observed, it was the women who were in charge of cooking. If the woman could not cook because of her employment or other commitments it was rare for men to assume the responsibility. In such instances, men often went to a nearby Sri Lankan shop and bought rice and curry lunch parcels. This reflects the pervasive view in contemporary South Asian cultures that, even if she was employed outside the home, it was a woman’s duty to keep the husband and children well fed (Caplan 2008; Donner, 2008; Wilson, 2010).

Moreover in Sri Lanka, as well as in other parts of the Indian subcontinent, there is a particular convergence of positive emotions surrounding nurturing activities by women in a household, in
which home-cooked food, especially by the wife or mother, is centrally valued. Wilson (2010) writing about the implications of food and consumerism on cardiovascular diseases in Kerala, South India, argues that

...as the essence of emotional and physical well being, the embodiment of food creates a particularly tight bond in India, where the body is shared and nourished through the bio-moral qualities of home cooked food.... (p.264)

Preparing a special meal for someone in the family reflected notions of love, nurturing and care. In some households I visited where the woman was a housewife, it was the norm that she woke up in the morning and cooked a rice and curry meal for the husband to take to work. Anula, who is a mother of a five-year-old daughter, stayed home on most days but worked part-time as a cooking assistant and a salesperson at an Asian food shop at the food court of an office complex in South Bank. She said that both she and her husband are not very keen on her working as they both value her staying home looking after the domestic work and their child. She perceived cooking as a very important responsibility. She usually prepared food with meticulous attention to detail. She had an impressive knowledge and experience of the preparation of many Indian, Malaysian and Sri Lankan meals and dishes.

...Because I can put more time for cooking I can carefully cook them and therefore we don’t get to eat any unhealthy food. Because I stay home at least I need to do the cooking to the best of my ability. And even for my husband, he does not really get a time to eat a good thing [healthy food]. So on Saturday mornings I make kola kanda and steamed grains...

She cooked rice and three curries each evening for the following day. During one of my visits to Anula’s home she had prepared a fried dhal (red lentils) curry, a dish of dry fish fried with onions and eggplant, as it is the norm in Sri Lankan culture to have rice for main meals, especially lunch, with two vegetables and a fish or meat dish. She used olive oil to shallow fry the vegetables and the dry fish and was confident that it is much healthier than the traditional coconut oil, on the

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29 *Kola kanda* is a type of rice congee, a thick soup made with coconut milk, ground dark green leaves and a handful of cooked rice brewed together in a mix. It has the image of a traditional herbal drink that was mostly more popular among the older generations than the young.
advice of friends who had used olive oil for shallow frying ever since they started living in
Australia. However Anula’s household was one of the few families I came across in which the
woman was primarily engaged in domestic work, including the task of shopping for and cooking of
food. In many other families it was the norm that both the husband and wife were employed
outside the house. In such families, cooking at home necessarily took a lower priority. When they
did find time to cook, these families still ate rice and curry meals.

Denver who has been diabetic for about twelve years, worked the daytime shift in a factory and
was also engaged in a cleaning job with his wife who ran a family day care at home.

...and then we eat red rice most of the time. Sometimes my wife makes vegetarian.
But she really does not have much time to cook as she is too busy... And sometime
earlier we all used to do a cleaning job...

This was also the situation at Athula’s and Athil’s households, where their wives were employed in
shift work at warehouses and a factory.

...I don’t do that every day (steaming vegetables for dinner) because my wife also
goes to work every day and she also goes to work on the weekends so we are really
busy here. Cooking everyday and cooking special things always is not very easy. So
it is really hard to control everything (Athil).

With the lack of rest and their work as a family, the traditional responsibility and role of the
woman in the family has been shifted more to that of a joint breadwinner. However none of the
male participants said that they have taken over the responsibility of cooking and provisioning
from the wife entirely. Instead they changed the patterns of eating and cooking in the family and
relied more on food bought from outside.

**Meaning of food at home**

**Food as building blocks of identity**

Ferzacca, citing Stoller (1997), notes that patterns of food selection and eating are determinant
factors of the “metaphoric organization” of self and experience and they also “trigger cultural
memories” that are based on habits related to food and eating (2004, p.45). Ferzacca calls these meanings attached to food, cooking and eating ‘life histories of food’ (ibid, p.46). In his research about food and eating in a group of elderly diabetic men, he asked them to relate their life history of food choices and eating. There, he found that those choices of food and eating are ‘historical statements’ of self, as well as ‘discursive remembrances’ of one’s sense of self and identity (ibid, p.46). Sutton illustrates how food and memories of eating patterns can function as construction blocks of the everyday identity of a person. He explains that memories of food and eating not only reflect idiosyncratic random associations, images and activities but also reflect “associative fields, or taste and smell-scapes in which they are learned and experienced”. These experiences and memories of eating are vital to the historical formation of self and identity (Sutton, 2001. P.76).

Ravi’s preferences of vegetables in Australia had strong connotations of who he was in Sri Lanka. He has continued to eat mainly “Sinhala vegetables 30” ever since he was diagnosed with diabetes. Thus it is fair to state here that for people like Ranil, Anula and Navin their memories of food and eating in Sri Lanka serve as an integral part of their own identity and their strong reluctance to change the way they cook and eat is testimony to their unpreparedness to let go of that identity.

Bourdieu’s concept of habitus is of great use here in understanding these embedded patterns of daily life and eating. Bourdieu defines habitus as the ‘acquired system of generative dispositions’, which are a set of embodied logics that one unconsciously makes use of when performing actions in everyday life (Bourdieu, 1990. P.95). He states that because these dispositions are imbibed during infancy, how one feels and treats the body can bring into light the deeply rooted dispositions of one’s habitus (Bourdieu, 1984, p.190).

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30 Eggplant, bitter gourd, gourd, pumpkin, cucumber, ladies fingers, snake gourd are referred to as Sinhala vegetables by Sri Lankans as they are grown in the dry zone of Sri Lanka mostly by Sinhalese farmers. These vegetables are placed in contrast to vegetables that are grown in the cool climates of the upcountry in Sri Lanka, and are referred to as Ingrisi vegetables (English or White man’s vegetables). They are referred to as English man’s vegetables because the upcountry was known in the nineteenth century to be inhabited mainly by British colonials. Some of these upcountry vegetables are leek, cabbage, beetroot, carrot, radish, lettuce that are known to be grown in the cooler climates. It is the belief that Sinhala vegetables are higher in their nutritional value than vegetables that are grown in the cool climate of the upcountry.
Cooking as a solace

Navin came from an urban elite family in Colombo, and was used to a lifestyle in which he was usually served with home cooked meals by domestic helpers. In Colombo he neither worried about where the food came from nor how it was cooked, as he was more focused on his job and the responsibilities that were derived from his political affiliations with influential Sri Lankan politicians. In Australia he leads a more carefree life when compared with the busy lifestyle in Colombo, but he is also lonelier. He now takes meticulous care in preparing his meals, to the point where cooking has become one of his passions and hobbies in life. The amount of care and attention he gave for cooking appeared to be symbolic of his attempt to recreate order and calm in his life that had gone through many disruptions that included diabetes and a divorce (his second one) in Australia.

I told my doctor listen whatever you say I like my sweets, my slabs of chocolate. But then for ten days I wouldn’t touch sweets or chocolate... He [the doctor] said... that there has to be a balance. I said I take only two teaspoons of sugar with tea. He said it’s not going to make any difference if you stop. But you have to manage it. And another thing I told him I won’t give up is my butter. I love my butter from my young days and I won’t stop. I said to him if I have to go I will go (When I have to die I will die)... I don’t think my life has changed in any way. I run the same way I did in the past. I like to eat a healthy meal. I like my red rice. Today I had *parippu* (dhali) with spinach, *mallum* (A green salad), *karawala* (dry fish), *pol sambola* (coconut salad) and *polos* (a curry made of the young jack fruit). I eat fish and pork and meat. I like the fatty parts. I love fried things. I like my bacon and butter. I haven’t changed anything. The language that my body is trying to tell me is that I’m fine.

Navin defends his food habits even in the face of criticism from his doctor, who has pointed out how they negatively affect his diabetes status. Navin did not even own a glucometer as he thought it too constricting of his lifestyle. Both Navin and Anula prepared meals painstakingly and they had recipes that they refused to change, mainly because of their strong associations between particular foods and recipes with the comfort and joys of family gatherings in Sri Lanka. The food itself embodies recalled happy familial occasions, when their mothers prepared meals. This strong
relationship in their minds between food and memories of mother’s cooking, childhood and
growing up, might be considered indicative of the psychological predicament presented by their
distance from kin, motivating them to turn to the food that they consider as “Sinhala kama”
(Foods that are made according to traditional Sinhalese recipes and traditionally consumed by Sri
Lankan Buddhists). Adherence to recipes and ideals of hospitality provided a strategy to gain
solace and peace of mind that they associated with home. Their dedication to cooking and
consuming Sri Lankan food that was redolent of the comforts of home compensated for the loss of
social and familial contact in their new environment.

As a means of confirming agency

Everyone in the study made at least one life style modification with respect to food intake.
However one of the most important themes that emerged from the in-depth interviews was that
almost all of these participants presented themselves as exerting agency over what they chose to
eat or not. The one exception was the older female participant Dayani, whose son and husband
kept strict surveillance over her diet. The others appeared to make autonomous decisions about
what to eat, even if they were aware that it could be detrimental to their diabetes control. Navin’s
fatalistic decision that he would not change the way he ate, in spite of the fact that it could have a
negative effect on his sugar level, is an example of this. He insisted that he would not give up his
butter, the pieces of fat in red meat, and curd and treacle31. His strong use of the possessive
pronoun ‘my’ with the food he likes reveals the way that he identifies with his food (far more than
with his disease) to the point where he obstinately refuses to adapt his diet to his medical
condition.

Navin had come to Australia leaving all his extended family in Sri Lanka and lived mostly alone in
his apartment. His son was studying at university and, while nominally living at home, stayed with
his friends most of the time. Navin arrived in Australia ten years ago after the breakup of his first
marriage, to join his second wife to live in her house near the Mount Dandenong area. After just

31 Curd and treacle is a uniquely Sri Lankan delicacy. Curd is a thick, plain buffalo milk yoghurt and treacle is
a syrup made from the sap of the kitul tree.
two years of living together, his second marriage broke down and he got a divorce. He attributes the onset of his disease to the mental suffering and stress that he went through during the difficult time of this divorce, which he had to deal with alone, without any emotional support. Two things he enjoyed doing were decorating his home and cooking. Even if it was most of the time only for himself, he paid careful attention to his cooking and often made elaborate meals. In the past, he had been an active member of many Sri Lankan social organizations. He often tried to go out for parties and gatherings organized by his Sri Lankan friends and he regularly went out to a fine dining Sri Lankan restaurant in the city with his friends. While he did not enunciate the idea directly, it seemed to me that his vehement assertions about dietary management were a response to the loneliness and disappointment that he experienced in life in Australia. For despite his active involvement in the Sri Lankan community organizations he lacked emotional support and perhaps compensated by insisting upon his autonomy in relation to diet. Ferzacca argues that the judgment of taste in the case of diabetes becomes such a wearisome task due to the contradictory nature that food is referred to in the etiology and the treatment and management of diabetes; the person’s diabetes is not only caused by food but also could be worsened by the misuse of it (Ferzacca, 2004, p.44).

This resistance to change in eating patterns and selection of food might also be interpreted as a way of expressing agency in contexts where familiar social habits are absent. As Ray and Srinivas observe, the practice of cooking is considered an important way of knowing the world and acting upon it (2012; p.8). Cooking familiar foods and consuming them in ways that are reminiscent of one’s past are thus ways of affirming deeply held values while acting in a new environment. Navin almost always cooked his own food at home and prepared it in Sri Lankan style, thereby asserting his identity as he defied his medical advisors.

**Food evoking nostalgia**

Once during a mealtime session with Navin, while eating a very traditional dessert he said jokingly, “You can see that I’m eating *pani with kiri...*” meaning that he eats a lot of treacle/honey with curd. Curd is usually enjoyed with only a moderate amount of treacle as it is a very sweet syrup.
The Sinhalese idiom “curd and treacle” signifies the love and friendship between two people, hence its place as the archetypal food of hospitality. In offering me curd and treacle, the dessert par excellence, especially among Sri Lankans from the Southern part of the island, he was simultaneously providing a warm, classically Sri Lankan welcome and asserting his autonomy over dietary decisions.

Obeyesekere offers a psychoanalytic explanation of this traditional Sri Lankan dessert as a symbol of love and affection reserved for visitors (so rarely enjoyed by young village women), noting that it was a food that was often craved by pregnant women. Obeyesekere writing about the psychological motivations behind the pregnancy cravings of women, argues that many foods that are craved during pregnancy were symbolic of the woman’s desire to regress to the safety, comfort and security that they experienced only during their childhood (1985: p.649). The food Navin cooked and the dessert he served me were typically Sri Lankan and possibly it evoked feelings of security and nostalgia in this man, with his strong sense of Sri Lankan identity. Certainly the background smells of spices appeared to provide an environment in which he was comfortable expounding his ideas about diet.

Early anthropological work on Sri Lanka refers to substitutes for rice, such as sweet potatoes, breadfruit, jackfruit and manioc, as having relatively low status (since they are considered as poor man’s food and therefore culturally inferior) (Obeyesekere, 1985). However many participants that I met during my fieldwork in Melbourne desired these foods as reminders of home, making long journeys to Asian markets in search of these food items. Anula, even though living on the small salary of her husband and barely managing everyday necessities in the household, said she would not think twice about spending any amount of money to buy them.

Awareness of nutritional advice that stresses consumption of natural, unprocessed food, especially fruit and vegetables, also evoked memories of a (perhaps idealized) life in Sri Lanka where such foods were abundant and easily obtained. For more middle class Sri Lankans there was a belief that the foods that they consumed in Sri Lanka were more natural, lighter and therefore healthier for diabetes than the food available to them in Australia.

In Sri Lanka whether we choose it or not we always automatically get to eat more natural things. At least you would buy a bunch of greens from the woman who goes
from door to door selling the village greens... or you could pick some greens from your garden. In Sri Lanka we would never eat bread if it is at least one day old. But if we go to Safeway here whether we go there today or tomorrow it’s the same batch of bread that’s available to buy... In Sri Lanka we automatically get to eat healthier and good food even without having any education about food... (Ranil).

He too appeals to the difference between eating at home in Sri Lanka and having meals in Australia. But the meal he wistfully recalls is not in fact ‘healthy’ in terms of diabetes management. Like Navin’s curd and treacle, it is a classic comfort food, combining starch and fat and heavily flavored with salt, spices and chilli:

There is nothing that can beat the feeling you get when wearing just a sarong and sitting outside the veranda enjoying the cool mild breeze and eating sambola (coconut sambol) with rice in a nambiliya...

Rice with coconut sambola in Sri Lanka can be considered as the most basic meal. Because of this, rice with sambola in the Sri Lankan context would be poor fare, the food of working class people. Certainly such a meal – low in fibre, high in fat and carbohydrates – would be ill-advised for diabetics. But the totality of this experience for Ravi, with its associated feelings of satiation and contentment, transforms it into a luxury.

Sutton demonstrated how sensory memory about food engages in the ‘construction of worlds’ whereby food practices induce ‘worlds of home, family, community and cultural definitions’ (Sutton, 2001.p.82). Marte too argues that embodied food memories breathe life into ‘past experiences of place, of social contact and who we were’ in the past (Marte, 2008.p. 37).

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32 Sarong is a long piece of cotton cloth that Sri Lankan men wear in the domestic environment.

33 A clay pot with a moderately shallow bottom and a very wide mouth that is used to wash and drain rice before cooking in Sri Lanka.
Food evoking feelings of security

Marte, like Obeyesekere, takes a psychological approach to food consumption, arguing that narratives of food and cooking (therefore the practices of food and cooking) symbolize one’s structures of memory and desire, of childhood and of history, of which the core effect is ‘longing’ in the direction of one’s origins (Marte, 2008, p.38). When analyzing the participants’ strong inclinations for cooking and food that were reminiscent of their memories of Sri Lanka, it can be surmised that it is a strategy that people like Anula and Navin followed to evoke or regress into the feelings of safety, attachment, love and sense of fulfillment they felt back in their home country. Perhaps this passionate inclination towards cooking and Sri Lankan food also stems from the need to overcome the feelings of insecurity that they feel due to their uprootedness as well as from the ambivalence towards life that is evoked by diabetes. During the time of fieldwork Anula was a university-educated woman who could not find any satisfactory employment that suited her educational qualifications as a graduate teacher in Sri Lanka. Navin, who was divorced twice and had experienced a lot of stress and anxiety, lived a quite lonely life in an apartment in Camberwell. They both expressed strong feelings about their enforced solitude and social isolation in Australia. Meticulous attention paid to cooking foods that they loved seemed to compensate for their estrangement from family.

Cooking at home for guests

This detailed and keen attention paid to cooking was also seen at homes when visitors were invited for a meal. Meals to which only one family was invited tended to include more Sinhala kama (Sinhala foods) than those that were served for a large gathering of guests. This could be because of the high prices for Sinhala kama foods such as bottled, frozen or fresh breadfruit, jackfruit and other foods that are imported from Sri Lanka. Another reason for this could be that the widely available vegetables in Australia take a shorter time to cook than the Sinhala kama, because most of these curries such as breadfruit and young jackfruit and even mango, require simmering for a longer time and pose more difficulty when cooking for a crowd.
Chandra, a university lecturer who had migrated to Australia six years ago, invited my family to a meal that was more than a typical\textsuperscript{34} Sri Lankan meal for a visitor. They had cooked a mango curry, a chicken curry, fried beans, a dhal curry, fish \textit{ambul thiyal}\textsuperscript{35}, a cashew curry and a Sri Lankan onion and tomato salad with a dressing of lemon, salt and pepper. They cooked all these curries in clay pots that were brought from Sri Lanka and the meal was also served in these clay pots (Figure 8). It is said that food is more flavorsome when cooked in clay pots because of the long time required for cooking. Although I had never seen meals served straight from clay pots on a table in Sri Lanka, it was clear that Chandra and his wife were proud that they were able to do so in Australia. It was equally obvious that the preparation of this lavish meal would have taken several hours. In Sri Lanka, where food is usually served on platters, serving food from clay pots for a visitor might have been construed as oddly casual. In the diasporic context, it takes on a quite different meaning as the pots are markers of cultural authenticity, and the shared knowledge of the time taken in meal preparation further conveys the attachment, love and respect shown by the hosts to the guests.

\textsuperscript{34} A typical meal that is served for visitors in a Sri Lankan home would usually be comprised of rice, a chicken curry, a fish curry or prawns, a mild potato curry, a deep fried eggplant dish and a fresh tomato and onion salad (this could change slightly depending on the number of visitors and also what is convenient for the host to cook). Commonly the rice and curries are served in porcelain dishes on a central table.

\textsuperscript{35} Fish \textit{ambul thiyal} is a trade mark dish of the Southern parts of Sri Lanka in which the pieces of fish are steamed first and then cooked in a mixture of salt and pepper and local spices for approximately four hours in a very low heat while stirring constantly without letting the pieces disintegrate.
Communal consumption of food

While the domestic consumption of food is undoubtedly critical for individual management of diabetes, the strong link between cultural identity and food is reinforced in diasporic community events. We might see this from two perspectives. First, Australian multiculturalism has consistently celebrated difference and emphasized the positive changes brought by migrants in terms of distinctive ethnic cuisines. For example, the television channel devoted to multiculturalism, SBS, has numerous food programs, many hosted by immigrant Australians, which extol the culinary delights of different nationalities. Second, but related to this aspect of multiculturalism, migrant communities quickly recognize that their distinctive cuisines can be a
source of pride in their new country and so their particular foods and dishes are effectively and positively ‘over-determined’ as markers of identity. Food was central to many cultural and religious events that I observed in the Sri Lankan community. In it, like in all other communities, food was consumed in public places under many contexts that included religious, social and familial events.

Use of more oil and spices

An important event where food was significant as a communal symbol, was the Sinhalese and Tamil New Year Festival held in mid-April at the Dandenong Showgrounds, and organized by the Sri Lanka German Technical College Old Boys Association. The festival starts with a huge breakfast table spread with *kiri bath* (milk rice), *kavum* (oil cake) of different kinds, *kokis* (a deep fried cracker like sweet that is made with rice flour and thin coconut milk that is made with a mould) bananas and plain black tea. This is the typical table spread that is prepared at any public place or in a house in Sri Lanka at the time of Sinhalese and Tamil New Year. At the festival on the showground, breakfast has always been free. Usually these foods were made at homes of the organizers of the festival early in the morning and then were brought to the grounds to serve to everyone that turns up in the morning. The festival goes on till the evening and has many events including games for all age groups. Lunch too is provided for an inexpensive price and one can make a choice between *kottu*[^36], fried rice and *biriyani*. This meal was also cooked in the homes of the organizers and therefore was authentically Sri Lankan with a lot of spices and fried vegetables. The difference between domestic cooking and this preparation of food for mass-consumption and sale, was that there was a profuse use of oil in cooking and frying as people think that frying adds flavor to the dishes. There was a deep fried eggplant curry, fried dhal curry, a deep fried chicken curry and a fresh carrot salad with scraped coconut. In normal domestic cooking the dishes would vary in the style of preparation; the norm is to have one fried dish with vegetables, one vegetable with gravy made with coconut milk, and a dish with meat or fish. Lavish use of oil is associated with luxury and indulgence – making fried food ideal for celebratory events.

[^36]: *kottu* is a very popular food in Sri Lanka. It is a mix of fried finely chopped pieces of roti, meat or fish and fried vegetables.
The use of oil to cook food was also common in many other public events in the community that I attended. One such important event was the Hoppers and Kottu Night that was organized by the Vikasitha Kala Kavaya in Keysborough, in order to raise funds for a computer and professional training centre in the Kurunagala district in Sri Lanka. The Vikasitha Kala Kavaya is an organization with a strong communist background. The members and organizers were active members of the JVP party in Sri Lanka. The main organizer and some others wore traditional sarongs and some women dressed in Kandyan\textsuperscript{37} and Indian saris, bringing an atmosphere of Sri Lankaness to the hall. The function started with the lighting of a brass oil lamp that was kept at the centre of the stage. This is usually done by people of high social status who are summoned to the stage.

A small fresh flower decoration was placed in the middle of each round table along with a tea light candle. The decoration matched well with the light cream colored table cloth, which appeared to be of silk. As I entered the hall and sat down I noticed that each table had two huge two liter bottles of soft drink (Solo Lime flavor and Sunkist, an orange flavored soft drink) along with plastic disposable cups for the guests. In a corner of the big table was the dinner served in big, silver-colored serving dishes.

The band played Sinhalese pop songs from the past. Most songs were by Clarence Wijewardana, Joti Pala and Rookantha Gunatilaka\textsuperscript{38}. The fact that they only played these Sinhalese songs, intended to entertain most in the crowd, revealed an important aspect of their class origins in Sri Lanka. The songs played by the band were all from the eighties and nineties. No songs were sung in English, for this period was marked by cultural nationalism. This in itself says much about the organizers, as the repertoire was drawn from the songs that would have been popular among middle class youth at that time and was intended for Sri Lankans from that background; mostly those who migrated in the 1990s with German Technical College certificate qualifications as skilled

\textsuperscript{37} Kandyan sari or the ‘up country’ sari (Originated from the word Kandy, the hill capital of Sri Lanka which is considered more traditional than any other part on the island because of their long resistance to surrender to British colonial rule in the seventeenth century) is considered to be the national dress for women in Sri Lanka as opposed to the Indian sari. The distinction of the two saris are attributed to the different ways of draping the sari and the former is considered traditional and more authentic in terms of Sri Lankan culture.

\textsuperscript{38} These three singers are considered to be three of the most popular singers in Sri Lanka and their songs have a distinctive Sri Lankan sound and so embody ideas of national identity.
workers. This middle class social status could also be assumed from the organization’s affiliation to the JVP party.

At the end of the musical performance, a documentary started to play on the screen. This depicted the organization’s earlier successful projects, when it contributed donations of computers to other institutions based in Sri Lanka. No one paid any attention to the documentary. The hall was full of the sounds of people’s convivial conversations, drowning out the commentary on the video documentary. It was evident that the attendees were more interested in mingling with others and talking to friends than listening to the documentary or appreciating the success of the project. Perhaps socializing could be considered as one of the primary intentions of this food event, only secondary to fund-raising.

Near dinner-time people started to queue up towards the long tables that were arranged in a corner on which the serving dishes were placed. There were hoppers (crispy pancakes made with rice flour), egg hoppers (a hopper with an egg cooked in its middle), and kottu (dishes made with roti and other ingredients, sometimes considered Sri Lanka’s ‘national dish’) that were made with chicken, lamb and vegetables. The curries were coconut sambol, dhal, a seenisambol[^39], and a chicken curry. What was most striking about the food was that the taste was intensified in all of the dishes by the lavish use of spices and oil. As a Sri Lankan migrant I have myself reduced the spices and oil in cooking at home partly as a personal preference and because my palate has become accustomed to the more bland tastes and creamy textures of food in Australia. So, at this community event I found that the spiciness and oiliness of the food offered was overwhelming. This extensive use of oil and spices in Sri Lankan cuisine has been noted in the literature and contrasted with Bangladeshi cuisine, which uses fewer spices than Sri Lankan and Indian cooking (Chowdhury et.al 2000). The extensive and profuse use of oil and spices in the food for public consumption, such as the event described, can be attributed to South Asian cultural ideals of culinary hospitality, where visitors and guests are honored by being fed the richest foods the host can provide. Thus offering fried vegetable curries to visitors was standard for most of the houses that I visited.

[^39]: *Seenisambol* is a traditional Sri Lankan spicy delicacy that is made with shallow fried onion, chilli, and dried and salted Maldivian fish with other spices.
Maintenance of group identity through food

In spite of the fact that the foods at this event were precisely those that diabetics are advised to avoid, my companions, Athula and Athil both of whom had diabetes, enthusiastically consumed all on offer. Their whole-hearted participation affirms the conclusions drawn by Delphy (1979) and Goody (1982) from their analyses of patterns of eating, which emphasized that ‘the identity and differentiation of the group is brought out in the practice of eating together or separately, as well as in the content of what is eaten’ across cultures (Goody, 1982. P.38). Anthropologists argue that sharing and consuming food in group settings reinforces group membership and the refusal of food at these occasions would jeopardize membership of this group and therefore lead to a loss of identity (Lawon et. al 2008). Reinforcing this conception of group identity and membership that is associated with communal food consumption, Caplan states “food is never just ‘food’ and its significance can never be purely nutritional ... it is intimately bound with social relations, including those of power, inclusion and exclusion” (Caplan, 1997. P.3). The enthusiastic participation of Athula and Athil at this occasion and many other accounts of my participants regarding communal eating demonstrate that group membership was more important to them than diabetes management.

It was evident in this research that the participants did not mind mingling with others where traditional Sri Lankan food was central to the event. Lawton et al. (2008) observed that the British Pakistanis and Indians in their study constantly encountered a dilemma, between preserving their group membership and identity by consuming South Asian foods at these social and cultural occasions and risking the loss of their group identity by not attending because participation posed a risk to their health. My own findings were quite different. Sri Lankan participants in my study clearly stated that they would always choose to participate fully in these occasions because of the feeling of inclusion and also because they enjoyed them as a change from the monotony of everyday life. Most of them said that they would rather go to these places and meet up with friends in the community and attempt to control what they ate. However, at this and other events I attended with them, the participants showed few signs of self-control; in fact they appeared to suspend management regimes entirely on such occasions. Anula said that especially during the April Sinhalese and Tamil New Year time she rarely even checks her blood glucose level. For her it is difficult to keep an eye on the sugar levels during this time as they attend many gatherings at
friends’ houses and exchange sweetmeats\textsuperscript{40}; “e dawaswalata nam meter kale”\textsuperscript{41} (Anula). Social interaction and the demands of being a sociable guest are privileged over self-management, in spite of awareness of the risks.

**Conceptualization of food**

**Food as a marker of class**

The socio economic and cultural background of all but four (Navin, Chandra, Damayanti and Kanchana) participants with diabetes as well as a majority of other people that I communicated with, during my field work in Melbourne could be considered as middle class. They represented urban and suburban Sri Lanka and came from an educational background that included Diploma level and University Degree level, which signals membership of the middle class in Sri Lanka. They were not suffering from any high level of socio-economic deprivation or unemployment. Statistics from ABS are evidence for this\textsuperscript{42}. To deliver the picture of how social class shaped lifestyles which included foods that were consumed, I would now give the following details of the participants. Only five participants out of twenty five knew that they had diabetes before migration. The others were diagnosed with the disease after migration. Of these twenty participants, six had lived in other countries prior to arrival in Australia, being employed in the Middle East for long periods of time. They had been exposed to non-Sri Lankan diet patterns before they arrived in Australia. One common speculation that the twenty participants made about the onset of diabetes in Australia

\textsuperscript{40} During the Sinhalese and Tamil New Year time in April it is the custom to make traditional sweetmeats at every home and exchange them with friends and relatives. Very often people also host gatherings of friends and relatives at their houses for meals.

\textsuperscript{41} “e dawaswalata nam meter kale” is a Sinhalese expression that is similar to the English idiom “at these times diabetes management is thrown out of the window”. The literal translation of the expression is “during those times my diabetes meter is thrown into the bush”.

\textsuperscript{42} At August 2012, the Sri Lankans’ labour force participation was high (72%) and well above the national average (69%). Of those Sri Lankans who were employed in Australia, 34% were professionals, 18% were clerical and administrative workers. Their unemployment level was just slightly higher (5.4%) than the national average (5.2%). (DIAC, 2012).
was that it was caused by the sudden change in their diet – changes that reflected their increased consumption of foods that are associated with wealth and cosmopolitanism in Sri Lanka. Athil remembered how his friends, including his family who arrived in Australia at the beginning of 1990s, drastically changed their food consumption,

...it is really when we first moved here that we liked them (ham, bacon and other processed meat) a lot. The same thing I have noticed among my friends’ families...but with time you understand the risks. It is mostly because you do not get that type of deli in Sri Lanka. And when we were in Sri Lanka we ate meat only for two or three times a week. But if you go to a house here we cook meat for every meal. And the other thing is we feel that apart from meat you don’t have anything else to eat. In this country we eat more meat than we eat vegetables. I know a lot of my friends’ houses especially the children eat very little vegetables. And even in our family our children eat very little vegetables. The thing is we can’t put the entire blame to the children. That is the way we first ate here with them. So they are used to that way of eating...

In Sri Lanka, meat and other products with meat are often unaffordable even for people who are middle class. Therefore no matter what the nutritional value of these products are, for a middle- or lower-middle class migrant from a developing South Asian society, newly-arrived in Australia, the sudden affordability and the wide availability of processed meat, products such as “ham and bacon”, the much used Sri Lankan idiom to describe the life style of wealthy urban people, represented their social mobility,. ‘Ham and bacon’ and ‘cheese and chocolate’ were luxuries they could not afford in Sri Lanka and so their consumption in Australia is a symbolic marker of the upward social mobility they had hoped for in emigrating. Athil’s observation of their dietary changes also reveals another issue about the eating habits of the children of these migrants and signals the danger of developing nutrition-related illnesses for the next generation.

Food as a marker of class comes into light again in relation to the topic of where they went to eat out. Upon asking where they would go out for a meal, all participants except Navin and Chandra,

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43 When returning to Sri Lanka for holidays, these things are even commonly taken as gifts for those back home.
said that they would usually go to McDonalds, KFC or Pizza Hut fast food restaurants. Denver offered this explanation:

We would not go to Sri Lankan restaurants as we are cooking them at home. If we go out we would normally go to McDonalds or KFC don’t we? Apart from that we eat Pizza. One reason for that is eating a pizza is cheap for the family. When there are many in the family it is difficult to go for other options...

In Sri Lanka, KFC and McDonalds are only available in the two big cities, Colombo and Kandy, and their prices are too high for most middle class Sri Lankans to eat there regularly. From my experience in Sri Lanka, people would have a meal at KFC or McDonalds only as a treat to celebrate an important event. These restaurants cater mainly for the cosmopolitan upper class. People do not consider KFC and McDonalds food as ‘fast food’ and certainly do not view it as ‘unhealthy’. This could be because in Sri Lanka the label ‘fast food’ is more commonly attached to food that is sold by street hawkers or at locally owned restaurants. Compared to the latter, McDonalds and KFC restaurants, with their impressive and attractive interiors, their distinctive Western food and their status as multinational enterprises, have an aura of sophistication and cosmopolitanism that identifies them with the upper class. It is clear that even after migrating to a developed, industrialized society, and after exposure to warnings of the dangers of ‘fast food’ from health care providers, the participants’ positive perception of restaurants such as McDonalds and KFC persist.

Most of the participants explained that they went to these restaurants because of their children. In Australia much fast food advertising is explicitly directed at children and young people, appealing to children’s desire to appear ‘trendy’, as well being affordable. Denver also said that when the responsibilities of children diminished they could go out to other places for meals.

…but now it’s a bit different. We buy Chinese now... or if we don’t have time to cook we just buy two parcels of rice from a Sri Lankan shop. And from very recently we started going to La Porchetta [an Italian chain of restaurants specializing in pizza and pasta dishes]... So until recently we couldn’t really afford to go to any place like that because of our financial situation. That is also because children go out for
dinner now. The other day they (the children) were calling us to join them to go and eat out. So then we went with them.

This suggests that sometimes the adult children of first generation migrants introduce their parents to the restaurants where they would like to go and eat with their friends. Prior to this they would only go to fast food restaurants, partly because they did not know the other types of restaurants and partly because of the fact that even if they were aware of them, they found it difficult to afford these restaurants, especially for a family.

Denver’s mention of Chinese restaurants raises another issue suggestive of the persistent influence of Sri Lankan values in the diaspora. Over the past two decades, Chinese restaurants have gained in popularity and there has been a proliferation of them across Sri Lanka – to the point where people jokingly surmise that there are now more Chinese restaurants in the country than there are in China. These Chinese restaurants are often located on side streets of cities and village centers and cater for the lower middle and middle classes. In Sri Lanka ‘going to a Chinese’ is now synonymous with ‘going to eat out’. Denver’s choice suggests that even in a country where there are many other ethnic cuisines and restaurants available, the familiar remains dominant.

In contrast to most of these participants, Navin came from an urban elite family and was connected to many Sri Lankan elite politicians’ families. In Australia, he worked at an office liaised with Public Transports and did not have any financial resources that the other participants did not have. He was educated in an elite private school in Colombo and spoke very fluent English (the marker par excellence of high social status and class). He went to fine dining restaurants even when he chose to eat Sri Lankan cuisine.

Bourdieu argues that all cultural practices, which include preferences in literature, painting and music, are strongly linked to educational level and social origin (Bourdieu, 1979). He further states that “to the socially recognized hierarchy of the arts, and within each of them, of genres, schools or periods, corresponds a social hierarchy of the consumers” (1979, p.1). In Australia and many other industrialized countries, appreciation and knowledge of culinary arts and gourmet food have become one of the markers of cultivation that signals a person’s ‘cultural capital’ in Bourdieu’s sense. Fine dining is mainly the province of the wealthy, but there are numerous restaurants that cater to the aspirations of middle class people. Sri Lankan migrants in my study generally
continued to hold to the ideas of cultural capital prevailing in Sri Lanka, although Denver’s comment suggests that the second generation is becoming more oriented to Australian cultural distinctions regarding food consumption.

**Acting upon food: fighting an invisible danger**

As food exerted cultural, social and personal meanings in their lives at individual and community levels, it is important to examine how participants acted on these meanings while engaging in diabetes management.

Although everyone exerted some form of control regarding food, in this group of participants there were hardly any who had given up their favorite foods, even though many of these are contra-indicated for diabetes. No one adhered to a continuous regimented diet based exclusively on what is considered healthy for diabetes management. They were inclined to only adhere to dietary advice when their blood sugar levels rose. Participants were more motivated by the instant gratification and the sense of wellbeing associated with eating what they desired, than the need to maintain healthy blood glucose levels. The immediate and pleasurable sensation of eating favored foods far outweighs any satisfaction that might be drawn from rationally responding to an unseen danger. This aspect of human behavior in the face of chronic diseases has attracted attention in other studies. Wilson, writing about diet and cardiovascular diseases in Kerala, South India argues that “as a predictor of potential future harm, acknowledgement of risk maybe a limited guide to health behavior in the present given the immediacy of bodily desires and the reflexivity necessary to consider the long term health behavior in the present” (Wilson, 2010. p.264). To this I would add that in the domestic sphere, the habitus of household meals and the emotional satisfaction derived from consuming familiar foods works against the acknowledgement of risk. The security of home in a land where one is a migrant and the fact that the foods themselves evoke nostalgia for the comforts of the native land, mother’s cooking and other pleasant associations, diminishes ideas of risk.
Making active choices of food

However there were also noticeable dietary changes that incorporated new foods and all participants reported making conscious efforts to choose from what they liked in the so called ‘healthy’ Australian foods. Damayanti had Weetbix (cereal biscuit) with fruits for breakfast; Athil had only a vegetable sandwich for lunch. Athula liked Vegemite (yeast extract) on toast for breakfast because it was easy to prepare when his wife was unable to cook because she worked night shifts. As Anula said:

...in this country there are enough and more alternative foods, more than in Sri Lanka. In Sri Lanka for a main meal there is only rice. But here you get a lot of other foods like Indian rotis, different types of bread. And unlike in Sri Lanka here things like vegetables are very cheap. We can eat more fruits and vegetables in Australia. But I don’t control food limitlessly thinking of diabetes. I eat what I want by carefully choosing them. And I have not entirely given up on sweets ...

Among the Sri Lankans I talked to during my fieldwork one of the most significant modifications that all had implemented in their cooking was the shift from using coconut oil to olive oil, because they all thought that the latter was healthier. They used olive oil for frying vegetables, fish and meat. Previous studies too have noted this incorporation of western foods in to the diet by other South Asian groups living in developed countries. Just as noted in this body of previous literature, even among the participants of this research there was a higher tendency to incorporate more western foods such as Weetbix, and sandwiches, for breakfast and lunch than at dinner (Anderson and Lean, 1995).

Kraidy and Murphy argue that the migrant of any origin is not just a passive recipient of tastes in a different culture, “…that another place, another food, is not merely the ‘global’s presumptive victim, its cultural nemesis, or its coerced subordinate’ but an increasingly assertive player in transactions of tastes” (Kraidy and Murphy, 2008; p.339). Participants’ willingness to embrace change affirmed that this is certainly true for Sri Lankan migrants.

So, on one hand, their cuisine in the domestic arena can be characterized as conservative and symbolic of an ongoing effort at the individual level for the reconstitution of a sense of security,
fulfillment and identity that they experienced in their land of origin. On the other hand, their attempts to incorporate elements of Western cuisine into their meals can be viewed as a pragmatic response to the time pressure experienced when working in two jobs and when living in suburbs with long commutes to work. Of note, this incorporation of western foods into their meals can also be viewed as an embracing of the new and a desire for inclusion in their land of settlement.

**Intensified nutrition and flavor in Australia**

Chowdhury et al. (2000) studied another South Asian diasporic community – Bangladeshis living in Britain – and found that there was not only a strong retention of the ways of cooking and consumption of traditional meals, but also distinct change in the type of traditional cuisine. More elaborate and rich foods were consumed than had been in the case in Bangladesh, due to the increased availability and affordability of culturally luxurious ingredients in Britain. Many of the participants in their study came from impoverished rural areas in Bangladesh and the dietary changes fitted their aspirations for a better life (Chowdhuri et al. 2000). My own findings among the Sri Lankan community in Melbourne echo this. For example, when *kiri bath* (milk rice) is cooked in Sri Lanka, the rice is first cooked with the second or third versions of milk from the scraped coconut, which is watery and thin. This was done to save thicker coconut milk for other curries. The very thick coconut milk is added to the rice only towards the end of the cooking process to preserve the thickness of the *kiri bath*. But in Australia, instead of the plain, thin coconut milk, from the beginning of the process, the participants chose to use tinned thick coconut cream which they buy from Asian shops, as it is cheap and more convenient than scraping coconut at home. The end result is a creamier, thicker and oilier *kiri bath* than that which would be eaten in Sri Lanka.

Avoidance of the consumption of food with starch and fat is fundamental advice that all diabetes patients receive from the health professionals of the diabetes care team. It is obvious that many of the changes the participants made in diet are potentially deleterious and contrary to the medical advice received by all diabetes patients to consume foods with very low fat and sugar (Australian Diabetes Council, 2012).
One of the crucial issues that all participants faced in their lives was controlling their food intake. Some had found, through the processes of testing and retesting, the effects of specific foods on their diabetes and were happy to discuss their control of food on the basis of these discoveries. However, difficulties in managing diet were not initially the main topic of discussion, as the majority of participants wanted to project themselves as “good diabetes patients” who knew what and how much they had to eat to maintain a healthy blood glucose level. So my initial questions about the difficulties and challenges in maintaining effective blood glucose levels were commonly fielded with answers that stressed their ease with the constraints and their ability to control what foods they ate. It was only in subsequent conversations, as people became more relaxed with me, that their struggles and problems were raised, often obliquely or subtly expressed in a range of contexts.

During the preliminary interview Anula confidently mentioned that her blood sugar was reduced only when she reduced the starchy foods that she used to eat in Sri Lanka. But on another occasion she added,

...but I don’t control food infinitely because of diabetes. I eat what I want by carefully choosing them. And I have not entirely given up on sweets. Sometimes I think why do I need to give up on so much food. So sometimes I just eat whatever I feel like and think it doesn’t matter whatever happens in future...

Like Anula, many others voiced this idea about the constant tension between the moral responsibility of having to change, reduce and control food and their weariness of having to do this constant monitoring. But they spoke in a way that indicated that they had given up the idea of a very strict control over food and testing and would often resume old habits. Athula always had a glass of wine in the night despite its negative effect on his blood glucose level.
...to tell you the truth I’m sick of pricking myself (with the needle) like this every day...I had dinner last night and had a glass of wine and when I checked in the morning it was 16⁴⁴! (Athula)

**Rice at least once a day**

Another modification most participants who were employed incorporated into their regime was the omission of a rice meal for lunch for practical reasons. Athula, who is a mechanic at a factory in the western suburbs of Melbourne, and Athil, who is a computer technician, both said that they do not take rice for lunch at work because their wives do not have time to prepare rice and curry meals for them. Nevertheless many male participants including Athil, Ranil and Denver stated that they need to eat rice at least for dinner because they “survive” on only a sandwich for the whole day. The expression “surviving on a sandwich” itself implies that it is only a rice meal that could give them a feeling of contentment. This observation was similar to the findings of the study conducted among British Pakistanis and Indians by Lawton et. al (2008), where they observed that most elderly first generation migrants were very resistant to the idea of changing long established dietary habits for their main meal. The Sri Lankan participants were convinced that at least once a day a person needs to have a meal of rice and curry.

It is actually after coming home that I get to eat something “proper”. When at office I get to eat only a sandwich or something like that. So because I don’t eat meat I usually eat my sandwich with just vegetables. I buy it from outside usually...so for morning I would take a toast or something. It is only after coming home that I would have rice. There is no alternative for us. I don’t feel ok with anything that I eat from outside really. I have to come home and eat rice to feel full. There is no fitness or steadiness in the body until I eat home cooked rice and curry (Athil).

⁴⁴ It is recommended that a diabetes patient needs to maintain a number between five to seven or eight on the glucometer. Thus sixteen in this case is a very high level of blood sugar for the participant.
Rice is the staple food of many South Asian groups. Obeyesekere’s concept of ‘personal symbols’ (1981)– which he defines as a class of symbols that operates at the levels of personality and culture simultaneously – is most useful for interpreting participants’ relationship to rice. Rice is at once a personal preference (redolent of specific, pleasant, familial connotations) but also an essential part of a daily life that manifests social and cultural values. In Sri Lankan culture, a rice and curry meal is usually comprised of a much bigger quantity of rice than vegetables. Having a main meal is equivalent to the colloquial expression of “bath kanawa” (Eating rice). It emphasizes that the place of rice in a main meal in Sri Lankan culture is much more significant than the curries that it accompanies. Participants associated pleasant feelings of satiation with the consumption of rice, while affirming cultural norms about the function of rice in the Sri Lankan diet.

Given the starch content of rice\(^{45}\), this pattern raises a question about the potential harmful effects of this habit of eating the rice and curry meal for dinner for effective diabetes management, especially when people do not get time to do any physical exercise at night. Participants were advised by their doctors to eat ‘light foods\(^{46}\) for dinner as the consumption of rice would increase the blood glucose level fast and as this particular time of the day would not allow them to exert the excess energy produced by glucose in the rice.

**Idiosyncrasies and myths**

Individual notions of diabetes management were sometimes based on idiosyncratic understanding of the disease and socio cultural myths. One participant, Chandra, responded to his illness in ways that were derived entirely from his cultural beliefs about the diagnosis, management and treatment of diabetes. He had the highest level of education – a doctorate in economics – and confidently used modern communication technologies, such as the Internet to develop his vast knowledge of diabetes. Although Chandra was aware that consuming traditional Sri Lankan dishes was not conducive to the control of his diabetes, he tended to disregard medical advice about

\(^{45}\) Apart from a few types of brown rice, rice in general is considered as a grain rich in carbohydrates and it is advised to avoid consuming too much rice at one time (Australian Diabetes Council, 2012).

\(^{46}\) Soups and boiled vegetables were some examples the participants gave.
diet. He called himself ‘an idiosyncratic diabetes patient’ as he did not avoid food that he liked. His main strategy for controlling diabetes was by doing yoga exercises. In Sri Lanka he had controlled his condition entirely by taking alternative and Ayurvedic medicines and making herbal soups from the greens that could be found in the garden, without relying on any of the western medicines available. Even in Australia Chandra continued to rely on natural remedies and yoga to control his diabetes, paying little attention to dietary measures.

...the fact that I need to go to the toilet in the night signs that I need to start controlling. So what I do is I control or stop eating everything bad, and start drinking *kothala himbutu*\(^{47}\) and eating bitter gourd\(^{48}\) or I have cinnamon powder with everything I eat...

At this comment his daughter and wife who were present interjected that they had never seen Chandra give up sweets such as the cake and ice cream of which he is so fond. Rather than banish specific foods from his diet, Chandra always tried other mechanisms that he thought were more effective in controlling sugar, such as having alternative medicines for a long period of time and doing yoga exercises and going to the gym. Chandra’s rationale for not adhering to the medication prescribed by the doctor was his belief that Western pharmaceutical medications do not have external validity. He said that he learnt the weaknesses of the scientific method in high school under the Advanced Level subject Logic. Using this knowledge he justified his non-adherence to medicine and dietary restrictions stating that the medications lack external validity and are not necessarily correct.

...that is because I have no faith in western medicine and I regulated well from alternative medicine. I just take western medicine because of convenience and sometimes I’m left with no option because you sometimes are pressured to take it...

\(^{47}\) *Kothala himbutu* is a dried branch of a plant found in Sri Lanka that is boiled and drunk as an alternative medication for diabetes. Ayurvedic doctors recommend diabetes patients to have this herbal drink.

\(^{48}\) Bitter gourd is a well-known vegetable among Sri Lankans as a medication for diabetes. Many participants cooked bitter gourd as a curry to eat with a rice and curry meal as an alternative mechanism to reduce blood sugar.
However it was clear that Chandra’s lack of dietary control in Australia was a source of anxiety, mainly because he could not obtain some of his Ayurvedic soups and concoctions that had worked so well in Sri Lanka. Even though he still did not always restrict his diet according to the guidelines given to him by the doctor, he always tried to follow alternative pathways to control the blood sugar, pathways he had more faith in than controlling what and how much he ate. For example, at the time of my fieldwork he was taking powdered cinnamon with everything he ate, as he had read on the Internet that cinnamon lessens the effect of the sugar in food that is absorbed into the body.

A universal strategy of management of diabetes for Sri Lankans that I met in this research was the giving up of sugar in their daily cups of tea. Sugar was rarely taken with tea and it was thought to be a major modification of their daily diet. However, as Tissa mentioned, most had a sweet biscuit or other sweetmeat with the tea. Tissa said that he drank his tea without sugar but he liked to have the plain tea with a piece of dodol or an oil cake that he would find at home especially during the Sinhala Tamil New Year time. It was sugar as an added ingredient to their tea that was thought to be detrimental to the management of diabetes. It was clear from conversations that sugar as a distinct substance was conceptualized as ‘bad’ for their condition rather than as an ingredient of other foods. The sugar content in the sweetmeat was at not considered to have the same detrimental effect on glucose levels.

In this chapter I have demonstrated that although there was an overall tendency for people to maintain eating habits that they had practiced in Sri Lanka, their diet after migrating to Australia has also undergone important changes. Taking Sutton’s argument, that food and eating patterns function as building blocks of the concepts of self and identity, then it can be surmised that the changes that take place in these patterns of food and eating over time should also signify a shift in their identity. The consumption of certain foods that were scarce and unaffordable in Sri Lanka, but that are readily available and affordable in Australia, manifested a symbolic transition of social classes for some participants who felt that they had attained the social mobility that motivated their migration. Many participants explained that increased consumption of ‘luxury’ foods occurred quickly, in the first few years after arrival. Nonetheless none of them continued to eat in the same way. The subsequent diagnosis of diabetes usually forced them to recognize that excessive consumption of these so called luxury foods constituted a risk to their health. But while
many modified their consumption of rich foods, they also continued to incorporate other eating patterns, such as eating out from multinational fast food chains.

In this chapter I have shown the complex ways that changes in food and eating patterns are enmeshed with dynamics of identity and social class in Sri Lankan migrants’ lives. The social, cultural and psychological factors that are involved in the maintenance of culturally engrained habits affect the ways that people respond to the novel foods and consumption patterns in their new environment. In their changed circumstances, adherence to a dietary regime for diabetes management is clearly problematic for most of the participants in this study. It is clear from my research that they cannot be characterized as conservative, for they willingly embrace new foods in some contexts and are prepared to modify their cuisine. However it is equally clear that most of the changes, as well as the continuities, are not explicitly directed towards deliberate and conscious diabetes management. In fact most appear to be triggered by needs to maintain and develop concepts of self and identity associated with food and eating, incorporating aspirations for social mobility that motivated migration in the first place.
Chapter 6: The doctor-patient relationship

One major component of this research was interviewing and consulting general practitioners and diabetes educators who were involved in providing diabetes care for the group of Sri Lankan patients. This chapter presents an analysis of the views and understandings of lay participants and health care professionals (HCPs) regarding their clinical relationship, and of the observations of the clinical encounters between the members of the two groups. In this chapter, I aim to provide an understanding of the nature of the patient-provider relationship and its effect on the lay person with diabetes with regards to their understanding and management of the disease.

Several contradictions of perceptions between HCPs and patients regarding diabetes management were revealed during the HCP interviews and observations of clinical encounters. They also revealed the disparities between the HCPs' perceptions of their lay participants’ management of the disease and what was actually taking place. Some disparities might be attributed to miscommunication. But there were also prejudices, concealments, and failures of disclosure, cross-purposes and misunderstandings in these clinical relationships, all of which have effects on the participants’ management regimes.

In this chapter I draw from experiences and perspectives of lay participants, their families and their HCPs in relation to trust in the health care system, adherence to diabetes management guidelines in everyday life, and doctor-patient relationships. Using these sources, I will discuss issues that revolve around factors such as compliance, self management, application of agency, subjective perceptions about personal regimens and health identities, patients’ expectations from the HCPs, trust, selection of HCPs by patients and the clinical encounters in depth. In this chapter I will argue that although Sri Lankans have high levels of literacy, and skill and knowledge regarding health, several of their ‘tribulations’ in managing diabetes stem from contradictions in the expectations of doctors and patients, and miscommunication between them.
Compliance vs. Self management

Having diabetes usually requires the maintenance of a lifelong relationship with a team of health care professionals due to the chronic nature of the disease and associated health complications, which develop over time as a result of the physiological effects of poor glycaemic control on other systems within the body. In addition to the use of medications that help to regulate sugar control such as insulin or oral hypoglycemics, the key elements of diabetes management (sometimes the only elements in mild or early diabetes) include regulation of dietary sugar intake and exercise. Both these lifestyle elements additionally assist in diabetes control where successful weight loss positively influences diabetes. Because management is intrinsically related to life style it is an imperative that the patient adheres to particular behavioral regimes that have been identified as crucial to the maintenance of safe blood sugar levels. These include regular testing, appropriate medication, dietary modifications and regular exercise. Failure in any of these practices can precipitate crises and sometimes lead to other physical problems that are life-threatening.

In diabetes management, one of the major issues that both patients and HCPs complain about is ‘compliance’ (Goodall and Halford, 1991). In the discussion of the dynamics of doctor-patient relationship, the term compliance could be regarded as a lens or a key concept through which these two parties, as well as diabetes researchers, conceptualize diabetes management. In medical anthropology, compliance is interpreted as a situation where people’s explanatory models of diseases are at play, which include instances where they conform or depart from medical advice (Ferzacca, 2000).

Compliance has been interpreted by many authors as a continuum with two extreme ends. On the one hand, according to Trostle (1988) it can be interpreted as an ideology that upholds and justifies the authority of the health professional, asserting the doctor’s control over the patient in the health care setting and preserving biomedical hegemony (1988, p.1299). On the other hand there is the patient-centered perspective, in which compliance is understood as responding to the meaning of medications in everyday life rather than abiding by the orders and medication regimens of the health professionals (Conrad, 1985. P.36). However, more recent writers on chronic illness management and compliance argue that compliance is generated by “idiosyncratic regimes” that combine the self care of the patient and the clinical practice of the health care
professional. They argue that these regimes are informed by commonly agreed upon cultural referents and values among patients and health care professionals (Ferzacca, 2000, p.29).

Compliance is a contentious term and it is only for the purpose of convenience I shall use ‘compliance’ to describe how much the participants diverged from the course of management prescribed by the health professionals.

**Importance of self-management**

Researchers observe that self-management of diabetes is granted high importance in a majority of health care systems. Fox and Ward (2006) consider that it is due to governments’ tendency to promote expertise in patients, and to the increased availability of health care products such as glucometers that patients can use to measure their blood glucose level (p.464). Ferzacca (2000) argues that ever since the discovery of synthetic insulin, the diabetic patient has been burdened with responsibilities, and commonly held as solely responsible for the management of diabetes by health care professionals. Ferzacca in his study about diabetes patients and doctors, describes the relationship as loaded with tension between the ideas of compliance and self-management; the former signifies the surveillance over management by the doctor while the latter signifies the self responsibility of diabetes management.

‘What I believe is that I’m not diabetic’: application of agency

Although everyone in this group had a doctor for diabetes care, their adherence to medical advice varied widely from almost complete non-adherence by some to “expert patients”. In this context, by “expert patients” I mean those who ‘always’ tried to measure the portion of rice they had for all three meals and those who engaged in physical exercise every day. From the twenty five participants with diabetes, only Kanchana had the perseverance to continue such a rigid regimen. The application of agency to medical advice by those who seemed to come from the extreme end of ‘close to non-adherence’ can be demonstrated as below.
Previous writers emphasize that trust in the health care system plays an important role in patients’ adherence to management regimens (Borovoy and Heins, 2008; Stewart and Nam Do, 2003). An ‘idiosyncratic’ case that I came across in this study is Chandra’s situation. As described in Chapter 5, he himself called his situation ‘idiosyncratic’ because unlike any other participant, he did not have a fixed GP.

...I said that it is an idiosyncratic case because I know about research philosophy and research methodology, I do not have 100% faith in the scientific method. That is because they do not have external validity in their experiments. So I am very cynical about a lot of drugs. I just use them because I cannot manage to do away with them completely. But I just don’t have any faith in them...

He appealed to his knowledge of scientific methods and limitations on validation of research findings as the grounds for his lack of faith in Western medicines. Hence he admitted he does not have ‘great faith’ in strict adherence to lifestyle recommendations. Chandra believed that the Western medicines that doctors prescribe were too ‘broad spectrum’ and would not be effective in various unique situations posed by the lifestyles of different people. He thought that medicines could be ineffective in circumstances not tested in laboratories. This belief led him to have minimal faith in Western medicine and Western doctors in general.

... I did not have a regular doctor in Sri Lanka. I do not have a regular doctor in Australia either. I just get a doctor to write a prescription for me when I need. That is because I have no faith in Western medicine and I regulate well from alternative medicines. I just take Western medicine because of convenience and sometimes I am left with no option because in this system you are pressured to take them (Western Medicines).

Chandra is a participant who exercised a high level of agency and autonomy, who was defying one of the most commonly accepted ‘laws’ of diabetes management: having regular appointments with health professionals. He did not worry about navigating his way through the Australian health care system or being pressured by health professionals to maintain a particular diet or to exercise for a certain period of time every day. Instead, he had his own method of diabetes management, using alternative medicines and yoga exercises. He was ‘forced’ to take Western medicine only
when he had to get medical checkups for work-related responsibilities and only if his sugar level
rose suddenly to an unexpected level. He believed that his knowledge and understanding of his
own condition was superior to that of any doctor. He always knew when his blood sugar increased
to a high level through bodily signals such as extreme anger and an itchy feeling in his armpits.

...I know it’s high when I get unnaturally angry. I can feel it very well in my body. It is
such a different feeling... I can smash anything and be extremely angry. And that
level of anger is not possible for me when its (blood sugar) normal or low...Later on
when reading about diabetes I found that extreme anger is one of the symptoms
and a side effect of high blood sugar...

During such an episode, if the doctor recommended a higher dosage of medicines he would ask
the doctor to give him one or two weeks and then have another blood test, to prove that he did
not need a higher dosage. During this period he would start taking alternative medication and
doing yoga intensively until his sugar level reduced to the normal level. Chandra reported that in
this way he has been able to avoid increasing his dosage. He considered his management
strategies had so far been very successful while also admitting to phases of very high blood
glucose levels. Chandra’s response is unique. He was manipulating and even subverting the
processes in the health care system based on his belief, experience and knowledge and his ability
to manage blood sugar level adequately.

Navin was another participant who did not follow the advice of his doctor. He relied more on what
his body signaled than on the doctor’s assessment or the results on a glucometer to evaluate his
diabetes control. When asked how his life has changed due to his diabetes and medical advice,
Navin claimed that his life has not undergone any drastic changes because of diabetes,

As presented in Chapter 5, he claimed, “...The language that my body is trying to tell me is that I’m
fine”.

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Trivialization of diabetes

Denver too can be considered a participant who placed faith on his own judgments (rather than on those of health professionals) of his health status, based on his embodied experiential knowledge of the disease. He recounted his experiences of sharing diabetes tablets and other alternative medicines from Sri Lanka with his good friend Edward:

...we exchange a lot of things about diabetes. Sometimes if either of us does not have medicine we exchange between each other herbals medicines and even Western medicines from Sri Lanka... some people of course grind karawila (bitter gourd) and drink. But I don’t really do it. I believe... what I believe is that I’m not that diabetic.

His somewhat insouciant response to his diabetic condition owes much to the way he situates it in his life. He diminishes its adverse effects on his health and attempts to normalize the severity of his diabetes management problem by trivializing it through comparison with worse problems he has encountered in life. Denver came to Australia with his family seeking refuge from political violence in Sri Lanka at the beginning of the 1990s. His story is full of tribulations that he and his wife had to endure as a result of various external political and social pressures. In comparison to these tribulations, compliance to lifestyle recommendations and self-management of diabetes are trivial in his life.

All participants were aware of the processes of diabetes care in the system and they were aware of their appointments with other health professionals in the team. One of the important things that is apparent from this awareness is that these Sri Lankan migrants with diabetes were far from helpless as they knew where they had to go and what they had to do to get appropriate care for their disease. No one overtly expressed any sense of helplessness in accessing services in managing diabetes. A very noticeable aspect that I came across in all participants was their belief in themselves and reliability of self-assessment, and confidence in own their opinion and judgment, in all activities related to care-seeking and disease management. The accounts of Sri Lankan participants show that they had a high level of reliance on their embodied experiences of bodily signals related to diabetes. They also have a high level of assertion and confidence in
interpreting these signals in the processes of decision-making, rather than the judgment or advice of the doctor. Their agency in choosing whether to comply with medical advice was coupled with a tendency to judge their status as close to normal and to trivialize diabetes as a determinant of their overall well-being.

Sri Lankan doctors saw this trivialization in the ways in which they came to the appointments. They observed that Sri Lankans generally came alone to see them in contrast to patients from other ethnicities who came as a family or with a partner. They perceived this as a problem. Dr. Vignesh stated:

... it is really important that if the man is diabetic then the wife needs to know what to cook and what foods are good. Often the family member that they come with wants to know what is going on and they too ask questions. For Sri Lankans, it is only the patient who turns up. Usually it is just the person who has it that turns up. And even if they come with the wife I can see that the wife is quiet and they are more scared to ask questions or raise issues with the husband and the doctor. Sri Lankan men have a big ego... So the belief is that the man in the family is dominant and the woman is subservient and should be passive. And the downside of this is that sometimes they would leave here and go and do the opposite of the advice they get from the doctor. I have seen many men who come here with their wives, sometimes if and when the wife starts to talk or ask a question they would get angry with her. And just brush off the comment in front of them. And because of this reason I have seen that the woman does not open the mouth. I don’t know to answer if they have any questions because they don’t talk.

Dr. Sanjeewa felt his patients gave disease management little attention because they accorded more importance to earning and saving money than to their health. Being a recent migrant himself, Dr. Sanjeewa had an understanding of common social and economic aspirations of many of the Sri Lankan migrant patients who came to see him, but his response was nonetheless judgmental and condemnatory.
Subjective perceptions about personal regimens explained through health identities

Fox and Ward’s (2006) concept of health identity is useful in this instance for us to understand perceptions of these three participants (Chandra, Denver and Navin) about health and its relationship to biomedicine. Fox and Ward contend that concepts of identity, embodiment and notions of health and illness are mutually constructed within circumstances that involve relations in the material world, culture and psychological engagements (Fox and Ward, 2006. p.462). They examine two broadly defined health identities. These two broad identities are placed on a continuum ranging from the sort of expert patient who constructs his/her health identity based on concepts that originate in biomedical models of health and illness, to the “resisting consumer” who rejects these explanatory models. The latter identity can even function outside the dominant health care system in a society by incorporating the lay and experiential models of health, illness and the body. The “resisting consumer” asserts a radical self to understand one’s health (p.461). Chandra, Denver and Navin each express identities that involve self-assertion and confidence in their own experiential knowledge as well as their personal, but culturally-grounded, values. They demonstrate a strong resistance and sometimes indifference to the established explanatory models within biomedicine even though all three of them did go to see the doctor.

However on the other hand there were participants, especially females, who were prepared to meticulously quantify the number of cups of rice that they ate for every meal, adhering to the precise advice of the doctor. Kanchana, an experienced quantity surveyor who was in her mid-fourties, migrated to Australia with her husband and daughter six years ago after working in Oman for more than five years. She attributed her diabetes to heredity and the type of lifestyle she led in Oman. According to Kanchana, this life style was not conducive to effective diabetes control by any means. She said it was only after coming to Australia that she acquired knowledge about diabetes and learned it is a disease that may be controlled by lifestyle modifications. She liked method and orderliness in everything she did. She said that she got this habit from her mother who was an English literature teacher in Sri Lanka. She often tried to cook healthy food and tried to select her foods in a manner that would positively influence the dietary choices of her only daughter. She followed the advice of her doctor closely on most days. Kanchana related,
... I try to exercise every day for thirty minutes. I usually go for a brisk walk every day after lunch at work. If I only get to walk for twenty minutes then I come home in the night and would do a ten minute walk on treadmill before going to bed to make up that thirty minute daily exercise...

Dayani, a woman in her early seventies, a retired nurse, lived with her husband with their son’s family in Blackburn. She claimed that she has to control a lot of food that she eats partly because of her awareness of diabetes management due to her training and experience as a nurse and partly because of the pressure she gets from her husband. He always keeps an eye on his wife’s eating. During the interview – while serving me Tim Tams (chocolate biscuits) – she had a dry Salada cracker. While having tea she confessed somewhat apologetically, that it is with a lot of reluctance she eats the crackers with tea, as from a very young age she was ‘addicted’ to eating a lot of sweets. With the onset of diabetes she found that it was very difficult to give up sweets entirely. Saying this, she too had a Tim Tam with her tea. Observing this, Dayani’s husband (who was watching a cricket match on television) complained that it is with a lot of his effort that he controls her habit of eating sweets. Dayani’s behavior in this scene parallels the argument of Campbell et al (2003), who claim that there is a strong congruence between the aim of achieving a balanced life with diabetes and the approach they call "strategic non-compliance". They maintain that strategic non-compliance entails the ability to strike a balance between the monitoring and observation of symptoms and the ability to manipulate dietary and medication routines to live life the way one desires (2003).

These different cases demonstrate that the participants’ adherence to medical and health advice regarding diabetes management varied widely, from a strong resistance to medical advice, through reluctance to comply with specific measures, to adherence to medical advice enforced by family members. Common in all these stories is the fact that understandings of compliance and adherence to medical advice are affected by individual life experiences beyond those directly related to the illness and to cultural values. A person’s compliance with disease management regimens appears to be significantly related to his/her own health identity, which is in turn shaped by his experiences and social and cultural circumstances. Fox and Ward argue that health identities are brought about by “concrete embodiment practices in relation to material, cultural, technological and emotional contexts” (Fox and Ward 2006. P.475). Fox (2005) also contends that
culture is only one component within which health identities emerge. He states that while taking culture into consideration, we also have to take into account the “physiological capacities and limits of the body, the sum of psychic and emotional lived experiences, the valuations, the beliefs and attachments that a person holds and the reflexive and social expectations of what a specific body could do” (Fox, 2005; Fox and Ward, 2006. P.476).

**Unmet expectations**

In addition to adherence/compliance issues, some participants experienced different problems in their relationships with HCPs. Kanchana had changed from her much respected Thai doctor to a Sri Lankan doctor because of difficulties in accessing the former after hours, as she had long working hours. As she explained during the long waiting time for her Sri Lankan doctor at the medical clinic, she felt that this change of doctors had negatively affected her diabetes management.

> ...Dr. Sanjeewa is very lethargic about his care and my health as he is not asking or saying anything about the details of management. As opposed to him the Thai doctor was a really good doctor because he always set goals for me. For example he used to set goals of low sugar levels for me at each doctor’s visit no matter how well controlled I was. I liked his direction and leadership in the management. I felt challenged and motivated when he set goals like that...

Kanchana’s lack of regard for her Sri Lankan doctor stemmed from her doctor’s perceived lack of interest. She expressed her disappointment with the lack of authority and interest the doctor had in her disease management. However Fox and Ward – citing Tuckett et al (1983) – describe the doctor-patient encounter as an encounter between a professional expert and an expert patient in relation to chronic illness management; suggesting that with time and with the progression of the chronic illness, patients will know how to read their own illness symptoms and they come to manage their own illness according to the knowledge that they have gathered through the years while receiving guidance from the doctor (Fox and Ward, 2006). Kanchana, despite having
‘suffered’\(^{49}\) from diabetes for close to ten years, still expected close monitoring and guidance from the doctor and a closer rapport and communication with the doctor.

**Non-compliance attributed to laziness**

One of the main concerns raised frequently, by Sri Lankan doctors in particular, was the non-compliance of their Sri Lankan patients. ‘Non-compliance’, especially among immigrant diabetes patients, has been attributed to migrants’ unfamiliarity with and lack of awareness of the health care system of their new country and the unfamiliarity and lack of awareness of the cultural and social background of the migrants by the health professionals (Borovoy and Heins., 2008; Stewart and Nam Do, 2003). Dr. Sanjeewa is a Sri Lankan health professional who worked in a newly opened medical clinic in a North Western suburb of Melbourne from four in the afternoon to eleven or midnight. He said:

> The most important thing is that they do not adhere to the medical advice. And compared to white people Sri Lankans are very lazy. Especially those who are above 50 are the ones who have a very lazy attitude towards the management. I think one of the reasons for this laziness and the light attitude towards health is that the Sri Lankan education system does not stress on the area of maintaining health enough...

Dr. Sanjeewa observed that most of his Sri Lankan diabetes patients come only to get prescriptions for diabetes medicine. He thought that unlike his Caucasian patients, Sri Lankan patients rarely wanted to know more about the disease and risks associated with it. Other Sri Lankan-born doctors too thought that "laziness" and "lack of motivation" of Sri Lankan patients was a reason for non-compliance and this was often attributed to their lack of health consciousness. Often they contrasted the attitudes of Sri Lankans with those of their Caucasian patients. Dr. Vignesh said:

\(^{49}\) The term suffering is put within inverted commas as it could be considered as doubtful to consider diabetes as causing any obvious and specific physical pain due to the asymptomatic nature of the disease.
Diet and exercise are an obvious issue. Some of them do not go for regular blood tests. And mostly it is because they are just lazy. They do not test their sugar regularly and it is because of their laziness. Health consciousness of Sri Lankans is very low. Health is something Sri Lankans are unaware of until they fall sick because in Sri Lankan education system does not address the importance of the maintenance of health in schools, or to the general public. In Australia there is lot of stress on the prevention. And people are aware of prevention from ill health. But generally Sri Lankan people think that we do not have to worry about health and it is enough to worry about health only if something goes wrong or when ill health strikes. The doctor is important to them only when there is an illness...

Dr. Vignesh has been a GP in Melbourne for close to forty years. He received his medical training in the Faculty of Medicine, University of Colombo in Sri Lanka. Dr. Vignesh has earned enormous popularity, respect, faith and trust in his ability within the Melbourne Sri Lankan community because of his reputation for meticulous patient care. He was especially popular among the community who migrated to Australia in the 1990s, who predominantly spoke Sinhalese at home, as he was one of the very few doctors who spoke Sinhalese and who was also considered to be an experienced and skilful doctor. During my fieldwork I encountered several stories that related Dr. Vignesh’s incomparable skill and experience in the Sri Lankan community.

However, Dr. Vignesh had quite negative reflections on Sri Lankan diabetes patients. He was extremely critical of what he described as their ignorance, recalcitrance and non-compliance:

… no matter how much or how many times you tell the patient sometimes they would just not get it. It’s a problem of lack of intelligence, which is intrinsic in some people. If they come here and I give them advice as to how many tablets they should take, if you go and ask them to repeat what I said at the counter they would not be able to do that…”

He thought that Sri Lankan patients did not take active steps to change lifestyle habits, such as cooking methods that were not conducive to more effective diabetes management. What was disturbing about his despondent tone of voice regarding this ‘stubbornness’ was that he thought there was no advantage or use in urging them to consult a nutritionist or a dietician. This view was
shared by Dr. Pethiyagoda, who thought that it was pointless to refer his Sri Lankan patients to dieticians because, according to him, this group of patients did not trust or value the information that dieticians gave as the professionals were unfamiliar with typical foods that Sri Lankans consume in everyday life. Dr. Vignesh stated:

[The] unhealthy habit of eating rice for three meals is impossible to change in these people. Added to this they also eat a lot of rice and not much vegetables. It’s what they were always used to do. And the other thing is that they cook it only in one way. For example they would always make curries of vegetables or meat or fish with coconut cream. This is because in Sri Lanka the most popular method of cooking is curries. And methods like grilling, baking are not popular, or not even known for that matter. There is also very low intake of fruits... At least if they know that eating more proteins is better than eating more carbohydrates. It is though useless telling them about diet and how and what to eat over and over again because they do not change. I usually don’t send them to dieticians because I know that it would not do them any good as they are not ready to change their habits...

In Sri Lanka, grilling and baking are rarely done as few possess ovens. Middle and lower middle classes’ everyday cooking is done usually using a gas stove or traditional firewood stove. Ownership of an oven symbolizes upper middle class social status. The doctors’ perceptions of their Sri Lankan patients are redolent of the class distinctions that they too had brought from Sri Lanka. These class notions in turn affected their decision-making regarding the care plan of their Sri Lankan patients.

Even though all lay participants denied having rice for three meals a day – in contrast to their doctors’ beliefs – they appeared to be more concerned with the consumption of sweets. The differences in perceptions are crucial for considering forms of patient education and ways of ensuring better communication between patient and doctor. Both parties in effect act on misunderstandings: doctors stress change in main meals because they think patients are eating too much rice and coconut cream; patients think that compliance with medical advice requires reduced sugar intake. Both are in part correct, although many participants did reduce rice intake and most did not use coconut cream to excess, they struggled to give up sugar. But their emphasis
on sugar consumption most likely stems from their misunderstandings of the causes of the disease and the metabolisation of starches and fats in the body.

Doctors’ accounts of Sri Lankan patients were laden with moral judgments. They also implied that physicians know what is best for their patients, exemplifying Talcott Parsons’ characterization of social hierarchy: that the physician is the technically competent person whose competence and judgments cannot be understood or judged competently by the lay person (Parsons, 1951). Previous studies have articulated the ways in which doctors, intentionally or unintentionally, diminish the decision-making authority of the patients and their families and enhance their own (Guillemin and Holmstrum, 1986; Katz, 1984; Mannon, 1985). Katz argues that the common assumption of authority by the physician is based on the presumption that patients are childlike ‘because of their anxieties over being ill and because (they) consequently regress into childlike thinking and therefore are incapable of making decisions for themselves' (Katz, 1999.p. 87).

**Variations of expectations**

While the doctors in the study were taking a paternalistic but a very distant approach to them, patients were engaged in a complex process of analysis about their unfulfilled needs. The doctors remained oblivious to these internal dilemmas. Emmanuel and Emmanuel (1992)’s four models of doctor-patient relationships provides a useful framework for analyzing the expectations of these Sri Lankan participants’ with regards to their health providers. They delineate four models of doctor-patient relationship:

- **The paternalistic model**, wherein the doctor’s role is as a guardian of the patient to whom she dictates appropriate responses;

- **The informative model**, in which the doctor acts as the competent technical expert, providing all the necessary information for the patient, enabling the latter to make an appropriate decision;
- **The interpretive model**, where the doctor acts as a counselor for the patient and in which the aim is to elucidate the values of the patient and assist the patient to select what he/she wants, based on these values;

- **The deliberative model**, wherein the physician acts as a friend or teacher to the patient, and in which the aim of the physician is to help the patient in the processes of decision making and choosing from the medical options available (1992, p.2221-2222).

It is apparent that as Kanchana appreciated the paternalistic approach of her Thai doctor, who delineated and set goals for her, she expected the same from her new Sri Lankan doctor. Conversely, Anula, who was in her early thirties, had lived in Australia only for three years with her husband and daughter of preschool age. She spoke slowly in an emotional tone. In Sri Lanka she lived in a semi urban village and she had a social life with her relations and friends most of who lived close to her house. After coming to Australia these close ties were strained and she led more or less a restricted and lonely life in an old and worn out apartment. During our interviews I felt that she was very enthusiastic about the study and looked forward to the dates that I was supposed to go to her place. Perhaps the interviews provided her with an outlet to express her feelings and experiences of life in Australia that she could not express with anyone else. During the time of my fieldwork in 2011 she neither had very good communication skills in English nor driving license. Therefore since her choices were restricted, she had to go to a Sri Lankan doctor whose clinic was located in walking distance to her apartment. Her experience with the doctor was not a positive one. When examining Anula’s expectations of her doctor it is clear that she did not appreciate the stern, curt and indifferent attitude of the doctor. She desired a conversation with her doctor regarding her health concerns. In her account of the doctor, Anula described the atmosphere as uneasy and the dialogue with him as strained. His unfriendly and matter of fact tone and facial expression only intimidated her so that she remained silent and failed to express her inquiries about her health. In contrast to these examples, Damayathi’s story about her doctor is a very rare one. She regarded Doctor McDonald, who was Scottish, as a friend who helped her make the right choices. She had high regard and respect for the doctor and was relaxed during the

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50 Anula used to call on my mobile several times to remind me and confirm the times and dates for the interviews.
clinical encounter. Clearly what was in play at the clinical encounter between Damayanthi and her doctor was the deliberative model.

‘Sri Lankans do not speak up’

Ironically the HCPs all thought that non-compliance of Sri Lankan patients in regard to the medical advice regarding regular tests and control of food and exercise was exacerbated by the one way communication within the therapeutic relationship. Sri Lankan doctors unanimously reported that their Sri Lankan patients did not ask them questions about management or their health status. Some Sri Lankan doctors also thought that there was lack of honest revelations by Sri Lankan patients. And all five Sri Lankan doctors interviewed contrasted this lack of sincerity and lack of curiosity about the disease and management in their Sri Lankan patients with their Caucasian patients. Dr. Kumararatne claimed:

They (Sri Lankans) do not talk much really as opposed to white people. They do not ask questions that much... This is partly because of respect. It is coming from our (Sri Lankan) culture. There is always a barrier between the doctor and the Sri Lankan patient. I feel it all the time. They are scared of asking questions. It is very Sri Lankan. However people with Sri Lankan heritage who are born and bred here in Australia are not like that. They are very relaxed and behave like the white Australian patients. The white people are very different to this. They would treat you like just another person and behave normally and naturally with their doctor. They would communicate with you like the way they do with a friend.

Dr. Sanjeewa expressed his concern about his Sri Lankan patients’ reticence, especially regarding sexual issues that stem from diabetes.

Another thing that I notice in Sri Lankan patients is that they are not very open about their situation or medical conditions with the doctor. This is very noticeable about Sri Lankan patients regarding sexual problems because diabetes has repercussions and effects on one’s sex life and they are very reluctant to say anything at all about aspects like that. Aussie patients are a contrast. They ask
about every question they have about diabetes and they are more open about their life, and even sexual problems.

Recent studies indicate that patients in primary care increasingly wish to make decisions about their health and illness as a joint project with the health professionals, embracing treatments that reflect a combination of their own preferences and those of the health care professional (Levinson, Kao, Kuby and Thisted, 2005). This preference by patients in primary care fits neatly within the interpretive model of Emmanuel and Emmanuel (1992) that is described above, in which the doctor acts mainly as a counselor to the patient. For example, with regards to Anula’s story, she desired her doctor to act as a counselor in diabetes management and give her the freedom of choice. But this desire was never fulfilled due to lack of communication between the two parties. There is also a vast body of literature that argues that how clients rate the quality of care and their satisfaction with it, are significantly determined by the effective communication between health care practitioners and their patients (Michlig, Ausfeld-Hafter and Busato, 2008; Bensing, 1991; Thorne, Harris, Mahoney, Con and McGuiness, 2004).

Lack of trust

One important factor that I noticed in some Sri Lankan participants (seven) of this study was the apprehension and unease they felt about the health care system in general, despite the length of time they have spent in Australia. For example, Dayantha who had spent twenty-two years in Australia expressed his strongly felt qualms about the experience of the doctors who were trained in Australia. Anula who had spent only two years in Australia had the same doubts and disquiet about the doctors and the health care system. She found the inability to go and see a specialist doctor for diabetes care in the Australian health care system very disempowering as she believed that a General Practitioner’s skill level and medical training is lower than a specialist’s.

However this perception could not be generalized to all the participants as many of them were satisfied with the level of attention they received from various health care professionals. Nevertheless a majority of them expressed their misgivings and lack of confidence and trust in some health care professionals, if not the entire system. Some participants, especially those who
had been living with the disease for more than five years, were more inclined to feel satisfied with their own judgments regarding management and resisted dependence on health professionals.

Despite living in Australia for twenty years, Dayantha did not trust the expertise of Australian doctors. He believed that if one had money in Sri Lanka one could get the same high quality medical treatment there.

...I think that doctors in Sri Lanka are more experienced than those who are in Australia. The doctors in Australia are just dependent on machines and they can’t read or analyze anything beyond what they see from machines. I believe that doctors there [in Sri Lanka] have more practical knowledge. Therefore I think the doctors in Sri Lanka are better than those we see in Australia. Doctor Vignesh is one good doctor you see here. He can tell you by keeping his nalawa\textsuperscript{51} to your chest whether you have a heart problem. A doctor trained in Australia can’t even say that even from an ECG report...

He drew upon his negative experience with his child’s treatment for a brain scan reading in the past in a children’s hospital and through his friends’ negative experiences with doctors to justify his opinion. While such negative perceptions could stem from unfamiliarity of the health care system of the new society, this view of the health care in one’s native country as better than that of the country of settlement is not limited to Sri Lankan migrants. Borovoy and Heine, while demystifying the so called ‘non-compliance’ to medical advice of the elderly Russian émigrés with type two diabetes living in the U.S.A. state that the elderly Russians living with their children and grand children too thought that the health care system in Russia that they experienced was far better than what they experienced in America (2008).

Sri Lankans’ concerns about the quality of their doctors’ care were not really based on the doctor’s ethnicity. Their misgivings extended to HCPs from other ethnicities and several participants were dissatisfied with practitioners of Sri Lankan origin. Four participants expressed their unhappiness and lack of trust in the qualifications and the experience of their Sri Lankan health care

\textsuperscript{51} Nalawa is a term used mostly by rural Sri Lankan folk to mean the doctor’s stethoscope.
professionals, particularly those trained in Australia, suggesting that they believed medical training was superior in Sri Lanka.

Anula, at the time of my field work, was thinking of planning for her second baby. She intended to settle back in Sri Lanka once she had another baby. In our initial interview she was reluctant to share with me her thoughts and experiences with her GP, but during consecutive interviews she expressed her frustration about the lack of advice and information she received from him regarding her concerns about diabetes and her future plans of having another baby.

Dr. Leel is useless. You feel like the moment you enter in his room he wants you out of it as soon as possible. There is no way that you can get any further information about anything from that doctor...

Anula’s next step in progressing towards her future goal of a second child was to look for a ‘better’ doctor that she could rely on.

Denver had good knowledge about the workings and processes of the Australian health care system, as his daughter was a senior medical officer at a reputed Melbourne hospital. However he still had misgivings about it and did not feel at ease in the Australian health care system when he or his family members had to undergo any treatment at a hospital.

... my wife had a surgery back in Sri Lanka recently. If we had to do it here we had to wait in the queue for a long time and its cost was 8,500 dollars. We took two tickets to Sri Lanka and we stayed in one of the best hotels and we selected one of the best doctors there and also for the surgery we only had to spend one and half lakhs (1250 dollars). I always tell them that if I get really sick I would always go to Sri Lanka. It is also because of the expenses here...the other important thing is that it is anyway our country and our people and our language... things that we are familiar with. I don’t know that it may be because we haven’t turned into Australians yet, even if we go to a doctor we always go to a Sri Lankan doctor don’t we?

These stories of lay participants demonstrate that along with the mistrust and unease felt towards the health care system in Australia, some Sri Lankans’ were also nurturing a desire and a dream to receive care in their home country. This could be partially due to the feeling of alienation they felt
in Australia, which engendered distrust in the care they received in the Australian health care system.

**Desire to go back to roots in search of care**

Denver described how when he was in Sri Lanka he maintained strong friendships with a lot of his work mates and friends from school. He said that they made it a point to go to Sri Lanka every year if the financial situation was favorable. He maintains strong and regular ties with his work mates at the Sri Lanka Customs and three of his school friends, and has a very strong social presence in Sri Lanka. In Australia he felt lower self-esteem as he could only work in a factory despite holding a high status position in the Sri Lankan Customs for a considerable period of time. While he did not say so explicitly, it seemed that his feelings of alienation and disappointment led to his view of the Australian health care system as less humane and motivated him to seek care from Sri Lanka.

Bury (1982), discussing the onset of arthritis in patients of British descent while conceptualizing chronic illness as a biographical disruption, argues that chronic illness, especially a sudden exacerbation of symptoms, is a major disruptive experience and a ‘critical situation’ in everyday life structures (Bury, 1982. P.169). He claims that the analysis of an onset of a chronic illness combines three factors, including the disruption of taken for granted assumptions and behaviors in everyday life; the disruption of normal explanatory systems (as examples he brings forth reconceptualising of self and identity); and a response to disruption regarding the mobilisation of resources.

Denver’s decision to seek medical care in Sri Lanka and his reasons for doing so indicate that ‘reconceptualisation’ in his case meant a privileging of his Sri Lankanness over his migrant status and a retreat to the familiar – which he considered superior – forms of care. It is evident here that what Denver values as a patient is to be surrounded by his own people, his language and to be around the familiar surroundings as he still does not feel well integrated into the Australian society.
Finding a way of problem solving: strategic use of doctors

While they did not express great trust in the system and the HCPs, Sri Lankans were generally confident in negotiating the health care system and taking advantage of opportunities to achieve their personal health goals. Tissa claimed that – just ‘to be on the safe side’ – he got opinions from two doctors as he was in doubt of his blood sugar when he checked it using his brother’s glucometer while they were on a holiday in New Zealand in 2004, before he knew that he was diabetic. Upon his return he visited his regular GP, Dr. Vignesh, who told him that it was not something to worry about too much. However the fear of getting diabetes continued to trouble him, so he sought a second opinion:

...then another Lebanese doctor who practices nearby... told me to get it double checked with a different glucose test as the first test results showed a slight increase in my blood sugar. There was 5.8. So I went and did that other test in which I had to test the glucose after two hours of having a glass of glucose drink. It was 6.2. And then that doctor told me I was in the margin. That doctor did all these tests on me because they were a new place and they wanted clients. So this doctor gave me a lot of time and spent an extensive time on me. Then he directed me to a dietician. But because Dr. Vignesh didn’t pursue a lot after that I didn’t pursue it. So I really did not change my diet. But I did register in NDSS [National Diabetes Services Scheme]. And I went to meet the dietician. So after that visit I was controlling diet for a week but then I fell back on the same routine meals as I tend to slack off...

Tissa’s narrative illustrates that he was proactive about his health and strategically used the health care system to come to a satisfying conclusion about his health condition. It is significant that in the end he followed his Sri Lankan GP’s advice, but clear that he was aware that he could seek alternative advice and of the process of registration. However “shopping around” for health care providers is not exclusive to Sri Lankan migrants. Grace and Higgs (2010) study of practitioner-client relationships in integrative medicine clinics in Australia, revealed that lay participants frequently used more than one type of care to get treatment for one condition and tended to see different practitioners for specific conditions simultaneously (p.10). Currently Tissa only sees Dr.
Vignesh to interpret his regular medical reports and checkups as he thought getting advice from two different doctors would confuse matters.

**Choice of doctors and English skills**

Even though they complained about the doctors and the medical system in Australia, very few of the participants (two women out of the twenty five participants) expressed any sense of helplessness or emotional vulnerability because of being diabetic. A significant majority followed various strategies as mentioned above, to navigate their way through the health care system and to incorporate diabetes care in their everyday life in a way that did not interrupt their ‘natural flow’ of everyday life.

Most participants preferred to go to a Sri Lankan health professional than to those of another ethnicity or nationality. This choice is attributable to various factors including trust, confidence and language barriers. Even though they did not always choose Sri Lankan doctors they often expressed the view that they had greater trust in them. In this study out of the twenty five participants with diabetes, twenty chose Sri Lankan doctors. Upon arrival in Australia the selection of the family GP was primarily based on word of mouth from other Sri Lankan friends, rather than factors such as distance and practical convenience.

The five participants who went to a doctor of non-Sri Lankan background could communicate in English fluently or had partners who could help them with interpretation during the conversation with the doctor. For example, although Athula could communicate with the doctor satisfactorily by answering the doctor’s questions, he always took his wife (who used to work as an English teacher in Sri Lanka), who helped him by asking any questions he had.

Even though the participants’ choice of health professionals does not permit me to arrive at an overarching generalization about their level of English or social class, it is reasonable to assume that people who chose doctors of nationalities other than their own, had confidence in communication in English with their doctor. Except Athula, the other four were confident about their relaxed and equal relationship with the doctor in marked contrast to how other participants
felt with their Sri Lankan doctor. Athula’s reason for choosing an Indian doctor was because of difficulty in accessing a ‘good Sri Lankan doctor’ from where he lived.

The Sri Lankan patients’ ability to communicate fluently in English becomes an important aspect that is taken into consideration by health professionals who belonged to other ethnic groups, as they considered this fluency in English facilitated their provision of care and the patient’s acquisition of knowledge regarding diabetes management. The two health professionals who communicated only in English with their patients thought that there was not a significant difference between Sri Lankan diabetes patients and diabetes patients who belonged to other ethnic groups. Dr. McKenna said

I’m taking the standard approach to everyone I think irrespective of the ethnicity or nationality. Because the things you have to consider in diabetes management are first their diet and exercise. So I usually start by asking what they eat and they do when they are diagnosed with diabetes. Irrespective of their background I go from those questions”.

These HCPs both claimed that unlike patients from other ethnic backgrounds, their Sri Lankan patients were highly educated and fluent in English and therefore had no specific problem in understanding the medical instructions concerning their diabetes management. Dr. McKenna also stated that

...It s not difficult for them (Sri Lankans) to understand this information. But whether they really follow the advice is a different matter. However this discrepancy between understanding and compliance is prevalent across all the groups. However compared to the other groups in the Glenroy area like Macedonian and Italian, Sri Lankans’ education level is very high and therefore they are receptive for information...

In fact, Dr. Nguyen, a diabetes educator, was more worried about the Sri Lankan patients who he referred to as ‘professionals’. According to him, these ‘professionals’ who came to him for diabetes education sessions, had ‘too much’ information about diabetes and diabetes management. He claimed that this often led those patients to a lack of management as they were not as receptive to the advice from the diabetes educator as they were to the information on
health and diabetes available on the Internet. Dr. Chew mentioned that this professional class of patients often thought that they knew more about diabetes management than their health care giver. His perception of the more educated English-speaking Sri Lankan patients resonates well with Navin’s account of his doctor’s advice about controlling food and of how he relies more on his body signals than the judgment of his doctor. Unlike many other participants in this study (except Athil who was a computer technician and who also used the Internet to find information about his illness) the participants who spoke mainly in English, Navin, Chandra and Damayanthi, were also very adept in computer skills and often used the Internet to find information. Compared to more upper class, educated or English fluent participants, those who mainly spoke Sinhalese used computers and Internet very rarely due to their lack of skills in the language and computer skills. Their only source of information about diabetes was their health care providers.

The approving responses of non-Sri Lankan health professionals stand in contrast with the much harsher judgments that Sri Lankan doctors made about the compatriot patients. This is partly explicable in terms of the fact that those who went to non-Sri Lankan practitioners were highly-educated professionals who were fluent in English.

‘Doctor-hopping’ from the eyes of health professionals

During two interviews with doctors, the issue of changing doctors without any notice came up as an important issue that they faced in providing care for Sri Lankan patients. Dr. Pethiyagoda noted “This is what happens. If I put them on insulin or increase their dosage they go to another doctor”.

Dr. Kumararatne’s experiences with some Sri Lankan diabetes patients in the Sunbury medical clinic confirmed the widespread nature of ‘doctor-hopping’. Dr. Kumararatne explained that sometimes, some Sri Lankan patients never come back after continuing care for six or seven months. Even after sending reminders for their regular eye, feet and other checkups they did not turn up. He did mention that such patients might be those who only come for a limited period, when their ‘regular’ doctor is on leave or when they cannot go to the ‘regular’ doctor’s appointment because of other circumstances, such as not being able to take leave from work.
Indeed, my investigations confirmed that Sri Lankan lay participants changed their doctors and consulted more than one doctor every now and then to meet their unmet needs and to suit their everyday life schedules better. Prior to my fieldwork, Kanchana, Athula and Tissa either had changed their doctors once or consulted more than one doctor because they could not accommodate the appointment times given by their previous doctors due to long work hours, the long distance that they had to travel to see these doctors, or because they did not trust the opinion of one doctor.

According to Australian clinical guidelines for diabetes management, having regular continuous medical care is a very important aspect in diabetes management both for the health care practitioner and for the patient, to explore the patient’s understandings and fears of diabetes management especially in the initial stages of diagnosis (Harris, Mann, Philips, Bolger-Harris, Webster, 2011). Apart from this, according to the Royal Australian College of General Practitioners guide for the team approach to diabetes in general practice, delineating communication pathways is an essential aspect that the health care organizations should provide to the patients and to the team of health care professionals in diabetes management (Evans, Lim, London and Reilly, 2010). When these guidelines are compared with what the doctors expressed about ‘doctor hopping’ and the actual reasons of the lay participants for changing doctors, it shows that even though it superficially seems that some participants navigate through the health care system with ease and use the system according to what suits them best, sometimes this navigation might prove hazardous.

**The clinical encounter: the façade vs. honest perceptions**

The clinical encounter between the patient and the physician is regarded as an important event in seeking care for chronic illness (or for any illness for that matter). One of the longest waiting times that I spent during field work, was waiting for the doctor with Kanchana at the Super Clinic in a northern suburb of Melbourne. It was for close to two hours in the evening. People from different ethnic backgrounds mostly occupied the waiting room. The notice board with the names of the doctors indicated that the doctors too were from various ethnic backgrounds including Sri Lankan, Middle Eastern and Chinese. There were two large televisions showing two different programs on
two different walls. In the middle there were some toys for children. Kanchana was clearly exhausted by the long wait. Even though there were a few other Sri Lankans who were waiting too, they did not interact with one another.

While waiting for the doctor, Kanchana expressed her dissatisfaction with her current Sri Lankan doctor’s service and explained that she goes to her present Sri Lankan doctor just for prescriptions.

During the consultation with the doctor she asked whether she should continue the medication for her kidneys that was prescribed by her previous doctor. At this, the doctor showed his surprise and it was apparent that she had been taking a medication for kidney function that her present doctor did not know about. This led to an uncomfortable situation for both the patient and the doctor in front of myself as the observing researcher, because the entire time was taken up for the clarification of her kidney medicines. Kanchana could not pose any of the burning questions she had planned to ask about certain new foods that she had started to incorporate in to her diet recently and their recommended quantities for a diabetes patient. During our prior in depth interview at her home and also in the conversation we had during the long wait for the doctor I got the impression that Kanchana was very methodical about her diabetes care and everything concerning her diabetes management: regular doctor and other health professional visits; control of food and exercise. During a conversation at her house she claimed that

...that doctor even told me that I am too dedicated to control diabetes. He even once asked me to stop the medication because I was very well controlled...I think even though I think the Thai doctor was better than the present Sri Lankan doctor I do not need any special attention because I do know what to do now and my reports have been good...even though the Sri Lankan doctors keep on telling me that it is ok to maintain a seven in the glucometer I know that the best is to have six. I think I know about it better now because of my previous doctor...

She thought she had a good knowledge of diabetes control. Kanchana was more under the impression that apart from the need to ask a few questions about the quantities of new foods she had started eating, her consultation was simply about getting a prescription for the diabetes
medication from the doctor. This scenario demonstrates two important issues that are posed for effective diabetes management in the group of participants.

The first is the danger that could arise when one patient ‘master minds’ multiple sites of care independently without having an open communication with the health care provider about disease management. Kanchana was one of several patients who claimed that they only go to the doctor to get a new prescription. Doctors complained that their Sri Lankan patients come to them only to get a prescription instead of communicating their challenges and issues they encounter in managing diabetes. It is evident here that this lack of communication between patients and especially Sri Lankan doctors was even made worse by prejudices about each other.

Second, there was incongruence between what the patient recounted to me about their concerns and what they maintained in front of the doctor at the actual clinical encounter. The participants did not express any concerns they had during the consultations and certainly did not voice any dissatisfaction with the care offered. Instead they maintained a façade suggesting that ‘everything is ok’.

Incongruence of illness explanatory models: a reason for maintaining a façade?

Athula is another participant who projected himself as an obedient, passive patient in front of the doctor and failed to speak about any of the problems he had spoken of in our conversations. Athula saw an Indian doctor and his wife was present at all appointments. She wanted to ensure that he attended the appointment, as Athula was inclined to be slack about appointments, and also to interpret the doctor’s advice to her husband when needed. In retrospect it seems that Athula’s lack of motivation sprang partially from his perception that the doctors did not take any notice of his subjective experience of diabetes, specifically of his symptoms of hypoglycaemia when his measured blood sugar level did not indicate a problem. In conversation he expressed his weariness with diabetes management, saying “mata anala anala epa wela thiyenne dan (I’m sick and tired of pricking myself with a needle everyday)”, but he expressed neither his disappointment at his inability to manage diabetes effectively despite his efforts, nor concerns about his inability to engage in exercise due to his asthmatic condition to the doctor. Throughout the consultation, in
which the doctor appeared frustrated with him and reproached Athula’s lack of control over diabetes, he responded mostly with a sheepish smile, like a child whose unruly behavior has been caught by a teacher or a parent. However previously, during the in-depth interview at his house, Athula said:

... when I had it and checked in the following morning it was only 5.5 (The glucometer reading). The other thing is usually people get drowsy and sleepy only when the glucose level decreases to 2 or 3 isn’t it? But for me I get drowsy even when I am 5.

Prabhathi: Why is that? (amazed) Did you tell the doctor?

Athula: Aney I don’t know. I feel dizzy when it's merely five. I told the doctor...

Prabhathi : So what did the doctor say? (Impatiently)

Athula: What else would the doctors say! She said that cannot happen and just asked me to eat a biscuit whenever I feel dizzy. Those days I felt dizzy when it was 3 but since 2 years now I feel dizzy when it is even at 5.... I have to go (to the doctor) every three months. Because the doctor asks me to come there is no way out. But the worst thing is Giyama ithin palu yanna baninawa\(^\text{52}\) (laughing)...

While Athula’s story demonstrates his dissatisfaction with the outcome of the doctor’s appointment, it also points to important discrepancies between the explanatory models of disease of patients and those of practitioners. Cohen et al (1994) define the explanatory model as a response to a particular episode of chronic or acute illness that are not static but which reflects a set of beliefs that is held at a particular point in time. According to Lau and Hartman (1983) explanatory models of physicians and patients are developed along the lines of five major areas that include etiology, time and mode of onset of symptoms, pathophysiology, course of sickness and treatment (Lau and Hartman, 1983.p.12-18). In this instance it is clear that the explanatory models of diabetes of Athula and his doctor differed significantly in relation to the course of sickness; while Athula considered five in the glucometer reading as very low blood glucose

\(^{52}\) The colloquial Sinhalese expression when translated into English means “when you go there she just scolds me until I’m broken down into pieces”. 

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hypoglycemia) from his lived experience of the disease, the doctor considered hypoglycemia as
two or three in the glucometer. According to his understanding the doctor was unable to explain
his diabetes experience through bio medicine and so was dismissive of his experience.

This situation of the patient and the doctor also resonates with Foucault’s description of the idea
that the patient as a person is exempted in the medical encounter. Citing Clifton’s work ‘Etat de la
médecine ancienne et moderne’ Foucault states

He who describes a disease must take care to distinguish the symptoms that
necessarily accompany it...from those that are only accidental and fortuitous...
Paradoxically in relation to that, which he is suffering from, the patient is only an
external fact; the medical reading must take him into account only to place him in
parenthesis... (Foucault, 1973. P.8).

Athula’s lived experience of diabetes was disregarded by his doctor as his experience of low blood
glucose level did not fit within the framework of biomedical definitions of the disease. It is possible
that Athula's façade of unaffectedness, withdrawal and retreat that was maintained in front of the
doctor, could be due to the feeling of hopelessness he felt at his lack of ability to communicate
convincingly his experiences. Kleinman (1980) argues that the incongruence between the
physician and the patient illness explanatory models in illness treatment, results in dissatisfaction
of the patient with the care he receives, failure in compliance and under-reporting of untoward
side effects of treatment.

The end result

Other researchers have also found that migrants tend not to raise issues of medical needs and
questions related to their health with their doctors. Stewart and Nam Do (2003), who conducted
research into the health needs of a group of Vietnamese women living in South West Brisbane,
showed that even in Australia, where health providers were regarded also as general confidantes
by patients, the participants did not make use of this ‘opportunity’ as most of them were afraid to
express their needs to the doctor. Even though the authors do not explain why the patients did
not want to communicate more about their problems, they state that because most of these
migrant women’s knowledge of English was low it hampered their communication. Participants stated that there is a gap between the English language used daily and the ability to describe medical complaints or to completely understand the doctor’s instructions. Health service providers too stated that misconceptions of medical advice often occur in daily medical practice. These women always tried to see Vietnamese doctors with whom they could express their concerns more comfortably.

Other researchers have also found that lack of English and problems of access associated with this are the major barriers that migrants face in health care. However unlike the migrant groups that are described in this literature, most Sri Lankans in my study thought they had sufficient knowledge of English to communicate, even with doctors from other nationalities; unlike the Vietnamese, the Sri Lankan participants did not express concerns about dependency on friends and relatives for transportation and lack of knowledge of health services. Sri Lankans’ problems regarding health care professionals and the health care system were very different from those that have been described previously in the literature.

In a study on a group of women from the Horn of Africa and the Middle East, Manderson and Allotey (2003) demonstrate how participants’ lack of English skills was linked to stories illustrating a strong mistrust in the medical and health care system and in the health professionals. They argue that ‘medical gossip’ among this community was an important factor that affected lay decision making, referral systems and the interpretation of health care advice and treatment in the communities. While acknowledging that the knowledge of English could be a determinant in the development of trust in the health care system and the health professionals, it has to be noted that with this group of Sri Lankan participants, despite the presence of many strengths such as the possession of English knowledge, health professionals who spoke their language and shared their culture, they still had the attitude that the doctors did not pay keen attention to their needs and they still did not express their own concerns or problems in consultations.

What the stories of Sri Lankan participants show us is a complex picture of the doctor-patient relationship. Despite being very expressive of their unmet needs outside the clinical encounter, they still did not express this at the clinical encounter. Despite their manipulation of the health care system to best meet their perceived health care needs, they still seemed quite passive in the
encounter, unlike the African migrant women in the study by Manderson and Allotey, who openly expressed their dissatisfaction of the care they received to the health professionals themselves.

In conclusion, a major finding of this study is that doctors and patients conceptualize each other and the clinical encounter in ways that are often mutually prejudiced and contradictory. This suggests that the issue of communication is not merely one of language competence. The prejudices were compounded by the lack of communication between the two groups, which stemmed from the social distance patients and doctors maintained.

The lack of confidence of the Sri Lankan participants to ask questions from HCPs that was evident in most of the doctor-patient encounters and in the accounts of the doctors, reflected the culture of the unquestioning and passive nature of patients in the face of the highly respected social status of the medical doctor in Sri Lankan society. The profession of medicine in Sri Lankan society is regarded as one of the highest achievements of an individual and confers very high social status. As Trostle (1988) states, the medical doctor at the clinical encounter is in a position that exerts authority over the patient and it is an integral part of the medical culture. He explains that the expectation for compliance ‘is a cultural phenomenon’ in medicine, that is ‘intimately linked to the self image of physicians and with their organized attempts to define the limits of their own discipline’ (Trostle, 1988.p.1303).

The hierarchical nature of the social distance between doctor and patient that was observable during in-depth interviews with the HCPs meant that Sri Lankan doctors were unabashed in their negative assessments of compatriots, as they were speaking of social inferiors. These judgments probably stemmed from the doctors’ personal experiences of the culture, lifestyle and habits of fellow Sri Lankans that they encountered. Some doctors’ prejudices about the level of compliance and the level of ‘intelligence’ were expressed by infantilizing their Sri Lankan patients, when in fact the patients’ behavior was deferential rather than childlike. Katz argues that this perceived childlike behavior could be a result of a combination of factors that include pain and fear due to illness, the physician’s authoritarian insistence for compliance, or it could even be triggered by the unwillingness of the doctor to share information with the patient. This could result in the patients’ stumbling attempts to ask questions and also answer the doctor’s questions, which could in turn
make them appear to be more incapable of understanding the doctor’s explanations than they really are (Katz, 1999.p.87).

Physicians’ assumptions, such as the belief that Sri Lankan patients have rice for all three meals and that they are a passive group of people where diabetes management is concerned, were not applicable to any lay participant in the study. Sri Lankan physicians appeared to be simply ignorant about the realities of the challenges faced by their Sri Lankan patients when managing diabetes. From their point of view, communication was hindered by their conviction that Sri Lankans were stubborn, resistant to change, and lacked intelligence.

Several lay participants depended on their embodied experiences and bodily signals of changes in their diabetes and when they were dismissed or ignored by the doctors, patients mistrusted their doctors. Many participants, who were confident about their diabetes management, claimed that they primarily visit the doctor only to get a prescription for Metformin. Doctors concurred that the purpose of the clinical consultation was only to obtain a prescription for diabetes medication. Even though patients’ adoption of responsibility for their diabetes management is strongly encouraged in contemporary medical guidelines, this assumption of the ‘expert patient’ role is expected to be played out in collaboration with medical advice and recognition of the authority of medical knowledge (Thorne et al. 2004). However, the stories of several lay participants suggest that their self management processes were not in accordance with the diabetes guidelines and that they would have benefitted from a clear explanation and advice from their doctor.

There was a clear failure on the part of the physicians to recognize the real needs of their Sri Lankan patients. Neither group was in fact transparent in sharing their expectations with members of the other group. This lack of communication was compounded by various sociocultural elements that reinforced prejudices, especially those that Sri Lankan physicians held of Sri Lankan patients. The combination of prejudices and lack of communication in turn posed a significant challenge to satisfactory diabetes management.

In conclusion, I believe that the challenges and problems that Sri Lankan diabetes patients encountered in the health care system cannot be attributed to the factors identified in studies of other ethnic groups. Sri Lankans have high levels of fluency in English (both in the general Australian population and in this study); they do not experience difficulty gaining access or
negotiating the Australian health care system. The participants in this study did not face the cross-cultural barriers to doctor-patient communication that have also been described in the literature, as the majority of them could access a Sri Lankan if they wanted to (an option many of them did pursue). The problems of communication described in this chapter are social rather than linguistic, owing much to the hierarchical nature of the doctor-patient relationship in Sri Lanka. The rather condescending attitudes taken by HCPs, especially physicians, suggest that the purely medical response to patients’ needs might in fact be the basis for their non-compliance.
Chapter 7: Feeling alienated at home away from home

Complexities and divisions in the community

“All migrants leave their pasts behind, although some try to pack it into bundles and boxes—but on the journey something seeps out of the treasured mementoes and old photographs, until even their owners fail to recognize them, because it is the fate of migrants to be stripped of history, to stand naked amidst the scorn of strangers upon whom they see rich clothing, the brocades of continuity and the eyebrows of belonging...” (Salman Rushdie, Shame)

Rushdie’s characterization of the alienation and helplessness of the migrant encapsulates some aspects of the migration experience. However there are also those who refuse their alienated status by embracing wholeheartedly the values and aspirations that initially inspired them to emigrate, and live their transplanted lives as a mission aimed at accomplishing these goals. Although it would be an exaggeration in respect to the reality of the lives of some migrants in this study, in this chapter I show how most participants in my study hold on to some of the ‘baggage’ that they brought from their land of origin as they try to reconstitute their lives in the new land. Far from being diminished by the journey, these ‘treasured mementoes’—the strings or the bits of old pictures that might be found in these bundles—are incorporated into the collage of their new lives. In this chapter I demonstrate in their dedicated endeavor to attain some of these goals, some people tend to forget or forgo other important goals after migrating to this country. I show also how they oscillate between pride in achievement of their aims and feelings of loss and estrangement, and how they believe this oscillation in their lives affects their health.

In search of greener pastures

In this section of Chapter seven, I first aim to show that the Sri Lankan Sinhalese community is by no means homogenous, nor do members of this community identify themselves as a tightly knit group. Rather, I show that there are subtle but conspicuous complexities and layers in the community that may result in alienation of the individual. I intend to show how these complexities function as sources of tension within the community and how my participants viewed them as
affecting their health and well being. In describing the various divisions in the Sri Lankan Sinhalese community, I will refer to its historical background that runs back to the island’s changes of economic and educational policies from the 1950s.

Most Sri Lankan Sinhalese migrants to Australia can be considered ‘economic migrants’. A vast majority of lay participants who I interviewed in this research had migrated to Australia with the primary intention of achieving financial stability, a higher standard of living and upward social mobility.

The overriding motivation for economic migration is the ‘lifestyle’ factor, which encompasses reasons such as political stability; a crime- and pollution-free urban environment in contrast to areas in South Asia; a relatively low cost of living; low cost and good quality education for children and good housing with modern comforts. Another important driving factor for Sri Lankan migration to Australia, especially to Melbourne and Sydney, is the existence of substantial co-ethnic communities in these cities and their suburbs (Liyanaratchi, 2006. p.12). The economic incentive for migration is an important aspect of this thesis, as all other aspects in life – including health – tended to revolve around participants’ primary migration intentions. In this chapter I argue that a conglomeration of economic, cultural and political factors related to economic migration has led to a state in which care for one’s health is relegated to a lower priority as socio-economic ambitions take precedence.

An examination of the recent history of Sri Lanka illuminates the sources of this economic motive. The social and economic upheavals that Sri Lankan society experienced after 1977, with the introduction of the open economy, contributed to the desire and aspiration for upward social mobility for the children of middle and lower middle class Sri Lankans. Prior to the introduction of the open economy by the United National Party, which was more inclined towards a liberal economic policy, there was a rise in the nationalization of many institutions by the previous government, which appealed to the demands and preferences of the majority Sinhalese educated rural and urban population. The period before the 1970s was marked by a rise in the vernacular education system and changes to the educational policy of the country, which caused the

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53 This is in contrast to most Sri Lankan Tamil migrants who migrate to other countries seeking asylum or as refugees.
restriction of English language education to urban elite population. By the 1970s the majority of the population was educated in Sinhalese or Tamil.

The 1977 economic reforms brought about major changes in the political economy of the country that included the rise of private industry and the decline of the nationalized sector in the economy which had previously favored Sinhala-educated people. In the private sector, communication was conducted in English. English language is a discernible marker of class in Sri Lankan society, education – the institutions attended and the qualifications gained – it had many connotations with the socio-economic and cultural status of the person. Thus the Sinhalese-only speaking majority found themselves with scarce opportunities in the private sector (Hettige, 2000.p.26). The section of the population that was hired to work in high positions in the private sector was from urban upper-middle and middle classes. With liberalization of the economy there was an expansion of this urban upper middle class, which Hettige identifies as the new urban middle class or NUMC (p.26). Hettige says that this NUMC represented the main threat and the reference point for aspirations of the majority of the Sinhala-educated, nationally oriented and conventionally disadvantaged lower-middle class rural youth. In the meantime, for those who had already reached middle class through Sinhalese medium education and through employment in the nationalized economic sector, their main aim became the aspiration for their children to reach this NUMC by providing them with the necessary education and other facilities. It was a near impossibility for Sinhalese-educated youth who did not have a tertiary education to join the ranks of the NUMC. An alternative strategy that most less educated youth pursued to reach middle class status was to seek high paying employment, especially in the Middle East (Hettige, 2000.p.27). Participants such as Tissa, Athula and Ranil belonged to this class who first moved to the Middle East in the 1980s on a short-term basis before migrating to Australia in the 1990s with their families. This also explains their expectations and aspirations for their children’s education and their emphasis on fluent acquisition of the English language. It is in this socio-economic environment that most participants of this study migrated to Australia.

With the opening up of the economy in 1977, the socio-economic inequalities that already existed in post-independence Sri Lankan society increased dramatically. This liberalisation of the market caused the expansion of a landless and near landless population, for whom the only hope of reaching the middle class was through the provision of a good education for their children.
Education as a determinant of life chances has been engrained, especially in the minds of lower middle and middle class Sri Lankans, ever since the expansion of the free education system in the country during the 1950s (Hettige, 2000. p.22).

It is in this context that these Sri Lankans formulated their goals for themselves and their children when migrating to Australia in the 1990s and after. Even though most of them arrived in Australia with fairly similar aspirations and concerns in mind, they came from varied socio-cultural backgrounds, hence giving rise to a very multi-layered Sri Lankan community in Melbourne. In the following section, while describing the levels of segregation in the community, I also demonstrate how it results in the cultivation of a sense of alienation and lack of belonging in the community which ultimately undermines their health and wellbeing.

Aspirations vs. reality

When examined in depth, aspirations of my participants subtly varied according to the socio-economic class they came from in Sri Lanka. Several lay participants with diabetes whom I interviewed had obtained Australian permanent residency through the skilled migrant visa category. Eight out of the twenty five participants with diabetes had migrated to Australia with a German Tech College certificate qualification, holding mechanical and other trade qualifications. They were all engaged in factory work. Ten participants had university degrees and were employed in fairly high status jobs in Australia. In Sri Lanka, there is a great deal of prestige attached to university entrance, which is even more competitive than in the Australian system. Possession of a university degree is prized far more than qualifications earned at a technical college (Wickramasinghe, 2012. P.83). Social prestige is even higher for those who obtain an engineering or a medical degree.

Within the nation’s schooling system there is inequality and imbalance in terms of facilities and resources in different regions. For example, Freeman, who conducted a study about social factors impacting on the perceptions of self and identity in Sri Lanka, found that the prestige of the schools in the urban and rural sectors was a reliable indicator of family socio-economic status in the Sri Lankan context (2001, p.296). The difference in prestige attached to urban and rural
schools in Sri Lanka reflects much of the social class imbalance and inequalities that are present in the society in general. Added to this education-related disparity that is linked to social class, there was also the urban and rural divide. Freeman considers that Sri Lankan social structure is considerably more hierarchical when compared to developed western societies such as America where the drive to maintain a positive social image or status is not a principal motivator in achieving or maintaining a higher social class. The urban and rural origin of Sri Lankans were social factors that affected self perception in Freeman’s exploration of the psychological perspective on social identity in Sri Lanka; he observes that in the Sri Lankan worldview, urban or rural origin is symbolic of the person’s exposure to social change and industrialization.

In the large sample (603 respondents) of a study based in Sri Lanka about self perceptions of communities, Freeman notes that the salience of achieved status variables such as education, occupation, class identities are considered more important with increasing proximity to the urban areas (Freeman, 2001, p.301). Many participants of this ethnography came from urban and semi-urban sectors of Sri Lanka. Therefore when considering this argument we can surmise that their urban and semi-urban origin too provides a backdrop to the origin of most of their aspirations of migration; the drive for attaining social status and a higher social class in Australia.

Sri Lanka’s educational system is hierarchical (Liyanaratchi, 2006. p.60). Within this hierarchy, state universities are in the highest level, while technical skills training institutes are in the lower echelons. The lower status of technical schools is related directly to the ease of entry (Liyanaratchi, 2006. P.60). As university entrance is free and places are very limited, intakes for any faculty in Sri Lanka represent a small percentage of the total number of students who take the national Advanced Level exam. Competition is most fierce for the medicine and engineering streams. Those who gain entrance are considered to be the cream of the population of students in the country each year. Those who fail to get university entrance have to seek avenues in other higher educational or vocational training institutes, such as the Ceylon German Technical Training College. Although there are no comparative studies of the student populations of state universities and technical colleges, it is generally believed that most who go to the latter come from more economically and socially deprived backgrounds than students attending university. Students attending technical colleges are also perceived to have limited capacity for upward social mobility. Liyanaratchi, using his observations and experience as a senior instructor and a principal in one of
these technical colleges in Sri Lanka for several decades, concludes that the lack of a background where English is used regularly is the crucial factor in exclusion from university (2006).

Technical educational institutions such as the Ceylon German Technical Training Institute were the secondary choice of many students due to the attribution of low status in this hierarchy of educational institutions. Typically the students who opted to do courses in these technical institutes were from social backgrounds and secondary education institutes that did not foster any strong English language skills (Liyanaratchi, 2006, p.60). This lack of English skills was generally associated with a lower socio economic background of these students. For most of the participants in my study who had migrated with qualifications from the Ceylon German Technical Training Institute, migration to Australia signified their aims of upward social mobility. Their educational background clearly distinguished them from those who had migrated with university degrees and higher educational qualifications, for whom maintenance of their social status, but with higher salaries and a better standard of living, were primary motivations for migration.

Tissa, who had migrated to Australia in 1991 as a skilled mechanic, received his training from the Ceylon German Technical Training Institute. He observed the significant upward class mobility of those who migrated with qualifications similar to his, relative to those with degrees and higher qualifications:

...In a short time we could come to the same position or even higher than those doctors and engineers because the doctors and engineers were more concerned about preserving their status and profession than about settling in and surviving. We all came from the middle class in Sri Lanka and we did whatever that came our way to earn a good living and today we have achieved a very high place in the society...

Cheung and Leung suggest that attributes such as education status prior to migration and social network size at the time of migration particularly facilitated Chinese mainland migrants’ upward social mobility in Hong Kong (Cheung and Leung, 2012). However, most Sri Lankan migrants, especially those who migrated during the 1990s, felt that they had achieved a remarkable upward social mobility in Australian society without any of these prior resources such as strong social networks and good English language skills which Cheung and Leung refer to as social and cultural
capital (Cheung and Leung, 2012, p.3 and 8). While demonstrating that those from more humble classes were more adaptable to the new situation, another important aspect that this example shows is that these Sri Lankans were extremely hard working and were dedicated to their migration goals despite drawbacks such as lack of tertiary education, they had to encounter in the host society. The rest of the goals including rest and relaxation and maintaining or achieving good health came after the achievement of these main goals.

**Solidarity or Segregation**

Tissa’s observations regarding the difference between the present social status of the Sri Lankan migrants who have affiliations with the German Technical Institute and those who are highly qualified and educated professionals in Australian society signals a very important aspect of the Sri Lankan migrant community living in Australia: status rivalry. Places such as temples and events such as the April New Year bring the community together from time to time throughout the year. Especially at the New Year festival and at rituals at the temple there was no visible sign of segregation in the community into educated and less educated and/or uneducated. However when they were in the privacy of their homes, most lay participants, especially the more educated people who had a University degree from Sri Lanka, were candid about the difference between themselves and those who had migrated to Australia with much lower educational qualifications. The more educated group was also very careful not to sound too condescending about those to whom they referred as ‘some Sri Lankans’ or recently migrated Sri Lankans. According to Freeman, studies of social hierarchy and stigma show that individuals in hierarchical cultures are more willing to emphasize criteria in those hierarchies in which they are highly ranked and others too tend to accept it as often these ranking and hierarchy are socially sanctioned (Freeman, 2001.p.303). In Sri Lankan society back in Sri Lanka, among other factors, education level was an important marker of social class in the social class hierarchy. As expected, except for one person

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54 The terms social and cultural capital are originally taken from Bourdieu’s work on “The forms of capital” in Bourdieu, P. (1986) The Forms of Capital in J. Richardson (Ed.) Handbook on Theory and Research for the Sociology of Education (New York, Greenwood), 241-258
(Tissa), those who came from less affluent and less educated backgrounds were either hesitant to, or did not refer to the distinction between ‘us’ and ‘others’ that was based on the level of education. However, during general conversations with people about topics such as organization of the Sinhalese New Year festival, the German Tech organizers referred to the ‘doctors and lawyers’ as ‘them’ when explaining to me about how their association took over the organization of the New Year festival from the more elite organization comprised of the more educated compatriots, thus indicating their acknowledgement of the distinction between themselves and others. This distinction was loaded with subjective views of social status, such as education and urban and rural origins.

Apart from Buddhist temples and the German Tech old boys’ association, old pupils’ associations mainly of urban and elite schools and universities organized many functions throughout the year. Two social events that I observed, one organized by the German Tech and an old girls’ association of St. Michel (an urban elite girls school in Sri Lanka) had different characteristics, reflecting the socio cultural status of those who organized and attended them; dress codes, music and even food were symbolic of the different inflections in the community.

The former, which was a fund raising activity by JVP and the German Tech organizers, was called an appa and kottu night\(^{55}\); a buffet with popular Sri Lankan foods. I went to the function with Ari, who was a chief organizer of the event, and with Anura and their families. They were both past pupils of the German Tech.

As I went in and sat at a table around which Athula and his family were sitting, Ravindra, a key informant for this research project was announcing on the stage and welcoming the guests. He was in a sarong and a red short-sleeved shirt. The sarong was of bright batik colors and reminded me of the casual dress code of men at paduru parties (the Sinhalese word for reed mats) in Sri Lanka which are usually held in the night\(^{56}\), and involve people sitting on paduru and singing popular Sinhalese songs. As I entered and sat down he announced that it was the auspicious time

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\(^{55}\) Appa (hoppers) and kottu (a mix of pieces of roti, meat or fish and fried vegetables) were served in buffet for twenty dollars a person at this event.

\(^{56}\) Paduru parties are a typical Sri Lankan musical event organized more commonly at homes where all guests dressed in saris and sarongs sit on mats and sing along old Sinhalese songs and old pop Hindi songs to the music of an eastern music group and enjoy music.
for lighting the traditional Sinhalese oil lamp. There were also a few women wearing the traditional Kandyan sari.

The atmosphere was celebratory (see Chapter five). The use of Sinhalese for announcements and for conversation, the type of food served, people’s clothing and styles and the music that was playing in the background all denoted an aura and atmosphere of a celebratory, middle class social function.

In contrast to this, the high tea function that I attended with Damayanthi, which held at the Claridon Hotel in Box Hill, had a quite different atmosphere. It was organized by the Old Girls’ Association of St. Michel College in Colombo. As the theme was high tea, there were sandwiches, tarts, quiches and scones, perhaps reflecting the Anglophile elements of Sri Lanka’s elite. For drinks there were tea, coffee and fruit juice. The theme ‘high tea’ itself conveyed an aura of a more upper middle class event. Announcements were in English and the atmosphere was decidedly formal, with people paying more attention to the public announcements than during the earlier event. The dress code was western and in the background old and new English language songs were playing. My interactions and communications with Damayanthi and her friends to whom I was introduced were more in English than in Sinhalese, unlike in the earlier event, where all communication was in Sinhalese.

The contrast between these events gives us a glimpse of how the ways of socializing, culture, foods that were enjoyed while socializing differed greatly in these two different groups. Dresses and styles that the participants enjoyed wearing for public occasions differed vastly. Perhaps this was the exact distinction that that the two groups refer to about each other in the privacy of their homes.

Divisions in the community, based on people’s internalization of a hierarchy of educational institutions and professions were reflected clearly in this study. It is clear in this situation that even though the participants shared a common ethnicity and religion, and despite their social mingling in public places such as the temple, each group had clear preconceived notions about the other that were based on the other’s educational background.

57 Damayanthi was university educated and went to a urban elite Girls school, St. Michel in Colombo. She worked for a well known communications company as a sales manager in the Docklands.
Internal alienation

Chandra, a university lecturer in economics who migrated to Australia seven years ago, reported that he does not get the chance to socialize with those more educated Sri Lankans who migrated to Australia about thirty years ago, but rather mixes with those who migrated in the 1990s. He sought ways to network with the former, as he thought that the values that they admire in a western country would be very different from those who had migrated comparatively recently. He was curious as to how other more educated and professional Sri Lankan migrants led their lives. He believed that those who migrated to Australia recently are crassly materialistic and distanced himself from them. Chandra experienced feelings of alienation within his ethnic community:

...I just feel that in this society I don’t have anyone that I can talk about something that interests me. And there are those people who have come from very ordinary or even lower social classes when they were in Sri Lanka who have gone blinded by the badu baanda\(^58\) like the cars and televisions that they see in Australia and they are dwelling on those. And in these people there is no sense of togetherness. And these are the people that as new migrants we get to associate and build social networks with...

Chandra dissociates himself from the more ‘ordinary’ and the ‘not so educated’ compatriots while expressing his feelings of estrangement from his own community. He differentiates his way of life (that of the more educated) from those who are not so educated based on the propensity for indulgence in material possessions as well as based on their formal education. He views this propensity as something that is alien to his class and the status that he acquired through education in Sri Lanka. In this instance, Chandra’s criticism of his fellow Sri Lankan migrants could even be viewed as a critique of class fluidity of the migrant community.

Anula, who was also a graduate teacher, had similar feelings about her less educated counterparts in Australia. She inferred that more educated people are not lured by the material luxuries that are readily available and affordable in Australia – luxury houses and cars and electrical gadgets –

\(^58\) It’s a Sinhalese idiom used to denote the meaning when referring to a person’s dwelling, material goods such as electrical gadgets, furniture, vehicles etc.
implicitly critical of those who pursue them relentlessly following migration. Her criticisms were directed at those whose trade qualifications would have meant much lower socio-economic status in Sri Lanka, who could not have afforded such things had they remained there. It was her belief that more educated people, particularly those who had received a state university education, would not be so materialistic because their values, acquired in the context of their university education, were more refined and honorable. She claimed that she and her family would remain in Australia for only two or three years until they received Australian citizenship, so that their daughter would have a more secure future for higher education, as in Sri Lanka the competition for university entrance is so strong and seems to involve chance as much as ability. For Anula, providing her daughter with an Australian primary or secondary education was not so essential as she was convinced that even in Sri Lanka one could provide children with a good primary and secondary education. She said, “We have come this far in life by receiving education in Sri Lanka. So I can’t see why our children too couldn’t succeed in life by getting education in Sri Lanka...”

Clearly in the Sri Lankan migrant community’s stratification in terms of status is predominantly based on the educational level of its members. This is also an important indicator of the socio-economic class of the person, especially in Sri Lanka. Each group had preconceived notions about the other. But the university-educated group actively attempted to differentiate themselves from the others in terms of life aspirations of migration and ways of life in Australia. Even though this was often not straightforwardly expressed during in-depth interviews, they often attempted to position themselves and their ways of life against that of those with lesser levels of education. Often there was a subtle isolation of the more educated but very recently migrated Sri Lankans because of these preconceived notions of the others. In the intention of differentiating themselves from the lesser educated ‘others’, they participated in communal activities such as rituals and festivals at the temple, only half heartedly and with lukewarm interest. Some educated participants such as Anula, Dineth and Ranil did not participate in these religious activities where the majority of the community gathered, at all. It is my contention that this reluctance to take part in community activities is caused by the absence of sense of belonging in this group of more educated people. In other words this alienation was a feeling that was arising from their own efforts to distinguish themselves from members of the community that they perceived to be of lower class, which ultimately left the more educated migrants feeling disgruntled about their life in Australia.
Social life curtailed by gossip culture

These accounts of participants demonstrate subtle divisions of the community that are based on the social class they belonged to in Sri Lanka and to educational achievements. Segregation in the community was noticeable in other contexts too. Many accounts of the general nature of the Sri Lankan community showed there was a tendency to be inquisitive about others, and to gossip about them, in public places such as the temple and the Sri Lankan community shops. According to Dineth, who had migrated to Australia about twenty years ago, this propensity prevented them from even going to a particular temple in the Northern suburbs. They would only go to a temple in Dandenong area, which was far away from their own suburb and local community, as that way they could escape from being gossiped about. Dineth and his wife got married four years ago and they did not have any children at this time. They were both in their mid forties. Dineth was very outspoken about how they felt exhausted with their acquaintances’ curiosity about them not having children. They both felt sad and angry at being the centre of gossip in the community for not being able to have children. Gossiping is a common cultural aspect in Sri Lanka too. However being subject to gossip in a small community, such as a small migrant community, could have a more harmful impact on the person especially if that person already lacks a feeling of integration with the rest of the community. On the second day I went to interview Dineth, I went to his house in the night. The house was in the dark and only one little lamp was lit inside. A cassette was playing the calming sound of Buddhist sutras. When his wife opened the door I saw Dineth listening to it with his palms brought together sitting on the floor in the dim light. Later on Dineth said that both of them listened to pirith\(^{59}\) every day in the evening before dinner. They said they adopted the habit of listening to Buddhist sermons and pirith from home without going to the temple as in that fashion they could obtain peace of mind without having to socialize and associate with others in the community.

\(^{59}\) Buddhist temples usually have one day of the week for regular sermons and pirith or chanting of the Buddhist sutras. Many in the community attempt to go to the temple on this particular day and it usually becomes the regular temple visit day for many families. Naturally the temple during this occasion becomes a regular meeting place for many families.
This tendency to gossip about others in the community was also quite conspicuously brought out as a major theme in several conversations I had, especially those with Sri Lankan shopkeepers. For example, young Shaleen who was working at the cash register of Nissanka’s shop in a northern suburb said:

(Shyly)...there is nothing that they do not talk about others when they come to the shop. Sometimes it’s embarrassing how critical some can be of others. They gossip a lot about other’s children and family matters, issues between husbands and wives...

Dineth’s account of his experience with other Sri Lankans in the community provides important information to help explain the nature, dynamics and tensions within the Sri Lankan community in Australia and its negative impact on the consciousness of the average Sri Lankan migrant individual. Participants such as Dineth, Ranil and Athil avoided religious places such as Buddhist temples and Sri Lankan ethnic shops as they thought that they inadvertently functioned as community hubs where gossip about the community was nurtured. For some, this gossip culture engendered feelings of marginalization, anxiety and disappointment about one’s own compatriots and hence drove some individuals away from integrating into the community through these important centers.

It was not only segregation created on the basis of education attainment, but also the gossip culture that exists in the community that kindled a sense of estrangement from the community in some participants. Although this might not be unique to the Sri Lankan community, it is worthwhile considering how such exclusion and disintegration in one’s own ethnic community affects the management of a chronic disease related to everyday life habits. There is a vast body of literature that discusses the health inequalities and disadvantages that communities face as a result of social exclusion and marginalization (Klein, 2004; Warr, Tacticos, Kelaher, Klein, 2007). In diabetes care, one’s psychosocial wellbeing is considered to be fundamental to effective diabetes management (Bradley and Gamsu, 1994; Greenhalgh, 1997). There is also literature that describes the impact of psychosocial stress on the susceptibility for the onset of diabetes and exacerbation of symptoms during the course of illness, especially among South Asian migrants living in Western societies (Williams, Bhopal and Hunt, 1994). These studies associate the psychosocial stress caused by low income, crowded housing, racism and lack of social support, with the onset and
exacerbation of diabetes of these ethnic minority groups living in Western societies. It is my contention that, although it was specifically not low income or crowded housing that were the problems that Sri Lankan participants faced, lack of social/community support and the absence of feelings of inclusion in one’s own community were situations that affected the wellbeing of most of the highly educated Sri Lankans with diabetes in Australia.

Experiences with racism

Conversations about notions of Sri Lankanness and nostalgia about ‘home’ eventually led to the topic of experiences of racism during several in-depth interviews. Even though experiences of racism were not common in this group of Sri Lankans, those few experiences had a strong impact on their future aspirations and on their overall sense of stability in life in Australia.

Dineth had very bitter experiences of racism from his early days of migration. Dineth believed that his position was recently made redundant in the company he worked, on the basis of racism. Perhaps this experience and belief were shaped and colored by his previous experiences of racism in Australia.

...there are three people working at the same position with me including me at this department. The other two persons are an African person and a white person. But last Friday I was given the letter of redundancy. I cannot think about a reason why it was me out of all three people. What I understand is that it’s because I’m the brown person there. They left out the Black person and the White person. Brown is a color that neither belongs to here nor there. We are always in the middle. And therefore we are the most harmless and dispensable people from the point of view of the employers when it comes to striking back. I feel like being brown means that there is no clarity or definition and therefore I feel that anyone can act upon us with impunity...

He believed that the lack of distinction in his skin color was symbolic of the lack of social status he had in Australia. He believed that as a race, migrants with brown skin received the least amount of
respect from the wider community, which he thought caused this unfair treatment from his workplace. It was with strong emotion that he reflected on this denigrating experience he had to encounter at his workplace. According to him, in Australia, “brown skinned people” just stand in the middle of cross roads, between white Caucasians and Black people; “they belong to neither here nor there”. This disgruntled self perception was extended to how he perceived and acted upon the outside world. From what he explained about everyday life encounters it seemed that he was often on guard and defensive.

Another participant who brought up the topic of experiences with racism was Dayan. Dayan’s account of racism had powerful reflections on the perception about his own identity as a Sri Lankan migrant. He thought that there was a significant similarity about feelings of marginalization between the dark skinned migrants in Australia in general and the Australian Aboriginal people. An important concept that Dayan grapples here apart from racism is the different inflections of his identity as a migrant from Sri Lanka whose fate he identifies with those of the Australian Aboriginal people and other migrants with dark skin. He claimed that

... if we feel like second class citizens in this country because of elements of subtle but powerful racism in the society, imagine how the Aboriginal people feel about their situation, as they are made to feel like second class citizens in their own native land...

Even though in reality the comparison between the Aboriginal people and the South Asian migrants could be viewed as far-fetched and dissimilar, perhaps Dayan was projecting his feelings of disconcertion in Australia on the former. For him this comparison derived a sense of commiseration with fellow ‘second class citizens’ and that in turn provided him with a perspective of his own standing as a migrant in the Australian society. He thought that their situation as dark skinned migrants was still much better even if they were subjected to racism, than that of the Australian Aboriginal people, who in theory should have the highest social status as they are the original owners of the land.

Dayan knew many people in the community through his radio work and various other community activities, and, had encountered many oppressive stories of racism experienced by members of the Melbourne Sri Lankan community. He claimed:
I think as first generation migrants we are in a certain kind of depression. Even though we don’t acknowledge it and don’t discuss with others there is always a difference in treatment for us from our workplaces especially because of our skin color. This kind of difference in treatment also affects our health and how we feel in this country. Even though my workplace treats me well and I have a great boss at my company, and even though I have the ability to adapt to the mainstream Australian culture, I live with feelings for my country and culture caged inside me. There is always a feeling of restriction and being caged in all of us no matter how relaxed we try to feel in this society. I know that my boss talks bad of the Indian people who joined the company with me. So I know that they must be bad mouthing about me too about my color when I’m not there. That’s why I’m saying that we always live in a state of instability as migrants of color.

Being a first generational South Asian migrant has become an important aspect of Dayan’s identity here. Discussing migrant and refugee identity, Cohen (1969) and Krulfield (1993) state that identity is situational for this group depending on the specific experiences of settlement. As ethnic groups are found to act in response both to boundaries that they themselves create as well as boundaries that are constructed by outsiders, their identities are negotiated constantly in response to these various situations with different boundaries. Anthropologists argue that identity construction of migrants and refugees takes place based on factors such as whether the members of the group are interacting among themselves and whether group members are interacting with outsiders. This identity construction is also affected by how the outsiders regard them when interacting with them and how the outsiders perceive them with others when they are not present (Barth, 1969; Camino and Krulfield, 1994). What happens to Dayan is that his identity is shaped by all these situations, some of which he identifies as racist, which he perceives as affecting his health in a very negative manner. He says that the stress caused by his awareness of being subjected to racism and the feelings of inferiority that derive from this stress too affected his onset of diabetes.

One of the most poignant stories of racism comes from Anula. She was once asked to get down from a bus on her way to the Preston market on a freezing wintry Saturday morning by a bus driver who said that he had to divert his usual route that day. Anula had been the only passenger on board. When he stopped the bus she had no other option other than getting off the bus. This
incident took place during their first months of settling in Australia after their arrival when Anula’s husband was resting at home because of a work place injury.

...we called the bus company and complained about it but we were too scared to give our contact details because at that time we were very new to Australia. At those times all you feel is that we are only second class citizens and we just have to accept whatever and just lay low...

Through these stories what we can construe is that these migrants grappled with a very uncertain self perception about themselves as members who belong to a race of color in relation to the rest of the Australian society. This ambiguity, and the sense of foreboding of their precarious social position in Australian society, was a theme that recurred in many interviews. They perceived themselves to be vulnerable to racism and discrimination from the wider Australian community and they felt that it was natural and something they had to endure and accept. Evidence from the wider literature argue that racism is an added psychological burden for non-dominant groups and racism can have deleterious effects on people’s health (Williams, 1999; McKenzie, 2003). Previous authors also argue that acceptance of the societal stigma of inferiority about one’s race or ethnicity also can have a detrimental effects on health (Williams, 1999). For example while describing how she was subjected to racism by the bus driver, Anula said:

... my sugar level increased a lot in the first year or so upon settling in here. But it is not a surprise when looking back at experiences like that as I have noticed whenever I feel emotionally disturbed my blood sugar increases. At times like that I do not even get the motivation to manage sugar...

Here Anula’s experience of racism left her feeling despairing, so much so that she lost the interest and motivation to control her blood glucose level. Previous research points out that there is a close relationship between stress and blood glucose level and demonstrates that experiences of stressful situations themselves can destabilize glycemic control (Lloyd, Smith and Weinger, 2005, p.122).

I argue in this chapter that Sri Lankan Sinhalese community in Melbourne is one with many complex divisions and inflections that operate beneath the surface of the community. What is concerning is how these inner divisions evoked a strong sense of marginalization and alienation...
from one’s own community and therefore functioned as a stressor for the participants. Added to this alienation from one’s own community are the encounters of racism in the larger society that further inculcates and compounds this sense of estrangement, ostracism and isolation. It is possible that this kind of a double process of exclusion and alienation would result in serious, negative effects on their attitudes towards health seeking behavior and most importantly towards self-care. I demonstrate in the next chapter how this situation was compounded by the challenges the Sri Lankan migrants had to face when settling in Australian society. These included the challenge of living up to the expectations of the rest of the community which created an unspoken but very present sense of competition among each other. This was one of many other reasons that in turn made them steer away from the importance of caring for their health.
Chapter 8: Stuck in between two worlds

My research reveals clearly that participants' aspirations for a better life often resulted in the relegation of diabetes management to a relatively low priority. In this chapter I examine the ways in which they construct their priorities in the context of the migration experience. In order to explore these priorities, I concentrate on the circumstances that determine the postponement of attending to health concerns – particularly diabetes management – as the participants adopt new strategies for upward social mobility. I argue that some of the aspirations migrants develop after arrival are strongly influenced by their engagement with the Sri Lankan Diaspora and the values that are espoused in that context. I draw on in-depth interviews with lay participants and health professionals, as well as interviews with Buddhist monks in two Melbourne temples, and informal conversations with Sri Lankan community members at various social and cultural gatherings to analyze the priorities of the Sri Lankan participants.

Facing the challenge of settling in and enduring a demeaning social status

Tissa migrated to Australia in the 1990s as a mechanic with a diploma from the Ceylon German Technical Training Institute, and claimed that he had achieved a lot more in Australia than his better-educated compatriots here. He attributed his success to the solidarity of the community of people who migrated in the 1990s with German Technical College qualifications, and their habit of helping one another. He also believed that he and his peers were willing to take on challenges that they encountered in the new environment to achieve a better life, even if it involved work that in Sri Lanka would be considered demeaning, such as distributing catalogues, delivering pizzas and cleaning jobs.

However this acceptance of the challenge to start life from scratch in a new land was not in fact restricted to those who belonged to the lower middle classes in Sri Lanka. Anula and her husband Wasantha were graduates in education and architecture respectively, and they did not wait until they received job offers that were more appropriate to their high educational qualifications. Anula was a graduate schoolteacher and she went to work as a helper in a kitchen of a restaurant in the...
city. Wasantha, her husband, was a highly qualified architect and on arrival to Australia he was fortunate to obtain work as a trainee in a small architecture company owned by a Sri Lankan (for a very low wage). On weekends he also delivered pizza. In spite of their aspirations for a middle-class lifestyle or a higher standard of living, individuals from both groups – the highly educated and the not so well educated – felt compelled to take on menial jobs in order to achieve the financial stability they hoped for, even though this sometimes compromised self-esteem. For example, Anula was known to be an excellent cook of traditional Sri Lankan food and she sometimes provided catering for private parties in Sri Lankan homes as a means of supplementing her household income. However neither she nor Wasantha wanted to make catering a business. They thought it would make everyone in the community consider her ‘just a caterer’ – an occupation with low social status in Sri Lanka. She was aware that within the migrant community she would lose status. Anula explained:

...although I do it once in a while when an order comes, I don’t want to do it permanently as then they (others in the community) would call me a cook or something. What would our parents think if they come to know about it even after getting a university degree...

Whereas Anula was fearful of compromising her status as a university graduate by engaging in work that she felt was inappropriate to her class and status, Tissa was proud of his versatility and capacity to meet new challenges. From Tissa’s perspective, willingness to engage in jobs that might be considered demeaning in his home country demonstrated fearlessness and courage in a new environment. He believed that people like him would go to lengths that his more educated compatriots were not prepared to go to in order to attain financial stability. Our conversations revealed that for Tissa and others in his group (people who migrated with lower educational qualifications), social mobility and the achievement of middle class status was a matter of wealth.

Anula on the other hand had a more complex conception of class and status, which meant she eschewed casual menial work that risked, in her opinion, undermining her achievements as a university graduate. Irrespective of the years they had resided in Australia, many migrants in this study who had trade qualifications from the German Technical Training Institute were also engaged in the distribution of advertising catalogues in their local areas to supplement their incomes, despite having other regular employment. In fact, except for three households of highly
educated participants, all the participants in this study undertook additional jobs to earn extra money despite having regular employment. These means of earning extra money ranged from distributing catalogues, delivering pizzas or doing cleaning jobs at night, to operating family day care in their homes. This commitment to earning as much money as possible by working extra jobs severely limited their capacity, freedom and time to engage in leisure activities and spend time with family and friends.

Irrespective of the social and economic class they belonged to when they were in Sri Lanka, provision of good educational opportunities for their children was an important aim of the entire group in migrating to Australia. Because of the highly competitive nature of the education system in Sri Lanka, a large majority of participants thought that in Australia their children would be more readily able to achieve a higher education, and thus able to secure their future. Participants such as Anula and Tissa thought that if their children could communicate well in English and gained high educational qualifications in Australia, they would be well armed to study or work in any other part of the world, even if they were unable to find employment in Australia. As explained earlier, competence in the English language in Sri Lanka is an important marker of class and essential for upward social mobility for most rural and non-elite groups, urban and rural alike (Hettige, 2000, p.21). It is clear in the stories of these participants that their aspirations for their children are still derived from their experiences in Sri Lanka and the social norms inculcated there; they highly valued the English speaking environment that their children lived in now because it provided them with an asset that they could use in the upward social mobility if they ever returned to Sri Lanka. For older and more mature migrants such as Denver, Edward and Nalani, their children’s achievements in Australia gave them a sense of pride that they had not experienced in their own youth.

In fact, more educated participants such as Denver, who had had a high status job before migrating to Australia, thought that as long as they could achieve the goal of being able to provide all his five children with Australian university education, nothing else mattered; not even his déclassé job as a factory worker, a very low status job by Sri Lankan standards. In fact for him the attainment of financial stability was secondary to providing a good university education for his children.
... So what I am saying is that when having left a good job like that having to do an “odd job” in a factory like this is surely a stress... It was my dream to see my daughter becoming a doctor and I could realize that dream. And my youngest son is very weak in his studies. I don’t think he could have ever gone to a university if he was in Sri Lanka. He is very weak. It is because he was here from the beginning that he could go to the university... (Please see Chapter 3 for the full quote)

A difference that we can note between the university educated and the non-university educated participants is that unlike the latter, the university educated group’s idea of social class and status was complex. Even though the more educated participants did engage in so-called low status employment, some were resistant to engagement in low status jobs and tried to look for avenues in which they could regain their lost status, whereas some were melancholic and despondent about it. They tried to console themselves by reflecting on what they were able to achieve in Australia despite this loss of status.

Irrespective of the inflections of social classes in the part of Sri Lankan society that people originated from, aspirations of working and middle class Sri Lankan migrants for their children were very similar. Attaining higher education was a paramount objective, as they believed that it was through a good university education that their children would achieve a comfortable life.

**Competition and achievement**

Attaining financial success and stability was also another main aim of migration. The more educated and affluent migrants were of the opinion that most Sri Lankans, especially those with lower levels of education and from lower middle classes, were insatiable in their desire for the material luxuries that they could not have achieved, had they remained in Sri Lanka. Even though this tendency for accumulating material wealth was often scorned and viewed with contempt by more educated and affluent migrants, it is possibly the hope of attaining material luxuries that held the mind and soul of the less educated migrants together, despite unpleasant experiences of racism and alienation in their new environment. Despite these unpleasant experiences, they were admirably industrious and continued to pursue their goals; they earned higher incomes than other migrant communities in Australia and succeeded in sending their children to universities.
It is my contention that this aspiration of achieving material success in the land of settlement was engrained in the minds of many lower-middle and middle class Sri Lankan migrants due to a unique historical situation in the socio-economic background of the island. As Hettige points out, consumption of goods and services did not formulate a major part of one’s social identity before the 1970s. Before the liberalization of the island’s economy there was a stabilization of the consumer market due to the strict state restrictions imposed on exports. Identity was predominantly based on the position in the society one occupied (Hettige, 2000, p.27). While this prevailed in the nationalization period, the environment changed drastically in the post liberalization period. This gave rise to a very wealthy business class of entrepreneurs and a new urban middle class (NUMC) which flourished due to the expansion of the executive class – those who were engaged in the administrative jobs of the ever-expanding privately owned businesses. In the meantime, the NUMC also expanded considerably. Concurrent with these changes in the social class structure, there was a high increase in the availability of imported goods. This was especially true for these newly-wealthy classes who most benefitted from the liberalization of the economy, providing them with opportunities to emulate the consumption patterns of western developed countries. High status began to be symbolized by the consumer goods that the wealthy incorporated into their lifestyle. People who were lower on the social ladder tried to at least symbolically emulate these lifestyles. Hettige notes that with other socio economic phenomena such as wider exposure to the outside world through television (that started to spread on the island in the early 1980s) and the expansion of tourism, the consumerist tendencies of the society intensified (Hettige, 2000, p.28). During this time, the author notes how the culture became more conducive to a social environment that began to be characterized by ostentatious material acquisition. Observing the increasing shift of focus from the social position to the consumption pattern as a determinant of social status in the Sri Lankan society over the past twenty years Hettige states,

...more and more people appear to be resorting to consumption as a way of demonstrating their relative position in the social hierarchy. Unlike the nationally rooted middle class, very much a product of the state sector, the members of the new rich class do not derive their social status and prestige from the positions they occupy. Living in modern houses and apartments, owning luxury vehicles and other status symbols, overseas travels, educating children in private international schools,
shopping at modern supermarkets, eating out at expensive restaurants serving international cuisine, adoption of western food habits etc. have become the defining features of life of the metropolitan elite. With rising incomes, the adoption of these consumption patterns has not been difficult at all for the emerging, transnationally oriented business elite... (2000, p.29)

In short, Hettige argues that increasingly social classes, especially the social and cultural identity of middle and lower-middle classes, are based on a consumerist lifestyle: the goods and services that they consumed (Hettige, 2000, p.30). What is evident from my field work is that many whom I met in the Melbourne Sri Lankan community also maintained these aspirations to emulate the lifestyles of urban business class elites and the new rich middle class, as most of them came from middle and lower-middle classes in Sri Lanka. The middle and lower-middle classes’ desire to emulate the lifestyle of urban business elites is very similar to the fetishisation of luxury goods seen in sectors of the Australian society too. However it is my contention that the difference between the two societies is that, unlike in Australian society where most in the middle class can afford these luxuries, in Sri Lanka this is true for only a minority in the middle class.

Competition for success and the ostentatious display of that success was a major theme in interviews with many participants. Some of them felt this competition engendered or exacerbated a sense of alienation and estrangement from their own community that made them look at their own community with contempt and feel detached from it. Participants such as Anula, Ranil and Chandra expressed disappointment about such competition in the community. However this attitude of highly educated participants could also be viewed as one of envy of the industriousness of their lesser educated compatriots and the success that the latter have achieved in Australia. Many Sri Lankans in Australia perceived their compatriots as having fallen into a competition among themselves to achieve material success and to display it for others. It is my opinion that this social phenomenon can be viewed as symbolic of class and status rivalry that exist in the Sri Lankan community in Australia.

The notion of class mobility of these Sri Lankans can be further understood by exploring Bourdieu’s notions of distinctions between social classes. It is fair to presume that except for four participants (Navin, Dhamayanthi, Kanchana and Chandra, the last three were respectively a commercial employer, surveyor and an university lecturer), who respectively belong to the Sri
Lankan urban elite class and Bourdieu’s dominant class. The other participants fell in and between Bourdieu’s class concepts of petit bourgeoisie and working class. Bourdieu states that the habitus of the petit bourgeoisie is characterized by asceticism, rigor, legalism and the propensity to accumulation in all its forms” (Bourdieu, 1979.p.331). He further states that their best assets are:

...cultural good will and financial prudence, seriousness and hard work. These are guarantees which the petit bourgeoisie offer to these institutions while putting himself entirely at their mercy...pretention could be written “pre-tension”, the thrust to continue along the upward inclination had its reverse side of the economizing mentality and in all the “small mindedness” associated with the petit bourgeois virtues. If pretention forces the petit bourgeois to enter the competition of antagonistic pretentions and pushes him to live always beyond his means, at the cost of a permanent tension that is always liable to explode into aggressivity... he is convinced that he owes his position solely to his own merit and that for his salvation he only has himself to rely on... (Bourdieu, 1979. P.337).

This characteristic of the attempt to live beyond one’s means was often present among the less educated participants who, in Bourdieu’s terminology, belonged to the petit bourgeois class. For example factory workers such as Rohan, Sunimal and Anil were very candid with me during interviews that they frequently talked about the stresses of their house mortgages and having to work extra to pay them off. They all had double storey, newly constructed houses in developing suburbs in Melbourne. For example Sunimal said that he gets ‘stressed out’ just by the monotony of his busy work schedule that spread throughout night and day on most of the days of the week.

**Beautifying and living beyond one’s means**

Much has been written previously about refugees and migrants in wealthy developed societies and their pursuit of the material luxuries that they find in the host culture. For example, Mortland demonstrates how Cambodian refugees and immigrants in the USA attributed great status to those who acquired domestic luxury materials that they could not acquire when in Cambodia, such as video recorders and television sets (Camino and Krulfeld, 1994 p.12). Cambodian migrants also perceived it as ‘becoming American’. Even though this element of gaining social status through
material success was present among Sri Lankans, unlike the Cambodians who attempted to
measure their lives against the Americans, the Sri Lankans in Australia emphasized the acquisition
of these material goods as a means of measuring against each other.

But consumerism can also be viewed as a way of constructing and affirming identity more
personally. Miller observes that people decorate and shape their homes so that what has been
accumulated inside the house is an outward expression of themselves (Miller, 2008, p.3). He
states that

...material culture matters because objects create subjects much more than the
other way around. It is the order of relationship to objects and between objects
that creates people through socialization whom we can take to exemplify social
categories such as ...working class, male or young... (Miller, 2008, p.287).

For example Sunimal who worked as a forklift driver during the day and a pizza delivery person at
night, had a large double-storey house in which his family of four lived. Inside the house, in the
front lounge room, there was a sizeable television kept in a corner, beside which there was a large
wall unit that was decorated with bright plastic flowers and soft toys. In the middle of the main
living room was an ornate looking sofa set with a large floral design fabric. There was a marked
contrast of colors between the black furniture and the white tiled floor. To the side of the next
living room, which was connected to the main living room, was a very elaborately built bar. His
wife worked at Crown Casino and she said she wanted to design a bar according to the styles she
had seen at the casino. It was built with steel of copper and silver colors and mirrors. Another
television was kept in the second lounge room. Apart from the bedrooms that were upstairs, a
room was also maintained as a shrine for daily worship. It was full of colorful and white Buddha
statues. They were all kept on a plank that was raised high up near the ceiling. Clearly the content
in the house had juxtaposing relationships to each other (Miller, 2008, p.63) as in the Sri Lankan
context it was a mélange of the accoutrements of a rural but wealthy house and an urban new rich
house. Sunimal and his wife had tried to beautify their home through a mixture of what they had
admired in Sri Lanka and what they had seen in Australia, while conforming to the norm of what
was considered luxurious in the Sri Lankan community in Australia. They lived in a two-storey
house with five or six bedrooms, and had electrical equipment such as large television sets and
expensive furniture, as well as extensive areas for entertainment – despite having to work day and night continuously.

Bourdieu’s concept of working class habitus becomes useful when examining this inclination for ostentatious display and competition between fellow compatriots. Discussing the characteristics of working class habitus, he says:

...just as the rooms socially designated for decoration, the sitting room, the dining room or the living room, are opposed to everyday places...and they are decorated in accordance with established conventions, with knick knacks on the mantelpiece, a forest scene over the sideboard flowers on the table, without any of these obligatory choices implying decisions or a search for effect...What is the gaudy and the tawdry, if not that which creates a big effect for a small price ... (pp.379 and 380).

However it is my contention that living a life amongst these ‘luxuries’ did not in reality provide Sunimal with true contentment. He said to reduce his stress he spends an hour or so chatting to his friends back in Sri Lanka every Saturday night on skype.

**Breaking rest**

As many were driven to engage in two or even more jobs owing to heavy financial pressures, health consciousness was always on the margin of most people’s lives, except in situations where they could not do away with an encounter with the doctor. What some participants voiced about their own lifestyles and what some Sri Lankan doctors expressed about them is evidence of this observation. Dr. Sanjeewa said:

...and for them health is like last in their priority list. Money and children’s education are on the first and second of the priority list. Some people buy two or three houses and are at a rat race to earn so much money and pay off their mortgages. So when they finish paying the mortgage they are probably sick and that’s too late for them to realize what should have been the priority. But this is understandable because most of them have come here (either) to establish
financially... As opposed to them the average Australian people are established financially and socially and therefore their priority is to maintain it and therefore health becomes a main concern or at least one of the most important priorities to them.

Like Dr. Sanjeewa the lay participants tended to contrast their own people’s lifestyle habits and tendencies with those of other Australians, especially those of British descent. Athil contrasted humorously how ‘other people’ (suddo - Caucasians) save and go to other countries for holidays and recreation, but ‘our people’ (Sri Lankans) only go to Sri Lanka for holidays which often ends up not being a holiday in its essence because it is usually a trip full of paying visits to the houses of relatives and friends they had not seen for a long time. Athil is a key informant in this study and he held a significant position in the Sri Lankan community in the South Eastern suburbs of Dandenong, Hallam and Narre Warren as he was one of the main organizers of the ‘Vikasitha Kala Kawaya’, a fund raising organization or charity in Sri Lanka connected to the German Tech Old Boys’ Association. Because of this position he had a wide exposure to the real socio-economic situation of many Sri Lankan migrants.

Even though the financial situation of Sri Lankans is much better than when they were in Sri Lanka when we compare what they earn and their expenses here the pay does not suffice the needs often. For example most people buy or build big houses. And to pay off the mortgage they often have to do the normal work and also find a part-time job. Most would go to a regular daytime job during the day and then after they come home they go to a cleaning job in the night. So people lose the necessary amount of rest they need to have. It is with this breaking of rest that people get stressed.

A life full of incessant hopes and goals

Athil thought that many Sri Lankan migrants are driven solely towards the achievement of material success and are competing against each other by forfeiting other important necessities such as leisure and recreational activities. He had a good example for this situation.
...I have a friend who moved from a little house to a big beautiful house. So my friend and his wife both work during the day and when they come home in the evening they stay there a while and they both go to a night shift work or four hours of work every night. And they come home at eleven in the night. And they wake up early in the morning and leave home at five. And they pay about three thousand dollars per month for mortgage just to stay home for four hours a day.

Athil thought that the “materialist seductiveness” of the Australian society is inescapable for many migrants, especially those who come from third world developing countries like Sri Lanka, and he viewed it as a trap set by businessmen and bankers.

Athil had an encompassing view of the plight of his community in Australia. He worried that his fellow Sri Lankans living in Australia risked living a life without happiness and contentment.

...we will all feel so disillusioned about our life if we get the chance to turn back and look at the years we have passed by finally. We will think ‘Oh god what did we do at the time we could have actually enjoyed life?’ There is no good consequence from it. I have a friend who built a very big house and now the children are all gone from the house and they are wondering whether to sell the house as it is too lonely to live in that house for them.

This notion of feeling abandoned and lonely at the end of an incessant quest for a future life filled with luxury for themselves and their children, resonates with Bourdieu’s notion of the petit bourgeois class.

The whole existence of the rising petit bourgeoisie is the anticipation of a future which he will, in most cases, only know by proxy, through his children, on whom he projects his ambitions. The future he ‘dreams of for his son’ eats up his present. Because he is committed to strategies extending over several generations, he is the man of the deferred pleasure, the differed present that will be taken later, ‘when

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60 The concept of seduction in the Australian society by its outward beauty and the luxurious material goods that are for sale was referred to by many participants, such as Athil and Chandra, to explain the dangers that this seduction poses to the maintenance of health for people who come from developing societies such as Sri Lanka.
there is time’, ‘when we have paid off the mortgage’, ‘when the children are older’... there is no compensation for a lost present, especially when... the disproportion between the sacrifices and the satisfactions becomes apparent, retrospectively making nonsense of a past entirely defined by tension towards the future. (Bourdieu, 1979. P.353)

Many of the participants’ courses of action depended on their future aspirations. Sometimes their hopes and wishes came true (such as Denver’s wishes for his children) and at other times they faded away. Two years ago during my field work, when I first met Tissa at his house, his son was sitting for the Victoria Certificate of Education. The son attended a selective public school that was academically highly competitive in Melbourne City. Tissa spoke very proudly when telling me about his expectations for his son, his contentment evident. He had wanted him to become a medical doctor. However, much later when I met him at a Sinhalese New Year festival long after finishing my fieldwork, he had a very despondent tone to his voice when telling me about his children. Although his son had passed the exam he had absolutely refused to do medicine at University. Instead he was doing a Law degree at Monash University. Tissa blamed TV crime programs to which his son was addicted to watch, for this change of aspirations in his son.

...all we can do is sit and wait. They do not want to listen to us. My son told me not to press him as he would be even more stubborn. When they are grown up they do not want to listen to their parents and say that we don’t know anything about education opportunities here. He says that Sri Lankan parents only want their children to become doctors and laughs at it. We tell them only what we know. Other than telling them, there is nothing else that’s left for us to do. My daughter too is good for education. But who knows what she will do too...hopes for children’s future are only limited to hopes themselves...

Tissa was a factory worker and he dreamed of his son becoming a doctor, a profession that is accorded the highest social status in the Sri Lankan community. Even though he was aware of the low status of his own job he did not mind it as long as he could secure his children’s future by seeing them achieving high status in the Australian society by becoming medical professionals. Once Tissa realized that his children were not prepared to go on the path that he wished for them, he appeared pessimistic about his entire life. Tissa’s story fits in well with Bourdieu’s definition of
the petit bourgeoisie class well here, as at the end it seems that the inability to achieve these hopes and dreams in Australia can leave these migrants feeling defeated.

Deliberate ignorance: care for health as estranged from everyday life

Health and health care did not appear near any of their other priorities and aims of migration. Among all these achievements such as gaining financial security, and disappointments such as children’s choice of profession, they appeared to turn a blind eye to the importance of caring for their health and diabetes management whenever the situation permitted. Many of their accounts of life in Australia had a tone of deliberate ignorance of health matters, i.e., they took full advantage of the chances where they could choose not to adhere to diabetes management routines. This included participating in social activities where they did not have to adhere to strict diet regimes and even postponing doctor appointments as long as they felt they had no symptoms. They attempted to keep fears of health at bay by discussing issues that they believed they had more control over, such as gaining financial stability. One important aspect that emerges from many interviews is that they did not acknowledge the centrality and imperative of the close monitoring of blood sugar and effective control of diabetes in everyday life. Instead of careful monitoring they tended to downplay the importance of diabetes management by concentrating on other life objectives. Ranil’s account of using the car to travel even the shortest distance for convenience illustrates how behavioral patterns that undermine effective diabetes management prevailed among the migrant community, irrespective of education level or social status.

...But I think that if I was in Sri Lanka I would not have got diabetes this early. If we were in Sri Lanka we would just walk to the local shops. But here it’s just a five minute drive from the house but we still take the car for that. I think one reason is our mentality. We get what we did not have in Sri Lanka here in excess. In Sri Lanka it is a financial burden to maintain a car and the petrol price is very high. And you can never get petrol for 1.50 dollars per unit in Sri Lanka. Here is it the price of a loaf of bread that you pay for petrol. So here it is labai to go in the car rather than

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61 Labai in Sinhalese means in this context it is cheaper/ convenient/ easier to use the car instead of walking.
In Sri Lanka instead of paying 100 or 200 rupees for petrol you would rather walk to the shop and get the bread worth of 50 rupees. This is the story that everyone who lives here with diabetes say. When I talk with friends in other countries we talk about how we used to eat *thosey* (An Indian type of roti made with maize flour) when we were studying and how we used to hang in the bus footboard and come home. Travelling in the bus hanging onto the railing of the footboard itself was enough to burn what we had eaten. And there was just no problem in health those days. And here there is no problem even when you have to go to the shops for ten times. You only have to get in the car and just go and it doesn’t matter how many times. *Diabetes lankawedi innakota eliyata enne nethi hethuwa thamai kohoma hari mahansi wenna wena eka*.

Unlike some participants who simply overlooked or ignored diabetes management, Ranil was well informed about how to manage diabetes effectively; however he too still chose to travel short distances in the car rather than walking, despite his knowledge about the benefits of walking for disease management. Substantiating Ranil’s account of the use of a car to travel the shortest of distances rather than walking, Dr. Wijewardana saw a very apt similarity between his Sri Lankan diabetes patients and his African diabetes patients. He observed that among his Sri Lankan and African patients who used to walk very long distances in their mother country in everyday life, none chose to walk to the clinic even though they lived very close to it. It was his belief that in Australia these migrants fall into the bad habit of depending on the car for even short distances of travel.

The development of such lifestyle habits in the country of settlement and not having the motivation to replace them with better practices conducive of more effective diabetes management, were often attributed to the cold climate of Melbourne. For example, as demonstrated in Chapter 4, Ranil’s account reflects the concerns and worries of many I met in the study regarding their inability to exercise in winter.

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62 *anga mahansi karawanawa*. The saying *anga mahansi karawanawa* in Sinhalese means to deliberately making the body tired and exhausted by choosing to walk to the shopping centre rather than taking the car which is more convenient.

63 The reason that diabetes is not manifested in the body when in Sri Lanka is that you have to anyway work hard there unlike here in Australia. There is no other choice in Sri Lanka because working hard is a must.
...And I think the weather here has an effect on us that make us not feel like doing any activity, it makes you feel like staying in one place. There is nothing you could do during winter. You feel like sleeping all the time ... The short walk to and from the bus halt are things that we take for granted but which really have a positive impact on your health (In Sri Lanka) But here you don’t get them (Physical exercise). The only place you walk to is to the garage (Laughing).

Many encountered difficulties in adjusting to the seasonal changes in Australia. Despite their receptivity to health information and awareness of the importance of exercise, their level of physical activity was significantly affected by the perceived difficulty of being active during the cold months as well as other practical factors. Dayan was a man who tried to make the most of his time. As the sole breadwinner of his family, he prioritized earning extra money. In these circumstances, caring about health emerged only as an activity that he could do if there was spare time in his busy routine.

Dayan said:

...I come home in the night around seven thirty in the night and on the weekends I have very little time or no time to spend with my family. My daughters go to bed around nine thirty in the night. When I get back home it is only that time I get in the week to talk with them about their day and help them with their homework or something. If I think about only myself and be selfish I could go for a run or walk around the block for half an hour. Even that half an hour is valuable for me because of my busy schedule. Even if I do it after that I will be very tired and would not want to do any of that work with my kids. So apart from trying to eat healthy exercising is not practical in my life...

Dayan’s story highlights one of the important factors that make dedicating time for personal care difficult. When relating his story of diabetes management in Australia, I noticed a sense of helplessness in his response to one of my questions about what he thought of the diabetes care that he received in Australia. He noted that despite all the health care services he received in Australia, there are other life circumstances that prevent him from engaging in a routine that is good for diabetes.
I think the health care system is very good in Australia. We can get any information from organizations like Diabetes Australia, we can meet the doctor any time to get a prescription and the doctor charges are always free unlike in Sri Lanka. But I think it is our lifestyle that does not allow us to make use of any of these facilities. When I drop the kids to school and go to work and then have to always go for something else too like a part time job because the money that we are earning from the regular job is not enough. Even though we earn a lot more money than we were in Sri Lanka we cannot fulfill all the necessities from the money that we get to earn from the regular job. When I think that how on earth I can do exercise while also earning and balance these two it becomes clear that doing both on a routine basis is not just possible. So I always tend to forget about exercise and just continue to do the earning. It is because we are the first generation of our group of migrants so we have to do everything possible to stabilize and secure the future of our second generations. If we lived like the suddo the there would have been no problem. But as Asians we take that risk of health over risking the future of our children. And for a lot of us children’s duties become the first priority over anything else. If I thought about the rest of my life like how I think of my food as a sudda without sending my children to tuition and letting them be just independent and do what they like then I could have managed it without any trouble.

Dayan emphasizes the financial instability of life as migrants and its impact on his life and his family. In this quotation there is a clear undertone of an awareness of the risks involved in neglecting disease management. Even though he was knowledgeable about disease management and did not simply ignore the importance of being physically active, his busy work schedule and practical difficulties in life did not allow him to dedicate time for his health care.

Here one of Bourdieu’s important characteristics of the working class helps us interpret the ways of life of participants like Dayan in more depth.

...and if it still needed to be proved that resignation to necessity is the basis of taste of necessity, one only has to consider the waste of time and energy resulting from

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64 Anglo Australians or white people
the refusal to subject the daily management of domestic life to the constraints of rational calculation and formal life principles ... which only apparently contradicts the refusal to devote time and care to health (‘molly-coddling yourself’) or beauty (‘getting dolled up’) (p.380).

With the pressures to earn extra income, participants such as Dayan, did not have time to think about health matters unless these matters obstructed their routine life. Engaging in physical exercise or adherence to a strict regimen of diet to manage diabetes effectively were seen as interfering with their primary motive of providing a comfortable life for the family. For example Dayan even thought that it would be selfish of him to dedicate time to do exercise after coming home without spending time with his children. This view clearly demonstrates that, consistent with Bourdieu’s above account, devoting time to exercise and health care contradicted Dayan’s lifestyle and daily schedule.

**Illusion of engaging in physical activity**

In addition to this deliberate ‘ignorance’, some participants tended to engage in self-deception to give congruence and legitimacy to their lack of engagement in active diabetes management. Denver is a shift worker in a factory. He was paying mortgages for two houses in the southeastern suburbs and he also wanted to buy a car for his daughter who was starting university studies.

And until recently we all used to do a cleaning job. My youngest daughter, my wife and I did the cleaning job with two other students. During that time “our bodies went down\(^{65}\)” In one way it was good that we could lose a lot of weight. And it was good that we didn’t really have time to go to other things like parties and functions\(^{66}\). Then we had to just give up. It was a little too tiring. The driving was too much. Within one month we had to drive from Lilydale to Sorrento...

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\(^{65}\) The Sinhalese idiom *anga bahinawa*, or going down, means losing weight in English.

\(^{66}\) For many male participants in the study going to functions and parties provided an occasion to consume a lot of alcohol and have oily food, which they knew was very bad for their blood sugar.
For Denver, engaging in a cleaning job was equivalent to giving the body physical exercise and therefore he thought it helped to manage diabetes because of the nature of physical activity attached to commercial cleaning. However the intention of the activity was not gaining physical exercise but earning. As he could not engage in the commercial cleaning any longer his latent intention of being physically active soon became a failed goal for Denver.

**Deliberate ignorance and level of education**

According to previous literature the level of education of the patient plays a crucial role in patients’ understanding of the importance of close monitoring of blood sugar and management of diabetes through the control of food intake and exercise. For example Landman, Kleefstra, van Hateren, Gans, Bilo and Groenier’s study that spans more than a decade, demonstrates that the risks of mortality were high in patients with low educational level with type two diabetes (Landman et.al. 2013.p.79). The research was conducted among 656 Dutch participants with type two diabetes in Netherlands. These researchers divided educational level into four categories; primary education, lower secondary education, higher secondary education and tertiary education (bachelor degree or higher) (p.77). While there have not been many studies conducted between the relationships of socio-economic status and educational level and incidence of type two diabetes in populations, these authors argue that the aspects that are associated with higher mortality rates in populations with lower levels of education may be strongly related to health behavioral factors such as exercise, eating habits and health seeking behavior. They also argue that higher mortality rates in such populations may be equally related to factors such as access, financial coverage and quality of care and different communication styles of health professionals. The researchers concluded that educational level had a higher impact on risks of mortality of patients with diabetes even more than other health complications such as macrovascular complications and behavioral factors such as employment status and smoking had on mortality (p.78). The socio demographic information of the Sri Lankan participants in this research demonstrates that most of them (ten) had a lower secondary education (completed their Ordinary Level education) and some (five) had a higher secondary education (completed Advanced Level education) and ten had completed tertiary education (Bachelor/ post graduate/ doctorate level). What is significant in my observations and interviews with these participants is that despite the
level of education – higher or lower – the level of self-reported regular and everyday care and attention that they gave for blood sugar control was never continuous or persistent. For example Athil, who had a higher secondary education level (Advanced Level) said he tends to get enthusiastic about blood sugar control only after visits to the doctor and with time that enthusiasm tends to fade away in the midst of a lot of other everyday work. Denver and Chandra who had tertiary level and even higher than basic tertiary education were enthusiastic only before they had to go for the doctor’s appointment because they knew they had to be “guilty” in front of the doctor if they had an unacceptably higher blood glucose level.

Athula who only had the Ordinary Level certificate of education from Sri Lanka bashfully brushed off the importance of being proactive about taking responsibility for his blood sugar. His wife complained that no matter what the doctor said he never missed his glass of wine after dinner every day. Even if the doctor expressed her frustration with his inability to control his blood sugar at the observation session, he only smiled and accepted her expression of frustration. Eight months after my observation with Athula at his GP appointment, he was directed to an endocrinologist and was put on insulin as the GP thought he needed more intensive and closely monitored diabetes care.

What emerged from all these participant stories, is that unlike what has been demonstrated in previous literature (Dray-Spira, Garry-Webb and Brancati, 2010; Landman et. al. 2013) in the Sri Lankan community, the level of education did not function as a powerful determinant in shaping the health seeking behavior of those with type two diabetes.

Dealing with uncertainty and migrant life

When going through all the stories of lay participants, one significant theme that runs across all of them is the notion of uncertainty in several aspects in life in Australia. The constant fear of financial instability played an important role in the lives of many Sri Lankans. For example, the shop owner Champaka who had a Bachelors Degree in Commerce, was constantly worried about the difficulty of maintaining his business at a level that provides enough for the family income. He regretted that he could not do enough to help his relatives in Sri Lanka due to the instability of the income from the shop. Another of his biggest worries was that that he could never spend any time
with his young daughters as he and his wife had to come to the shop every day of the week. Physical exercise was not on his schedule as he could not even dedicate any time for spending time with his family. Thus Champaka had a bleak view of diabetes management. Sometimes he even forgot to take the daily diabetes tablets. At those times to be “on the safe side” he drank a herbal tea thought to be good for blood sugar that he sold at the shop. Even though he was worried about diabetes management and he acknowledged that he was not taking enough measures to control sugar, he believed his circumstances did not allow him to engage in actively taking measures to do so.

Uncertainty was also attached to their perceptions about their health professionals. There was a clear lack of faith in the doctor’s discrimination of their diabetic status. Dayan said:

> The doctor asks me why I don’t I come to him regularly and give him a book of recorded measurements from the glucometer. But it is difficult to say to the doctor that I just don’t have the time. I don’t really like to go to the doctor all the time anyway. For anything wrong with my body I first try my best to not go to the doctor by trying out other homemade remedies. I usually go to the doctor to get a prescription because I know and I feel that there is nothing particularly wrong with my body. So I don’t really get a blood test done. Because the doctor can check the memory of the meter and also I can explain to him what were the readings in the past few days it is not a problem... The needle is such a nuisance because I can’t do anything with my hands if I do it for a long time. So I usually do it only if I know that the reading is going to be good. I drink the water in which my wife soaks the sun-dried bitter gourd. So I take the tablet only once in a while when I know that my sugar is high especially if I get to go out for meals.

The way Dayan relied on the advice of the doctor was unconventional, as he did not completely disregard it. He believed that after being diabetic for ten years, he understood his body signals much better than the doctor and was doubtful about the latter’s advice to take a 1000mg tablet every day. He created his own regime of taking tablets without really consulting the doctor and believed that he only needed to take a blood test for the doctor if he started feeling odd about his body.
Uncertainty about the doctor’s as well as other health professionals’ advice, especially regarding special needs that arise during the management of the disease, was prevalent in this group of migrants. Especially during interviews and observation sessions with Anula, Kanchana, Dayan and Dayantha it was difficult not to notice unease and helplessness in their tone when explaining issues regarding the advice they were given by the doctor. For example, while relating to me about a growing numbness in her foot over a period of time, Kanchana told me that her doctor did not take notice of that and did not refer her to a specialist until she asked the doctor about the possibility of consulting a specialist doctor.

Kanchana: ...the doctor told me its nothing to worry and could be something temporary. And when the doctor says there is nothing wrong you cant go against his opinion can you? But it did not go away and so I had to stress about the numbness with him after that and asked to refer a specialist...

Prabhathi: Did the specialist diagnose what the problem was?

Kanchana: No. The specialist too told me that there is nothing wrong with the foot. But it was then only I could relax about it. With time the numbness went away...

Another form of uncertainty that was prevalent in many in-depth interviews was their indecision over whether to remain in Australia or to return to Sri Lanka. This tension was especially intense among relatively recent migrants, but also occurred among some who had lived in Australia or more than twenty years. For example Dayantha, who migrated to Australia in 1990s through the skilled migration category, stated that he always thinks about going back and settling down in Sri Lanka, but he has to wait until his children finished their education. Denver did not even opt to get Australian citizenship as he thought that getting citizenship would mean loss of his national identity as a Sri Lankan. He said ideally he and his wife would live in Australia for half of the year and would live in Sri Lanka for the rest of the year in future. Both Dayantha and Denver have been living in Australia for more than twenty years.

Anula went through much hardship when settling in Australia with her husband and five-year-old daughter. She left her teaching job and her husband left behind a very successful career as an architect in Sri Lanka before migrating to Australia. She also remembered nostalgically their beautiful newly built house that they had to leave behind in Sri Lanka. She was convinced that they
would go back to Sri Lanka as soon as they obtain Australian citizenship. Anula said that they cannot cope with the speed that the society in Australia moves at.

I thoroughly feel that there is nothing to achieve for us here by falling into a speedy race. What my husband and I want is to have a beautiful life with our children, and bring up our children the way we want to and *lassanata jeewath wenn* while treating our parents well. It is definitely hard to achieve them because I cannot even try to bring up my children the way I want to in this environment. Of course now it’s possible because they are still very small. But in another three or four years there are too many ways and paths that they can tread their feet on which we would not even understand... Even when you are in Sri Lanka you have to protect children. But it is not as hard as it is here...

Anula’s aspirations about going back to Sri Lanka resonated strongly with those of more mature and older migrants. Anula came from a non-English-speaking, but educated semi-rural background and found it difficult to identify with Australian society and culture. Her lack of experience and exposure to Australian society made her embrace her own culture even more tightly and adhere to its values more strongly. Even though Anula had lived in Australia for two or three years, her statement above is an expression of her uncertainty and apprehension about Australian society, its values and its ways. Her opinion of the adverse effect of Australian culture on children was common in this group of Sri Lankans. Champaka too was of the view that among the Sri Lankan families in Australia the connection between parents and children is very weak or more distant than in families in Sri Lanka. For this reason Nissanka, the shopkeeper said that many people with small children, rent Sinhalese teledrama DVDs that they record directly from Sri Lankan television channels. He further said that most people rent them because they say that when watching them they get the feeling that ‘they still live in Sri Lanka in their minds’. Adding to this notion, in interviews Tissa and Anula said that when watching familiar surroundings, nature and people on these dramas they get the feeling of being mentally ‘transported’ to Sri Lanka. Nissanka commented that another reason why most of them rent them is to show their children who were born in Australia what the real Sri Lanka looks like and to show them their ethnic and cultural

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67 This expression in Sinhalese means to live peacefully and happily. It can also be equivalent to the English expression “domestic bliss”.

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origins. Thus even though they felt an apprehension about raising children in a western culture they found other ways to socialize them into Sri Lankan culture.

Another noticeable pattern in in-depth interviews was that this uncertainty and indecision was less apparent among those who were more educated, who came from social backgrounds who were more exposed to English and the western culture in Sri Lanka, and who held a high status employment in Australia. For example, more educated participants such as Damayanthi, Kanchana and Navin did not emphasize this need to return to Sri Lanka. Although they reflected nostalgically upon their past in Sri Lanka they did not engage in planning to go back. For example, Damayanthi, when asked if they would want to return to and resettle in Sri Lanka said, “We have not decided on anything like that. We would go back only if our daughter wants to go back and live there as we would like to stay wherever that is close to where she would live…”

However, apart from this minority, all others dreamed of going back to Sri Lanka although they were aware that it could not be done easily because of their commitments in Australia. The main commitment and barrier they perceived was children. They attributed this reluctance and inability to decide to leave children as intrinsic to South Asian and Sri Lankan culture and to the closer bonds that they believed to exist between parents and children in South Asian cultures.

According to Nissanka, who interacted with many Sri Lankans in the northern Melbourne suburbs for more than fifteen years, many try to live in Australia while dealing with memories of Sri Lanka that strongly link them to family and relatives. He observed that the problems that their families and relatives encounter in Sri Lanka are very much alive in Melbourne as migrants often attempted to solve them by helping financially. He believed also that most migrants who came to Australia about twenty years ago now lead extremely lonely lives in Melbourne, especially when their children grow up to be very different from them.

...Some people of course live like they never lived in Sri Lanka and as if they do not have any one to worry about in Sri Lanka. But some always grapple with issues that are going on in their families and relatives who live in Sri Lanka and for them it is almost their everyday life. When children also start living on their own and tend to think differently from them these older people tend to bend more towards going
back. But because of children that too becomes a difficult choice for them... to tell you honestly most people who live here are stuck in between two worlds.$^{68}$

Nissanka here gave an overview of what he has seen and heard from many Sri Lankans about the perceived wide gap between parents and their children who have been born and raised in Australia. This concern about the dilemma between bringing up children according to the way of the host culture or one’s native culture has been a common theme in many studies about migrants and their children in developed and wealthy societies. For example, in Mortland’s study of Cambodian refugees and immigrants, the writer describes the anxiety of Cambodian men in their forties who fret about their perceived inability to take their children back to Cambodia as they perceived them ‘being turned into Americans’. What makes them become more disappointed about their life is also their realization that at that age they could never be American in their lifetimes even though it was their wish initially when they migrated to America (Camino and Krulfeld, 1994. P.12). Even though Mortland does not focus on a concept of being stuck in between two worlds or the permanent oscillation between two worlds, it is apparent that what these Cambodian migrants in America express about themselves and their children is similar to the experiences of the Sri Lankans in Australia. Dayan, while acknowledging that they would never be regarded as equals in the Australian society because of their darker skin color, also explicitly expressed his feeling of uncertainly about the future of his children in Australia. He had a resigned tone in his voice as he said:

We can never be *suddo* (Anglo Australians or White people) even though some of our people think that they have become Aussie after migrating. Our children think that there is no difference between them and those white kids. But they too would only understand only when they reach the ages of twenty or twenty five and they would see the difference that they are treated in situations like promotions at workplaces.

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$^{68}$ The idiom Nissanka used was ‘*delowak athara hira wela*’ and its literary meaning is that these people are caught and trapped between two worlds.
It might be surmised here that it is this realization of the reality of their lives in Australia that prompts these migrants to oscillate between wanting to go back to Sri Lanka and to remain in Australia for the sake of their children. What Nissanka summed up, and what most these Sri Lankans themselves said about their life in Australia seemed to make their stay here temporary. They missed the intense feelings of belonging that they had taken for granted in Sri Lanka. Such feelings are not necessarily conscious as one is born and raised in a specific community, but a heightened awareness develops upon migration, when connections have to be maintained from afar. It is my contention that this sense of temporariness was more intensified by the perceived lack of a sense of belonging in the Sri Lankan community. In the accounts of many people in the community, with and without diabetes, there was a noticeable discontent and a lack of solidarity with their own compatriots. Gossip about others and jealousies due to competition were identified as a major vice of the group when they gathered specifically at Sri Lankan community shops and Buddhist temples. Only a very few people commented about temples as places that elicit in a sense of belonging and peace of mind in Australia. Rather, for many of them, visits to the temple brought discontent and insecurity about themselves because of gossip. Even though this discontent was present in many of the older migrants that I interviewed too, it was more noticeable among the more recent and younger migrants. It was conspicuous that at the functions where I was a participant observer at the two temples the older, middle-aged and well established Sri Lankans were more at ease than the more recent and younger migrants with young families. Five participants, namely Ranil, Athil, Navin, Denver and Anula said that they do not usually go to Sri Lankan temples. Ranil and Anula chose to go to the Warburton Buddhist monastery instead, where there were no Sri Lankan monks and where they did not meet many other Sri Lankans, which they thought brought them more peace of mind.

From these stories, there emerges a significant aspect of the participants’ lives in Australia, i.e., they rarely diverged from the primary objectives that had inspired their initial migration goals: gaining financial stability and success and providing a good education and future for their children. As a consequence, what this group of migrants encountered and achieved in the land of settlement was not always exactly what they hoped for; they learnt that whatever they achieved at the end of the day always came with a cost; in this scenario a lifestyle disease. However as most of them realized this too late, they were only left with the option of going into a lifelong course of medication. Perhaps in order to maintain their conviction that they have taken the right course by
migrating, they rationalize and justify their past course of actions. They explain the forfeiture of health by engaging in a constant exercise of contrasting their lifestyle, aspirations, culture and values with those of the host society. They stress differences between eastern and occidental cultures that represent their choices as morally superior because they privilege family interests. Such rationalizations provide them with a reason for their prioritization, so legitimizing those actions and inactions, which gave rise to diabetes. Nevertheless what is most significant in this study is that even after this realization of their situation, most of them still did not seem to take active responsibility towards their health. While none said so directly, we can infer that the value they placed on financial prosperity and the secure futures of their children was deemed more altruistic than care of the self. Such attitudes, and the moral weighting of them, testify to the strong cultural emphasis on a web of relationships as the source of integrity and social worth.

The inertia that characterizes people’s response to their illness has logic. Relationality and the moral values entailed mean that people are reluctant to put their personal interests first. Participants’ failure to take active responsibility for their own health, despite the availability of all necessary health facilities and information and the financial capacity to pay for them, is perhaps caused by their embedded cultural values and the circumstances they find themselves in Australia. It is a paradoxical situation where they migrate in search of greener pastures and just as they start settling in, gaining the things they dreamed of, their hopes and dreams drift towards their homeland. Life in Sri Lanka is seen as greener, socially cohesive and more wholesome; life in Australia is associated with social dislocation, alienation and hard work and their migrant status as temporary. During their lifetime in Australia they oscillate constantly between two worlds, two desired futures, living in Australia temporarily and the hope of migrating back to home once the time is ‘right’. We can view this tension as a further illustration of the ways that their aspirations, formed in Sri Lanka, drive them to work hard and material accumulation but that their achievements have little of the social esteem that they would accrue at home. They live in their large houses with the accoutrements of bourgeois wealth, but without an ‘audience’ of friends and relatives. The desire to return and live their lives basking in the admiration of a community grows as they spend so much time working to attain these goals. They inhabit a world that they have created from their labor, but the social world that helped to create their aspirations is far away. This is the liminality of migrant life.
The critical issue in terms of health is that this ‘liminal space’ is also the long period of time in which diabetes takes hold. In this process of constantly moving between the two worlds, diabetes – which resides in the body asymptptomatically for a long period of time, or with no manifestation of complications – can be ignored or accorded a low priority. The liminality of the participants’ lives in Australia, the ‘two worlds’ that consume their physical energy and their dreams of the future, keep diabetes management in obscurity as long as the body can endure it.
Chapter 9: Conclusion

This thesis has explored the everyday life experiences of a group of Sri Lankan migrants as they come to terms with managing diabetes and deal with other complexities of their lives as migrants in Australian society. Although we know that Sri Lankans are an ethnic group with a high prevalence of diabetes in Australia, there is little knowledge about diabetes management in this group. In the course of the last 8 chapters, I have revealed the complexities that inform diabetes experience and influence diabetes management, showing that diabetes management cannot be reduced or confined to simple rates of compliance and blood sugar measurements. Instead, I have uncovered the way that a lived experience of diabetes may reflect the broader, richer and more complex experience of migration – that diabetes can only be understood and thus potentially addressed through an understanding of the history, present lives, and future hopes and dreams of these migrants.

This study was initially inspired by my personal experience – a process of meditation on an event that took place in my family more than a decade ago in Sri Lanka – thus, it engages with broader aspects of diabetes management in another country. It constitutes an attempt to question and scrutinize the complicated elements involved in the management decisions and life choices that Sri Lankans with diabetes make in their new environment away from home.

I begin the thesis by discussing what diabetes management is like for Sri Lankans at home in order to speculate that in theory I would expect these issues to be addressed in a more supportive manner in a better funded healthcare environment. Health professionals in Sri Lanka attributed the challenges that most of their patients faced in relation to diabetes management to economic hardship and lack of relevant educational information and guidance from health professionals. This suggests that, if financial insecurity and lack of adequate medical guidance obstructed the effective management of diabetes in their home country, Sri Lankans now living in an environment where they can afford medications and in which they receive appropriate medical guidance and information for effective management, might have better management skills and would be more motivated to manage diabetes effectively.
Previous research among racial and ethnic minority groups in developed countries suggests that diabetes management is often poor among people from ethnic minority backgrounds and among those with lower levels of education and socio-economic status (Hawthorne, 1990; Hill, 2006; Rhodes, Nocon and Wright, 2010). In addition, another body of research also points out that adherence to chronic illness management goals and strategies is much stronger among people with higher socio-economic status, and specifically those with higher levels of education (Goldman and Smith, 2002). Previous studies have also examined difficulties migrants face – including problems of access to care; low health literacy, relatively low socio-economic status, language barriers and the absence of health professionals from their own cultural background – and found that these problems adversely affect their management of diabetes (Jowsey et al. 2011; Le and Le, 2005; Rhodes et al. 2010; Williams, 1999).

All participants in this study were ‘economic migrants’. According to the Australian Bureau of Statistics, Sri Lankan migrants have a higher socio-economic status compared to other migrants, because of their higher education levels, income and the majority’s ability to communicate in English (ABS, 2011). Given that they do enjoy the advantages of a higher socio-economic status and higher levels of education than the general population and other migrant communities in Australia, then it would appear justifiable to expect Sri Lankan migrants to have more effective management of diabetes.

Participants in my research certainly believed that they were economically much more stable than they were in Sri Lanka and had better health monitoring and information regarding diabetes management than their counterparts living in the home country. But even though these practical barriers to effective management were reduced in Australia, they nevertheless encountered challenges that derived from their specific history, current social situation and from the way they tried to achieve their hopes for future.

There are no statistics or other data of diabetes management compliance or development of complications by specific ethnic groups in Australia, and it remains unclear whether diabetes management of Sri Lankan migrant patients is not effective or low. The interviews conducted in this research with people with diabetes and their health professionals indicate that problems related to diabetes management are not only related to diet and exercise but also are intricately
interwoven with other complexities of their lives as migrants. These complexities involved experiences and life style and dietary habits that they had encountered and inculcated when they were living in Sri Lanka. In this research, diabetes became a marker or a talking point for revealing the broader issues that were embedded in migrant life, rather than showing that migrant lives were revolving around diabetes.

Overall my thesis expounds the view that there are several sociocultural aspects of people’s lives other than socio-economic status and education level that affect the health care, health consciousness and diabetes management of the group of Sri Lankans whose lives I present in this study. I argue that challenges to diabetes management derive from a person’s specific history, their sociocultural and economic backgrounds as well as attachment to a collective cultural history. The challenges also derive particularly from the psychological discomfort and stress caused by the conceptualization of control around which diabetes management mainly revolves. For example, in diabetes management guidelines ‘control’ meant the consistent and regular incorporation of healthy eating habits and physical exercise in the patient’s everyday life. But for the people whose stories I present in this thesis, ‘control’ meant healthy eating and engaging in physical exercise only for a limited period of time. They viewed ‘control’ as a phase that could be practiced in intervals and not as a regular and consistent incorporation to their daily lives.

Limitations

It is with great gratitude that I thank the Sri Lankan people whose stories I relate in this thesis, and from which I have come to the following analysis and conclusion. However it is also with equal gravity that I emphasize that we cannot apply and generalize this conclusion to all Sri Lankans or to other migrant groups in Australia. This study gives us an in-depth understanding of the challenges that the people I interviewed encountered in their life in Australia when managing diabetes. Their experiences do, however, shed light on a range of factors associated with migrant status that appear to militate against effective management.
Main Themes

A variety of core themes emerged with significant implications for understanding migrant experiences of living with a chronic disease. In this concluding chapter I shall recapitulate briefly the findings and these core themes of my research, demonstrating how qualitative research facilitates a richer, in-depth understanding of the challenges faced by this group of Sri Lankans in this study. Although this particular group of migrants may be unique in some ways, their experiences speak to the broader experience of those who leave their homes to distant lands in search of ‘greener pastures’. The love of traditional food, hopes for a better life, embracing the new while remaining nostalgic about the past are themes common to the literature on the experience of migrants from many different settings. The methodology has demonstrably exposed the complexity of people’s behavior and their reasons for avoiding, limiting or failing to follow medical advice for the management of their diabetes.

One main theme that emerged from this ethnography is the pragmatics of health literacy in the management of diabetes. Health literacy and technical aspects of diabetes management are important factors that impact on health. However, their use is obliterated until explored in the context of lives, habits and culture. Recognizing the use of health literacy and the technical aspects of diabetes management in the context of everyday lives is critical for public health measures that aim to reach ethnic minority groups.

All participants knew the importance of managing and selecting foods that were safe for diabetes and they could all repeat the advice that had been delivered by the health professionals. Most of them could read and understand the English language used in the handouts given to them about diabetes management by health professionals and could read and understand the numbers on the glucometer. Health literacy has been defined as a patients’ ability to read, comprehend and act on medical instructions (Schillinger et al. 2002). This suggests that the Sri Lankans in this study were highly health literate. The Sri Lankans were also aware of the importance of regular exercise and that food regulation alone was not enough for the effective management of diabetes. Yet none of them stuck to a regular diet or exercise regime and they all faced constant dilemmas about management, from doctor’s appointments to self-management. There was pronounced dissonance between what participants understood and knew and what they actually felt and did.
Yet the participants in this study were not particularly financially disadvantaged and had above average levels of education. It is clear that there are several other sociocultural and psychological factors that are quite distinct from economic considerations and the ability to read and communicate with health professionals in English, which affect the management of diabetes. These are discussed below.

**Ideologies of social class and status shaping and influencing exercise and dietary patterns**

**Exercise and class**

There were marked differences in the perceptions and understandings of diabetes and its management that reflected pre-migration class origins. As described, the Sri Lankan socio-economic class structure is very complex. However for the convenience of analysis in this thesis, I divided these many inflections of socio-economic classes into two overarching classes: the more educated and or wealthy and/or English speaking upper middle class, and the less educated rural or suburban and predominantly Sinhalese speaking lower middle class. From the two main strategies of management – control of food and physical exercise – it was with regard to the latter that the two groups were significantly differentiated. The perceptions towards diabetes management and the manner in which they dealt with diabetes management differed between the two social classes. It was only the wealthy, upper middle class or educated or English-speaking class participants who regularly engaged in physical exercise to any extent.

The more educated and wealthy participants had doctors from other ethnic groups and they communicated confidently and candidly with their doctors (and with me) even about their frequent transgressions of compliance. This was in marked contrast to the other participants, who came from less affluent, less educated rural or suburban lower middle classes. The latter were defensive and covert especially in the initial encounters with the researcher as well as with the doctor. They expressed their grievances only outside the clinical encounter, in the privacy of their homes. This did not imply that they were continuously preoccupied by their inability to achieve ‘good’ glycaemic control. Rather, they were either ‘blocking’ the imminent importance of engaging in physical exercise or gave very low priority to diabetes management. They kept postponing
taking responsibility for disease management and were primarily focused on achieving their initial economic goals. This meant they could never get into a routine of regular physical exercise. It is my opinion that this was a strong reflection of the lower-middle class and working class belief that engaging in such physical activity is exclusively the life style of the wealthier, highly educated and urban elite: the availability of time for physical exercise and affordability of a gym membership, in Sri Lankan terms, reflected and symbolized someone’s wealth. They maintained the view that such activities were the province of the upper middle class. Their lifestyles in Australia were based on their upbringing they had and the perceptions that they held that were shaped by their socio-economic class in Sri Lanka. They had various honest explanations and excuses for not engaging in physical exercise – ranging from cold or hot weather, to having to fulfill responsibilities towards children and not having enough time to exercise as all of them were engaged in either one or two jobs, during the day as well as sometimes during night. Nevertheless most of their lifestyle changes after migrating to Australia were shaped by their aspirations to achieve either a higher socio-economic status or a higher standard of living. While to a lesser extent than Bourdieu’s working class in Paris who imitated the ways of life of the dominant class (1979, p.386), several participants in my study tried hard to emulate the lifestyle of a dominant or elite class in Sri Lanka, mainly by building large houses and buying expensive cars.

As Bourdieu mentions, “The scheme of the habitus, the primary forms of classification, owe their specific efficacy to the fact that they function below the level of consciousness and language, beyond the reach of introspective scrutiny or control by the will.” (Bourdieu, 1979, p.466). I contend that the innocent excuses participants of my study produced for not engaging in physical exercise were in reality representing their inability to think outside their habitus. Apart from this inability to recognize or change the values that inspired their working lives, there was also the perception, especially among the participants from lower middle class, that taking care of health is important only during a period of sickness. Bourdieu characterizes women of working class in Paris as not ‘concerned about sparing and saving them... that they do not value themselves sufficiently ...to grant themselves a care and attention...” (p.380). This description resonates well with the attitude some participants demonstrated regarding close monitoring of blood sugar, controlling diet and doing regular physical exercise.
However apart from the differences in attitudes to physical exercise, it is significant that participants of both classes – wealthy and educated and lower middle class – selected, cooked and ate food in a way that was not necessarily directed towards diabetes management. I could make no distinction between their dietary patterns or the meanings that they attached to them, a finding I explore further below.

Meanings of food and diet negotiated by migrant experience

Diabetes and food are inevitably intertwined and food is a critical part of human lives but also of the migrant experience as I have detailed in Chapter 5. The findings about participants’ cooking and eating practices and their perceptions about them reveal how this group of people made decisions to eat foods that diabetic patients should avoid, despite their understanding of the importance of nutritional values of food in diabetes management. The participants were not overly concerned about the cultural values of food, although many continued to eat Sri Lankan food. Cultural values attached to food did not determine their choices of food. For example, rice and curry, which is usually consumed for all three meals in Sri Lanka, was readily replaced with other foods while leaving rice and curry meal for once a day. Instead, their food selection and eating behaviors were more dependent on notions of affordability and availability that sometimes also incorporated notions of social class – especially regarding going to fast-food restaurants. They placed greater importance on having a comfortable and luxurious life in Australia than paying keen attention to healthy food selection, cooking and eating. Nevertheless, there were changes that were made to their food patterns. However many changes that had taken place in these food patterns arose from the exigencies of their work schedules, so that the achievement of economic goals was privileged over health or diabetes management. Briefly then, their ideas of food consumption contrasted dramatically with those of the health professionals, which were based on food’s nutritional values. Failure to identify the meanings that are attached to food by people, on the part of health professionals, would lead to diabetic patients with very low control of blood sugar. If we try to expand this point of view of food a little further, we could surmise that the widespread obesity epidemic in Australia too requires us to look further into all our food cultures and psychology to negotiate this taken for granted element of food in everyday contexts to find a realistic solution for it. The description of Sri Lankans’ food ways and diet in the thesis shows that
we must come to understand ourselves in order to understand our diseases related to diet and how they can be managed effectively.

**English language skills as a barrier for obtaining satisfying health care**

The findings of this study differ from much of the research on migrant diabetes management in developed countries, in that they do not endorse the view that the main problem facing migrants in their lack of, or limited ability to use the English language, and that this is the major barrier to effective diabetes management (Hsu et al. 2006; Hill, 2006; Stewart and Nam Do, 2003). This is because of the relatively uncommon fact of Sri Lankan migrants having good education and English as compared to most migrant groups studied. Most participants in this study had at least functional English – they could manage to get work done at different public contexts such as during shopping and while using public transport by using English. Their English knowledge was also enough for them to read and understand a diabetes management brochure given by a doctor or a diabetes educator. Some participants had excellent English skills and English was the language used at home. However, their English skills did not appear to make any difference in the way they perceived and conducted their routine diabetes management plan. Despite having competent English skills, participants ignored medical recommendations such as engaging in regular physical activities and taking regular medication. Even if they comprehended the medical recommendations they did not act upon them.

Thus there was a clear discrepancy between previous findings about the relationship between English fluency in migrants in obtaining satisfactory health care services and adhering to recommended regimes. This in turn raises the question of whether ensuring language acquisition and improving health literacy would necessarily ensure higher levels of adherence in migrant groups. It might mean that many of the feelings of alienation and isolation that people attribute to their lack of English might in fact be attributable to experiences of being a migrant that participants in this study identified. This is not to dismiss the need for language assistance for migrants, but to suggest that it might not prove the panacea that is suggested by other researchers.
Having doctors from the same cultural background

Despite most of them having doctors from the same ethnicity there was a significant gap in communication between the Sri Lankan lay participants and the health professionals. The former was often resentful of their Sri Lankan doctor and sometimes some participants even actively looked for health care professionals from other ethnicities, for better and satisfying care. Communication was often hampered between the Sri Lankan patients and their Sri Lankan doctor because of flawed conceptualizations on both sides. While the Sri Lankan patients tended to maintain distance with the doctor due to the cultural and social habit of treating the doctor with respect and awe rather than as a service provider, the doctors often formed their perceptions about their Sri Lankan patients based on their prior knowledge of the Sri Lankan culture and habit and missed active communication with the patients.

For example, despite significant changes that they had made in food selection and eating patterns, reinforcing notions and prejudices related to classes, all Sri Lankan doctors assumed that their Sri Lankan patients continued to cook and eat in the same way as they had before migration, and that was seen as harmful for diabetes management. Sri Lankan health professionals’ preconceived notions about their Sri Lankan patients, and their self concept as being superior to others in the community, demonstrate how just being of the same ‘culture’ or ethnicity or even a migrant does not induce understanding, given the constant process of ‘othering’ in the community that I have noted throughout the thesis. Health professionals often missed that their patients had brought in at least some significant changes to their diet. Some assumptions of health professionals were so strong that they did not expect or anticipate any positive changes in the lifestyle of the Sri Lankan patients regarding diabetes management and they did not direct the latter to other health professionals in the diabetes care team presuming that it would be a worthless effort. This observation confirms findings of previous research that have examined physicians’ perceptions of patients, demonstrating that their perceptions were affected negatively or positively by the patient’s race and socioeconomic class (Ryn and Burke, 2000).

Sri Lankan doctors held unfounded assumptions of their Sri Lankan patients, to base their decisions on their care plans. This is an important finding in the study, as it is contrary to the suggestions and assumptions made by previous researchers about migrants selecting health care
professionals from the same cultural and linguistic background to obtain better health care from the system (Kokanovic and Manderson, 2007). Previous studies that have examined chronically ill migrants’ use of services provided by health care professionals belonging to the same linguistic and cultural background state that it would enable these migrants to access better and satisfactory health care services. These researchers also argue that linguistic aspects of cultural competence in health professionals assist in reducing racial and ethnic disparities in health and health care system (Brach and Fraser, 2000; Johnson, Saha, Arbelaez, Beach and Cooper, 2004; Kokanovic and Manderson, 2007; Stewart and Nam DO, 2003).

Even though most Sri Lankan doctors had an in-depth knowledge of the life of their Sri Lankan patients, their knowledge about the culture and people prevented them from including the patients in the care plan and also from effectively communicating with their Sri Lankan patient due to conceptualizations based on prejudice. If this situation continues it would only decrease the quality of communication at the clinical encounter between Sri Lankans and their Sri Lankan doctors. Thus being able to communicate in a mutual language is perhaps over estimated in previous literature about migrant health. Preoccupations formed about the people as being non-complaint or too rigid to change from routine by their health professional could compromise the quality of treatment to a great extent that it could result in delivering suboptimal care for migrants such as those who belonged to my group of participants.

**Impact of externalization of responsibility and view of oneself as a part of a whole**

Self management is regarded as the keystone of diabetes management. It involves skills related to learning to modify diet and lifestyle (Deakin, McShade, Cade and Williams, 2005); managing the psychosocial aspects of diabetes; communication and interaction with support services including medical services; engaging in physical activity; effective usage of medicines; and performing and understanding blood glucose monitoring (Diabetes Australia, 2012; Harris et al. 2012).

Almost all people in my study externalized responsibility for the causes of diabetes. Externalization of disease causation has been described as a tendency of South Asian migrants living in Britain (Lawton et al. 2007). What is new in this research among Sri Lankan participants with diabetes was their equal inclination to externalize the responsibility for *management* of diabetes. Taking
individual responsibility and being accountable for the management of diabetes was rare. This trait was also confirmed by their doctors, who complained about their Sri Lankan patients, maintaining that they did not show any interest in learning about diabetes management, an attitude that they attributed to lethargy. However I contend that this blame is in reality directed towards the people’s inability to adhere to values of medical compliance which literature trace to capitalist logic of self discipline, productivity and health (Ferzacca, 2000). Attributing failure to comply to sheer inertia or lethargy is a deep misunderstanding that is especially ironic coming from Sri Lankan doctors, who might be expected to recognize the more complex underlying factors that inhibit compliance.

One reason for this externalization could be the sociocentric world view that my participants adopted to perceive life, its circumstances and events; a view that anthropologists like Dumont claim to be a characteristic of the inhabitants of South Asian societies. The Sri Lankan participants still identified themselves very much with the social connections they have with Sri Lanka. For many of them, a significant part of their identity was still based on their kinship, social, cultural and political ties they maintained in Sri Lanka. They continued to view themselves as a part of the collective they left behind. My analysis suggests that it was this same sociocentric orientation that the Sri Lankans applied to their diabetes management; hence their externalization of causes for diabetes and the responsibility to manage the disease. Even though they were aware of what to do and what to avoid if they are to ‘control’ the intake of fats and sugar, they maintained their standpoints about the types of food that they ate and how they cooked them with passionate enthusiasm.

As discussed in chapter 4, we can surmise that this is due to the social and cultural origins of the people with diabetes that is traceable to the collective nature of Sri Lankan society and to the lack of emphasis on the role and responsibility of the individual in this society. It is clear that despite understanding the importance of self management in diabetes, such externalization of responsibility hampered the agency of my participants in the process of disease management. This is a significant finding and one that affects diabetes management negatively, as it nullifies the principles of self management of chronic illness that are ardently advocated by modern medicine (Borrot and Bush, 2008, p.10). Even though participants understood these guidelines and principles, knowledge alone did not guarantee their adherence to them. Certainly if they did not
assume the responsibility it would contest the effectiveness of the self management concept that is taught at diabetes education programs and that is expected to be put to practice by diabetes patients.

The health consequences of this externalization of responsibility for disease management are compounded by the health professionals’ claim that Sri Lankan patients always come alone to the consultation – as opposed to patients from ‘Caucasian’ origin who always come with another responsible family member. One health professional thought the reason for this pattern of visiting the health professional alone was their busy lifestyle and the difficulty to find a common time that is convenient for both partners to visit the doctor together. If the emphasis upon self management and agency in diabetes care does not work with patients who externalize causes and responsibility, then a change of approach at the clinical encounter is warranted, on the part of the health professional. If patients tend to externalize and distribute the responsibility of management to outside factors, then the patient’s consultation with the health professional should involve not only the person with diabetes but also another person/s from the family so as to enlighten the family about what they can do to assist or encourage strategies of management.

Recognizing this need, it can be strongly recommended that in the designing of educational material or programs of diabetes management for people who come from ethnic minority groups, information should be included about the importance of involving other family members actively in the adherence to diabetes management regimens. It can be also suggested that health professionals need training in engaging patients and families especially in the management of chronic illnesses such as diabetes. In the long run, this extension of the involvement of the family members of the patient would also function as a medium of educating others in the community who are predisposed to type two diabetes.

Differences in the conceptualization of control and contextualization of control

It was clear that the people whose stories I present tended to contextualize, limit and delineate the concept and practice of control to one defined period: their next doctor’s appointment. An impending appointment was their prime motivation to achieve a healthy blood glucose value on the glucometer. Most of them followed diabetes management guidelines related to diet and
exercise only in the days before they had to go to a medical appointment. Their motivation to control was often dependent on the trust they had in their doctor, or because of their fear of reproach. Most of the time guidelines and advice provided by the doctor were regarded as impractical and inapplicable to the realities of their life. This perception of the impracticality of the medical advice extended to all health professionals, irrespective of ethnicity.

Control for most lay participants meant the obtaining of control through adjusting diet or medication when the ‘need’ arises. It only mattered during times of testing for blood glucose level by the doctor or when it was time to take the regular blood report – so long as they were feeling well, they continued their habitual lifestyle.

The delaying or prevention of diabetes complications is the main goal of effective management of diabetes or improved glycemic control (Diabetes Australia publication on diabetes management in General Practice, 2012. p.16). Clearly the continuation of lifestyle as it was in the time of pre-diabetes is hazardous to health and the diabetes management goal would be a difficult or impractical one to achieve in that situation.

**Control misused; an idiosyncratic conceptualization of control**

What becomes evident from this study is that despite reasonable fluency in English; knowledge about health care and diabetes management; having a higher socio-economic status; knowledge of the health care system; and attending health professionals from the same ethnic and cultural background, people did not engage in active diabetes management. They insisted on autonomous and idiosyncratic decisions about the very things that they were recommended to control. Irrespective of whether their avoidance was overt or covert, all subverted the guidelines.

The medically recommended controls were exercised only in phases when control mattered to them: mainly to maintain the positive impressions they had created with their doctors. The idiosyncratic regimes of the participants of my study did not derive from the capitalist values that clinical guidelines of diabetes management originated from (Ferzacca, 2000) but from factors such as convenience and the need to maintain these positive impressions created with the doctors. As a matter of fact, Sri Lankans were in many respects quite committed to capitalist values of individual
endeavor and personal achievement of financial security, but none of this was applied to diabetes management.

My research participants’ idiosyncratic regimes were more directed to the fulfillment of personal desires that derived from several particular sociocultural values and experiences as migrants. Alienation, social and cultural uprootedness, and experiences with racism, meant that they sought emotional comfort in particular cooking practices and eating patterns that were often at odds with effective diabetes management. These practices derived from their culture and upbringing rather than the recommendations of health professionals. When they were beset by anxieties or emotional set-backs, participants tended to resort to the familiar; more often than not their comforts were Sri Lankan habits and practices that were associated with childhood. Management strategies such as following a diabetes friendly diet and engaging in physical activity were given importance only during times that were close to the next doctor’s appointment.

**Biographical reinforcement and keeping life under control**

Although people had made some changes to their diets and despite the incorporation of exercise into their daily schedule by very few (only four participants), these changes and incorporations were sporadic; they were not permanent or stable changes to lifestyle. Though it might be expected that their lives were disrupted by contracting a chronic illness, subjectively they did not experience this as life changing. They continued consumption patterns that had formed before becoming diabetic; they continued to work in the same manner and were not eager to incorporate physical exercise in their daily schedules. They continued to take part in familial and community festivities and celebrations that revolved around traditional foods that were inconsistent with diabetes management. The ardor and the eagerness that participants of all backgrounds showed in maintaining their pre-diabetes lifestyles demonstrates an important trend that few previous researchers have observed in people with chronic illness: “biographical reinforcement” (Carricaburu and Pierret, 1995, p.82; Williams, 2000,p.50). The Sri Lankans’ confirmation or reinforcement of biography contrasts with the assumption that chronic illness is a biographical disruption (Bury, 1982; Williams, 2000). Conceptualized by Michael Bury (1982) chronic illness is depicted in the literature as a major disruptive experience and a critical situation in everyday life.
structures (p.169). The analysis of chronic illness as a biographical disruption encompasses three ideas: that it is a disruption of taken for granted assumptions and behaviors, a disruption in normal explanatory systems, and disruption concerning the mobilization of resources (p.169-170).

The tendency for biographical reinforcement can be attributed partly to their migrant status. Many of my participants’ accounts of migration demonstrate that their assumptions and behaviors, their explanatory systems and normal responses, have already been disrupted by the complex process of migration and the need to conform to the norms of their host society. In addition to this, they experienced feelings of exclusion from both the wider society and occasionally from their own ethnic community. Prevailing class and cultural divisions generated alienation and estrangement within the community. So there is a tendency to oscillate between the world of Sri Lanka and that of Australia, which generates feelings of temporariness in the participants’ lives in Australia. Perceived uncertainty concerning their social and economic circumstances added to their unease. The uncertainties that were posed by diabetes, which included oscillations of participants’ sugar measurements, augmented their difficulties. I argue that the migrants’ uncertainties in the outside world as well as in their individual life worlds as diabetes patients, motivated them to hold on to the aspects of life that they could be in control of, such as their habitual ways of cooking and eating, socializing and even earning a living. The participants’ inclination to perceive diabetes causation and management as attributable to the collectivity is not pervasive in all other aspects of life. They were very focused on attaining familial financial stability and providing their children with a good education, the two major reasons for migrating. In attaining these objectives, people engaged strongly with individualistic, capitalist values, which is to say that they were focused on being productive, concerned about being progressive, and concerned about work ethic and self discipline. Very few women stayed home as housewives and most men had more than one job. When examining this situation in depth, their tendency to attribute the responsibility of diabetes management to the collectivity could be even regarded as a form of escape from the responsibility that lies with the individual (or the self) in the process of managing the disease.

It is my contention that transgressions of diabetes management guidelines were in reality, manifestations of control over what was controllable in their life. Diabetes guidelines, knowledge
about diabetes management, and awareness of the importance of efficient diabetes management were irrelevant to this course of action.

One of the most important findings in this ethnography is that even though the Sri Lankans in Australia received most of the services that their fellow Sri Lankans living back home are lacking, and facilities that their health professionals assumed could help them achieve better diabetes management, other barriers remained. These were mainly migrancy-related aspects of their lives that prevented them from taking active responsibility for diabetes management. The nostalgia for the past and hopes for the future, negotiating the precarious nature of migrant existence perhaps would not be that different from any human life. What this ethnography demonstrates is that people tend to frame and understand a chronic illness from their own life perspective and circumstances and not from how the medical professionals conceptualize the management of a chronic illness that is often devoid of lived experience of it; hence have to be understood their managing or not managing a chronic disease and refusing responsibility for lifestyle diseases.

**Why and how are these findings important and be used**

When taking all these aspects of the participants' lives into account, one important issue that becomes evident is that they chose not to reflect upon their own behavior regarding diabetes management, despite having information and knowledge about the nature of the disease and the importance of regular control. Even those who were initially motivated to control diabetes, and who understood and experienced the ways and mechanisms of blood sugar control – especially in the initial period of diagnosis in Australia – their motivation waned with time, disease progression and especially with other pressures of life some of which were unique to their migrant status. Some of these pressures were specific to a migrant group who came from a culture that gave emphasis to symbolic representations of a class structure and hierarchy. One of the important consequences of this non-reflexive (in medical terms this may be defined as non-compliant) behavior regarding the continuous or regular management of diabetes is the early onset of other chronic conditions. As diabetes is a chronic illness that leads to a conglomeration of other health complications with disease progression, improving blood glucose levels (improved glycemic control) is a key long-term goal of treatment, achieved by the incorporation of regular self
management and monitoring and medical monitoring (Diabetes Australia, 2012). Regular self management through diet and exercise is only occasionally adhered to by the group of Sri Lankans, and even this occasional adherence was met with many challenges that were in fact precipitated by many circumstances related to their socio economic situation in Australia. These include their specific social situation in the host society as migrants from a South Asian developing nation, their socio economic situation in pre migration period, or the rung in Sri Lankan social hierarchy they belonged to before migration, and their idiosyncratic relationship with their doctor.

It is clear from this study and from anthropological insights such as those of Dumont, that the cultural value of relationality, especially towards close kin, in some way inhibits notions of individual responsibility, recasting it as selfish or solipsistic. Perhaps if health professionals were encouraged to take this into account when advising self-care, patients would respond differently. For example, the diabetic patient could be given information concerning the likelihood of genetic propensities and the need for the whole family to consider adopting habits (such as taking regular exercise and choosing foods that were on the low glycaemic index) as both a management and a preventative strategy. Stressing the patient’s responsibility not only to self, but also for children, could promote better adherence to a healthy regimen.

Although diabetes management aims at glycemic control (control of blood sugar levels) it was precisely the control of blood sugar that the Sri Lankan participants tended to relegate and trivialize in their lives when it came to regular and consistent disease management. Rather, when wanting to assert their agency in relation to their illness, they focused on other aspects of their lives, which were not necessarily supportive of effective diabetes control.

Diabetes is a key public health priority and a major health concern for Sri Lankan communities here in Australia and in Sri Lanka. Understanding their comprehensions of the disease and its management is essential if it is to be successfully addressed, to avoid premature deaths and high public health costs. However what this ethnography demonstrates is that understanding is more than simple framing of literacy and access to medicine as the previous research has suggested, and as Sri Lankan doctors in Sri Lanka suggested. It is more than about "telling them what to do" or planning diabetes care based on strong pre conceived notions about Sri Lankans with diabetes. Instead, listening to the voices of these Sri Lankan participants, I realize that effective engagement with Sri Lankans living with diabetes will require health professionals making an effort to ‘make
sense’ of their lives, and of the role that diabetes has in their lives. This comprehension of patients’ lives must be achieved by health professionals before, or at least at the same time as, assisting them to engage with their diabetes. Further research into understanding the lived experience of diabetes will assist in uncovering implications for understanding other migrants and other Australians in their efforts to manage diabetes.
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Appendices

Participants

Plain Language Statement for Lay Participants

Plain Language Statement for Health Professionals

Plain Language Statement for Health Professionals for Observation of Clinical Encounter

Advertisement
## Participants

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Education level</th>
<th>Occupation</th>
<th>Age</th>
<th>Urban/Rural from Sri Lanka</th>
<th>The number of years in Australia</th>
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<td>Rural</td>
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<td>Twelve (Living with daughter)</td>
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<td>Occupation</td>
<td>Age</td>
<td>Location</td>
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<td>Occupation</td>
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<td>Navin</td>
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</table>
Plain Language Statement for Participants

“How do Sri Lankan migrants with type 2 diabetes in Australia experience and negotiate their illness”.

You are invited to participate in the above research which is being conducted by Mrs. Prabhathi Basnayake (PhD candidate), Dr. Richard Chenhall and Prof. Martha Macintyre of the School of Population Health at the University of Melbourne. This project is Mrs. Prabhathi Basnayake’s PhD research and it has been granted approval of the University Human Ethics committee.

The Aim of the Study

The purpose of this study is to explore how the Sri Lankans with type 2 diabetes in Australia experience everyday life and how they negotiate diabetes management as migrants in a foreign land. We would also like to know about how you negotiate the relationship with your doctor regarding the management of diabetes.

What should you do?

Should you agree to participate in this research, you will be requested to contribute to this in three steps.

First, you are requested to participate in an interview which would last for about 45 minutes to one hour at a place of your choice and a time that is convenient for you. At the interview you will be requested to express your ideas about experiences of type 2 diabetes in Australia, the strategies you employ to manage it, the challenges (if there are any) you face in managing it, and your experiences of being a migrant with diabetes in Australia. With your permission the interview will be tape recorded to ensure that we record exactly what you say.

Second, if you agree, I would like to observe and participate in an everyday public activity such as going on shopping or participate in a public cultural activity and/or in cooking and mealtimes in these cultural activities with you. Third, if you agree again, I would like to observe a session you spend with your health care provider (GP) regarding diabetes consultation. Should you wish to participate only in one or more steps of the research, you are welcome to express your interest in it and regardless of which step, your participation will still be considered very important in the project. The interview will be transcribed later and you will receive the copy of the transcription to verify their accuracy.
What happens after your participation?

We will take every possible action to protect your privacy and confidentiality of the information you provide. The information you provide in the interview, observation sessions and your personal information will be kept separately in a password protected computer. The linking of personal information to data can only be done by the researchers for purposes such as sending the transcripts to the correct research participant after the interviews. In the final thesis, you will be referred to as a pseudonym and all personal information will be deidentified. However, please note that due to the small number of participants in the research, there is still a risk for the participants being identified. After the analysis, the data will be kept in a locked filing cabinet at the School of Population Health and will be destroyed after a period of five years.

Please note that your participation in the research is entirely voluntary and you are also free to withdraw from the interview or any observation session at any moment. You can stop the interview or the observation session or the tape recording at any moment should you feel uncomfortable. Please be also advised that this is a social research and not a medical research and therefore will not have any implication on your relationship with the doctor.

Getting involved in this study does not pose any physical danger. However if you become upset or stressed over a revelation of any upsetting incident or situation I shall be able to provide you with the necessary contact information of a counsellor or a relevant organisation.

Findings of the study

The analysis of the data will be disseminated through a thesis. A summary of the results will be provided for you by post once the thesis is completed. It is possible that the analysis of these data will be presented at academic conferences and published in journal articles.

Benefits of the study

Although there may be no direct benefit to you from this study it will give you an opportunity to express your honest and deeply felt experiences and feelings about how you experience life in a foreign environment while having diabetes.

Should you wish to participate in this research please indicate that you have read and understood this information by signing the consent form that is provided with this letter.

If you have any concerns or questions of this project, please do not hesitate to contact Dr. Richard Chenhall on 8344 0826 or Mrs. Prabhati Basnayake on (the study mobile phone
number is yet to be determined) or on p.basnayakeralalage@pgrad.unimelb.edu.au. Should you have any concerns or questions about how this project was conducted please contact the Executive Officer, Human Research Ethics, The University of Melbourne on ph: 8344 2073, or fax: 9347 6739.
Plain Language Statement for Health Professionals for In-depth Interviews

“How do Sri Lankan migrants with type 2 diabetes in Australia experience and negotiate their illness”.

You are invited to participate in the above research, which is being conducted by Dr. Richard Chenhall, Prof. Martha Macintyre and Mrs. Prabhathi Basnayake (PhD candidate) of the School of Population Health at the University of Melbourne. This project is Mrs. Prabhathi Basnayake’s PhD research and it has been granted the approval of the University Human Ethics committee.

The aim of study

The purpose of this study is to explore how Sri Lankans with type 2 diabetes in Australia experience everyday life and how they negotiate diabetes management as migrants. We would also like to know about how they negotiate the relationship with their doctor, regarding the management of diabetes.

What should you do?

You are requested to participate in an interview which would last for about 45 minutes at a place of your choice and a time that is convenient for you. At the interview you will be requested to express your ideas about experiences of working with and treating Sri Lankans with type 2 diabetes in Australia, the strategies you have to employ to motivate them to achieve optimal control over the disease, the challenges (if there are any) you face in doing it, and your opinion of the needs of this group of people with diabetes regarding achieving optimal health. With your permission the interview will be tape recorded to ensure that we record exactly what you say. The interview will be transcribed later and you will receive the transcript to verify its accuracy.

What happens after your participation?

We will take every possible action to protect your privacy and confidentiality of the information you provide. The information you provide at the interview will be kept separately in a pass word protected computer. The linking of personal information to data can only be done by the researchers for purposes such as sending the transcripts to the correct research participant after the interviews. In the final thesis, you will be referred to as a pseudonym and all personal information will be de-identified. However, please note that due to the small number of participants in the research, there is still a risk for the participants being identified. After the analysis, the data will be kept in a locked filing cabinet at the school of population health and will be destroyed after a period of five years.
Please note that your participation in the research is entirely voluntary and you are free to withdraw from the interview at any moment. You can stop the interview or the tape recording at any moment should you feel uncomfortable.

**The findings of the research**

The analysis of the data will be disseminated through a thesis. A summary of the results will be provided to you by post, once the thesis is completed. It is possible that the analysis of the data will be presented at academic conferences and published in journal articles. The analysis of the findings may also be published in the Sri Lankan community Sinhalese newspaper.

**The benefits of the study**

Although there may be no direct benefit for you from this study, the research findings and analysis may help identify issues that Sri Lankan migrants with type 2 diabetes face in the management of diabetes. This may assist health professionals to gain in-depth understanding of the areas that they have to address in achieving optimal results in the treatment of diabetes of this group of migrants.

Should you wish to participate in this research please indicate that you have read and understood this information by signing the consent form that is provided with this letter.

If you have any concerns or questions of this project, please do not hesitate to contact Dr. Richard Chenhall on 8344 0826 or Mrs. Prabhathi Basnayake on 042 5152048 or on p.basnayakeralalage@pgrad.unimelb.edu.au. Should you have any concerns or questions about how this project was conducted please contact the Executive Officer, Human Research Ethics, The University of Melbourne on on ph: 8344 2073, or fax: 9347 6739.
Plain Language Statement for Health Professionals for Observation of Clinical Encounter

“How do Sri Lankan migrants with type 2 diabetes in Australia experience and negotiate their illness”.

You are invited to participate in the above research, which is being conducted by Dr. Richard Chenhall, Prof. Martha Macintyre and Mrs. Prabhathi Basnayake (PhD candidate) of the School of Population Health at the University of Melbourne. This project is Mrs. Prabhathi Basnayake’s PhD research and it has been granted the approval of the University Human Ethics committee.

The aim of study

The purpose of this study is to explore how the Sri Lankans with type 2 diabetes in Australia experience everyday life and how they negotiate the diabetes management as migrants. We would also like to know about how they negotiate their relationship with the doctor regarding the management of diabetes.

What should you do?

Should you agree to participate in this research, we request permission for Basnayake to observe a clinical observation of a consultation session you have with your Sri Lankan patient regarding diabetes management. At this stage a patient has already provided us with his/her consent for this. During this observation, I shall take down notes occasionally. This observation session will be transcribed later and you will receive a copy of the transcription to verify its accuracy.

What happens after your participation?

We will take every possible action to protect your privacy and confidentiality of the information you provide. The information you provide at the observation session and your personal information will be kept separately in a password protected computer. The linking of personal information to data can only be done by the researchers for purposes, such as sending the transcripts to the correct research participant after the interviews. In the final thesis, you will be referred to as a pseudonym and all personal information will be deidentified. However, please note that due to the small number of participants in the research, there is still a risk for the participants being identified. After the analysis, the data will be kept in a locked filing cabinet at the school of population health and will be destroyed after a period of five years.

Please note that your participation in the research is entirely voluntary and you are free to withdraw from the observation session at any moment. You can stop the observation session at any moment should you feel uncomfortable.
The findings of the research

The analysis of the data will be disseminated through a thesis. A summary of the results will be provided for you by post once the thesis is completed. It is possible that the analysis of these data will be presented at academic conferences and published in journal articles. The analysis of the findings may also be published in Sri Lankan community Sinhalese newspaper.

The benefits of the study

Although there may be no direct benefit for you from this study, the research findings and analysis may help identify issues that Sri Lankan migrants with type 2 diabetes face in the management of diabetes. It may assist the health professionals to gain in-depth understanding of the areas that they have to address in achieving optimal results in the treatment of diabetes of this group of migrants.

Should you wish to participate in this research please, indicate that you have read and understood this information by signing the consent form that is provided with this letter.

If you have any concerns or questions of this project, please do not hesitate to contact Dr. Richard Chenhall on 8344 0826 or Mrs. Prabhathi Basnayake on 042 5152048 or on p.basnayakeralalage@pgrad.unimelb.edu.au. Should you have any concerns or questions about how this project was conducted please contact the Executive Officer, Human Research Ethics, The University of Melbourne on ph: 8344 2073, or fax: 9347 6739.
Sri Lankan Diabetes Project

University of Melbourne

Have you migrated from Sri Lanka?

Do you have Type 2 Diabetes?

Researchers at The University of Melbourne

Would like to talk to you

about your experiences of dealing with diabetes (in Sinhalese or English,

And/or

Participate with you in a routine activity in connection with diabetes management

And/or

Observe a doctor’s appointment

If you would like to know more about this research please contact Prabhathi Basnayake on (042 5152048) or via e mail on p.basnayakeralalage@unimelb.edu.au.
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