Local healing in northern Thailand: An anthropological study of its effectiveness

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The study presented in this book uses HIV and AIDS as an example to develop a comprehensive understanding of the effectiveness of local healing in Northern Thailand. It is based on the perspectives of both local healers and their patients and sketches the origin and historical development of Northern Thai society and its healing tradition.

The study describes how the local healers formulated their explanations of HIV and AIDS. It presents the healing process as a transformation of various kinds of meaning and introduces different aspects of the meaning attribution by healers and patients to medicines and their effects.

The local moral world is considered as enabling a local healer to continue with his healing practice in a moral way. The desirable effects of this moral healing are addressed in detail.

The limitation of clinical trials and the perspective of local healers on clinical trials is also discussed. The study finally suggests a proper methodology for research on the effectiveness of local healing.

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Local Healing in Northern Thailand
An Anthropological Study of its Effectiveness

Yongsak Tantipidoke
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An Anthropological Study of its Effectiveness

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List of abbreviations and acronyms

AIDS Acquired Immunodeficiency Syndrome
ARV Antiretroviral drugs
ART Antiretroviral therapy
CMV Cytomegalovirus
GMP Good manufacturing practice
GPO Government Pharmaceutical Organization
HIV human immunodeficiency virus
NGO Non-governmental organization
NAPHA National Access to Antiretroviral Program for People living with HIV and AIDS
TRIPS Trade-Related Aspects of Intellectual Property Rights
WTO World Trade Organization

A note on Thai language and spelling

The spelling of Thai and Northern Thai words follows the guidelines of the Royal Institute of Thailand for the transcription of Thai alphabet into Roman alphabet (1999). Pali terms are written in Romanized Pali according to the Dictionary of Buddhism (Payutto 2002).
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Chapter I

Introduction
Methods to evaluate the effects of treatment are a central issue in health care and medical research. They have been used to judge the superiority of one specific treatment modality or one whole medical system over another. This superiority was once a core argument used by nation states to legitimize the official imposition of Western biomedicine, supplanting traditional medical systems like those of China (Hsiang-lin Lei 2002) and Thailand (Prathip 1998; Vichai 2002; Yongsak 2007).

It has been assumed that evaluation methods developed by biomedical science are universal and can be applied without doubt to every healing tradition. This assumption has led to the use of biomedical methods for evaluating treatment outcomes for all medical traditions. This biomedical supremacy has a significant impact, since the result of such an assessment can be used to decide whether a certain medical treatment or technique should be included in a country’s formal health care system and whether it deserves state financial support. Opposition to evaluation methods based on biomedicine from, for example, alternative medicine proponents in Western countries and traditional medicine in India, call for the need to rethink the assumption that such methods are universally applicable (Borgerson 2005; Villanueva-Russell 2005; Jackson et al. 2007; Chopra et al. 2010). Biomedical assessment has been criticized as inadequate and for ignoring elements that practitioners in other traditions consider important for an effective outcome.

Concern over how effectiveness can be assessed has been an important issue in the field of medical social science in general, and in medical anthropology in particular (Waldram 2000; Moerman 2002; Barry 2006). Studies on the effectiveness of healing from various settings and across cultures acknowledge the existence of other effects of healing than what is accepted by biomedicine. To further explore alternative possibilities for assessing traditional medicine, and to understand the effectiveness of healing from the point of view of healers and patients, this study takes HIV and AIDS as an example. In the past few decades, the HIV/AIDS epidemic in Thailand has triggered both popular and academic interest in the roles of traditional medical practices. Traditional healing and herbal medicine has been trialed within hospital settings, in research institutes, as well as among traditional healers in communities, particularly in Northern Thailand where the outbreak was most extensive. This study represents an attempt to seek an alternative interpretation to biomedical notions of efficacy in terms of how the effectiveness of local healing can be assessed.

In this introduction, I will first describe local healing in Thailand and its socio-cultural context to provide some background understanding, before outlining the objectives and methodology employed in this study regarding the role and effectiveness of local healing in Northern Thailand during and after the peak of the HIV/AIDS epidemic in the 1990s.
Situating local healing in Thailand

Although local healing, as found in Thailand today, can be seen as the result of the eclectic merging of a variety of healing traditions, it can nevertheless be separated into two major sub-traditions: the royal tradition and the local tradition. The royal tradition refers to healing practices which are guided by royal classical texts and whose practitioners are officially acknowledged and regulated through formal and semi-formal professional training, a license examination, and control by a professional body. The local tradition, on the other hand, refers to practices that are informed by local beliefs, traditions, and resources, and are directed by local norms and morals. Both traditions coexist in a relationship of interdependence and have a mutual influence on one another (Irvine 1982).

The development of the modern Thai state in the early twentieth century had a radical and long lasting influence on the role of traditional medicine in Thai society. The most significant outcome of this development was the exclusion of traditional medicine from the official health care system. This exclusion included the abolition of traditional medicine from the curriculum of the Royal Medical School and the medical service of the royal court. This exclusion was then finalized by an attempt to control medical practices through the enactment of new laws, which inhibited the development of traditional medicine (Irvine 1982; Yongsak 2007). This inhibition caused not only the loss of traditional medical knowledge and healers’ expertise, but also the loss of the social recognition of traditional medicine, which led to a discontinuation of both royal and local traditions. For local communities, the final outcome of this development was an increasing inability to rely on local knowledge and resources for their own health management.

It was not until the 1980s that initial attempts were made by non-governmental health organizations, the Ministry of Public Health, and health personnel in some local settings, supported by a World Health Organization (WHO) policy, to help traditional medicine regain its role in primary health care provision, and subsequently in primary care as part of the formal health care system. Nowadays, many governmental and non-governmental organizations take part in the development of traditional medicine from different perspectives. Among them, the biomedical perspective nevertheless has the strongest influence because most health personnel and policy makers are educated and/or have a career in biomedicine.

My experience as director of a Thai traditional medicine program and a researcher in traditional medicine for more than two decades has taught me that the development of traditional medicine tends to go in the direction of the separation of traditional knowledge from its inherent values. Recently, traditional medical knowledge has been treated like a thing that can be isolated from the healer and his or her social environment. The healers who use traditional knowledge tend to be concerned with the treatment of the disease itself rather than with the patients, their suffering, and their social environment. Traditional drugs have become artifacts that can serve commercial purposes. A new generation of traditional healers has been created by modern institutions that have an officially recognized standard curriculum; however, it may be questioned how far the students of such institutions achieve socialization in the spirit of the healers who preceded them. Finally, evaluation of the
effectiveness of traditional medicine, according to biomedical standard procedures, focuses solely on its instrumental effects and ignores other effects, which are considered meaningful by healers and their patients.

The further development of traditional medicine, as driven by reductionism, commercialization, and institutionalization, is found not only in Thailand but also in many other parts of the world. It is the result of the general adoption of the biomedical perspective on how traditional medicine should develop. However, in several countries this adoption has been increasingly criticized by proponents of traditional medicine. The biomedicalization of traditional medicine leads, namely, to an abandonment of traditional medicine’s holistic and person-oriented approach, in which ample attention was paid to a patient’s social and spiritual well being.

The recent turn in the development of traditional medicine raises some important questions: Can we avoid the biomedically inspired direction that traditional medicine is currently taking and search for another way that is more in line with its origins? And what should be done by policy makers to ensure that policies, legal measures, and interventions are shaped corresponding to what is considered to be at the heart of traditional medicine?

To define what the heart of traditional medicine is we have to take into account specifically what the healers consider important to their healing tradition. We can identify this within the practices of healers who live and work in the communities to which they belong, and which are in the tradition of indigenous medicine. I will refer to these healers in this book as ‘local healers.’ Based on this assumption about how to identify the heart of traditional medicine, for this study I looked for local healers who play their role as healer and conduct their practice in a way that is grounded in what they know of the roles and practices of their predecessors. I decided that the HIV/AIDS epidemic in Chiang Mai, a province with a very high prevalence rate of HIV and AIDS, and the center of the HIV/AIDS struggle in Northern Thailand, would form an appropriate setting.

HIV stands for the human immunodeficiency virus, which is a slow replicating retrovirus that causes the disease known as AIDS (acquired immunodeficiency syndrome). In this study, the term ‘HIV’ is used when a patient is diagnosed as infected with HIV, but before it has developed into AIDS. The term ‘AIDS’ is used when severe damage to the immune system has occurred, which makes the body vulnerable to a variety of life threatening infections and cancers. When both are explicitly referred to, the term ‘HIV and AIDS’ is applied. If patients and/or healers, and/or myself as the researcher, could not be sure whether the term HIV or AIDS was most appropriate, the term ‘HIV/AIDS’ has been used.

Local healers in the province of Chiang Mai have played a crucial role in helping people with HIV and AIDS to deal with their illness within their communities. Some of these healers have been practicing for almost two decades. Antiretroviral therapy (ART) has been available free of charge in the formal health care service since 2007, but before the advent of free ART, the response and practices of these local healers and their patients after receipt of an HIV positive diagnosis can be considered to be at the core of this study of traditional medicine.

Based on my assumptions about how best to obtain answers to my questions about the role of traditional medicine in contemporary Thai society, I selected for my study local healers
who would be able to reflect on their healing experiences and evaluate their practices focused on treating patients with HIV and AIDS. The reflections and evaluations of the healers themselves were then analyzed so that they could be related to the issue that is considered to be at the center of any healing tradition, namely its effectiveness.

The expectation that the healers I selected would indeed be the best source for obtaining insight into what traditional medicine has to offer in terms of healing was justified based on the fact that, at the time I conducted my study, the duration of the experience of the healers with treating HIV/AIDS patients was long enough for them to conduct a self-evaluation of their etiological hypotheses, principles of treatment, and the effectiveness of their healing methods, including the specific medicines they used. Once the first phase of the HIV/AIDS epidemic, during which time biomedicine could offer no effective treatment, had passed, the time was ripe for these local healers to reach some conclusions regarding the issues that matter in their healing tradition.

The local healers who were selected for this study do not represent all local healers in Northern Thailand, either those with or without experience in HIV and AIDS treatment. This study uses a small sample of selected local healers as a way to investigate what local healing has to offer in terms of treatment for HIV and AIDS. It attempts to find out what matters in the local healing tradition and how this affects the effectiveness of healing, both from the perspective of healers and patients.

In order to conduct a study about local healing and its effectiveness, a theoretical perspective is needed which includes concepts referring to the interrelated components of local healing in its frame of analysis. This requirement can be achieved when healing is considered a process that takes place in a local world in which the meaningful experiences of healers and patients interact with a larger cultural framework that guides their beliefs and practices.

**Theoretical concepts**

The concepts of pluralism and local systems of health care have been used to situate local healing in the overall system of health care in Northern Thailand. By analyzing local healing in a real situation at community level, it has been possible to view it as a form of healing that is situated in a space in which healers and patients intersubjectively participate in the healing process. The nature of this process asks for a holistic exploration of the effectiveness of local healing. The main theoretical concepts I use for this purpose are the local world and its moral aspects, in addition to the concept of the healing process itself. The way I use the concept of effectiveness in case of local healing will be clarified through a discussion of debates about the concept of effectiveness as compared to the concept of efficacy, as represented in medical and anthropological literature.

**Pluralism and local systems of health care**

Pluralism in health care is a widely used concept in medical anthropology. It was developed based on cross-cultural studies that found that health care in any society is not confined solely
to the official health care system dominated by modern medicine. In addition, healers from other traditions play an important role in providing health care, most often in a way that patients are culturally familiar with (Helman 2000: 50). In other words, no healing tradition can serve every health care need of people living in a particular society. Pluralism of health care is therefore a phenomenon that is common around the world (Komatra 2004).

Kleinman (1980) introduced a model of three overlapping and interconnected sectors of a local health care system that has subsequently been used frequently in medical anthropology to map the pluralism of a given health care system. The model distinguishes three sectors of a health care system: the popular sector, the folk sector, and the professional sector. The popular sector is the domain where ill health is first recognized and defined, and health care activities initiated. These activities include consultation of other lay people in one’s living environment, soliciting advice on care seeking in the other two sectors, and evaluation of the outcomes of the various sorts of care that have been received. The folk sector is the domain of folk healers who are specialized in different forms of healing - sacred, secular, or a mixture of the two. Health care in both the popular and folk sectors usually relates closely to beliefs and values that are part of the cognitive structure of the community and usually differ from those of the professional sector, which is mostly occupied by modern biomedical practitioners. The latter tend to consider the beliefs and behavior of patients and lay persons, as expressed in the popular sector as well as those of folk healers, as irrational and unscientific.

When considering local healing from the perspective of pluralism, and considering the interrelatedness of the three health care sectors, it is required to clarify to which sector local healing belongs or whether it is the result of a mixture of certain sectors. The question of how local healing intersects with modern medicine in the professional sector also needs to be clarified. Other questions that arise are: How dynamic is the healing in a local community? How do therapeutic options that are available in the wider society influence the decisions of local people? How do local healers adopt knowledge and practices that belong to other healing traditions? And how do they affect the effectiveness of healing?

The local world and its moral aspects

The concept of the local world refers to a bounded sphere where everyday life is enacted and transacted and experience takes place. This sphere can be a village, a household, a social network, a neighborhood, a workplace setting, an interest group, an institution, a transient community, or even a transcontinental network in our globalized world (Kleinman 1999: 358; Yang et al. 2007). Usually, a local world is not completely shielded from the outside world, and the extent to which - and how - macro-level forces intrude in local worlds and interact with everyday life practices and experiences is a common theme addressed in ethnographic studies. It is also a theme of this study.

According to Kleinman, even though processes of contesting and negotiating actions take place in local worlds, these worlds are unified through the use of ‘the symbolic apparatuses of language, aesthetic preference, kinship and religious orientation, rhetoric of emotions, and commonsense reasoning, which, to be sure derive from societal-level cultural
traditions, yet are reworked to varying degrees in local contexts’ (1995: 124). Therefore, through the examination of these symbolic forms, which ‘work through individual and collective involvement in community activities to construct the flow of experience’ (ibid.), anthropologists can gain insight into the way a local world is structured.

It is through experience in a local world that one can acquire a moral life. Kleinman defines experience ‘as the felt flow of interpersonal communication and engagements’ (1999: 358), which takes place in a local world. He points out that experience is moral ‘because it is the medium of engagement in everyday life in which things are at stake and in which ordinary people are deeply engaged stake-holders who have important things to lose, to gain, and to preserve’ (ibid.: 362). Large-scale forces may impinge upon and remake what matters most for ordinary people, so they shape moral experience. This shaping involves the interaction of three things: cultural meaning, social experience, and subjectivity (inner emotion and sense of self). When each of these aspects changes, the others consequently alter as well (Kleinman 2006a: 836). There are many dangers to social experience that order the course of social processes (Kleinman 1999: 362-365). These dangers include suffering and its causes, uncertainty, and social change, as this book will demonstrate.

In his book What Really Matters (2006b), Kleinman chronicles the stories of the moral experiences of ordinary people and relates how they deal with the abovementioned dangers. He shows that at the moment of such danger, people are urged to reflect upon who they are, what they believe in, and how they engage with the local world. These moments provide an opportunity for people to strive for what matters to them. In other words, individuals who are caught in difficult circumstances and have been challenged by the world around them may respond by struggling to make sense of their moral experience, to find their own moral path in their world, and shape their response to such circumstances.

Difficult situations and troubles that confront people with an ethical dilemma may lead to moral breakdown. According to Zigon (2007), when faced with an ethical dilemma, persons or groups of persons may become committed to finding a way to resolve the particular ethical dilemma or problem. To get out of the breakdown, ‘persons or groups of persons are forced to step-away from their unreflective everydayness and think-through, figure out, work on themselves and respond to certain ethical dilemmas, troubles or problems’ (ibid.: 140). The aim is to get back to the unreflective moral disposition of everyday life, which, however, will never be the same. When people have worked on themselves, it will change their very way of being in the world.

In this study, the concepts of local worlds, moral experience, and moral breakdown will be used to analyze the intersubjective activities of the healers, patients, and other local people, as performed in their social world and in the healing process. While doing so, the study will reveal social, historical, and cultural forces that influence the local world of healers and patients. It will also look at the internal components that structure the local world, among which is local medical knowledge. The study unfolds how local medical knowledge in Northern Thailand was partly interfused with biomedical knowledge and how it influenced the way in which people initially dealt with HIV/AIDS and thought about the effectiveness
Introduction

of healing. Local cosmology is also explored as it situates the sacred things in the local world to clarify how it relates to local medical knowledge. Moral value as part of cosmology is also taken into account to explore how it shapes the moral world of the healers and how it influences the way in which patients think about healers. This study also explores how healers and patients acquire moral experience in a way that is believed to be advantageous to the healing outcome. It then investigates the period in which healers have experienced a moral breakdown, to search for what matters to their healing tradition.

The healing process

Healing is an active response created by humanity to deal with uncertainty, illness, suffering, and harm. Human healing goes beyond animal instinct because human beings can create knowledge from experience. They assemble, systematize, and share this knowledge, and transfer it from generation to generation. Various systems of healing knowledge have been developed throughout the history of humankind. The development of a system is always aimed at the effectiveness of healing, since this is the core of its outcome.

Healing systems may, however, deal not only with ‘how questions,’ such as: How to practice effective methods? How to gain maximum effectiveness with limited resources under real circumstances? How to achieve effectiveness in the sense of a broad accessibility for everyone? A system may also deal with ‘why questions,’ such as: Why does the suffering occur? Why does this person have to suffer? Why is someone a healer? Why is the healing successful? And why does the healing fail? The answers to these how and why questions are likely related to the effectiveness of healing as perceived within a particular culture, which may differ from perceptions of healing as practiced in another culture.

The concept of the healing process, which mediates between healing procedures and healing outcomes, is a concept that can help researchers to investigate healing effectiveness while taking the answers to the various how and why questions into account. It encompasses all the components of any part of the process involved in healing. Many of these elements have been listed by Csordas and Kleinman (1996: 10-11) in their discussion of the four distinct senses in which the concept of therapeutic process has been used in the related literature. The first conceptualization is of the process as the unfolding of a specific treatment event. Process is understood as the sequence of actions, phases, or stages undergone by the participants or as constituted by elements of verbal and other kinds of interaction and interpersonal relationships between therapist/healer and client.

The second conceptualization is in terms of experiential process. In studying this type of process, the focus is on the experience of healers and patients regarding the sequence of mental states, the emergence of insight, the interpretation of religious experience, and internally derived symbolic or somatic processes. This perspective may consider only the experience during a discrete therapeutic event or it might also look beyond. In the third conceptualization, the process is viewed as the progression or course of an illness episode. It focuses on the decision making process and the use of a variety of health care alternatives within a situation of medical pluralism, in which not only the patient and healer but also
the surrounding people are involved. It also includes the study of health care systems as complexes of health care resources in a society where professional, folk, and popular sectors interact with each other.

The final conceptualization goes beyond specific healing events and focuses on the broader economic, social, and political constraints, specifically social and ideological control, that affect individual suffering and healing practices. In my study of what I call the healing process - instead of the therapeutic process - most of the elements identified by Csordas and Kleinman are attended to.

In summary, the healing process in this study is identified in terms of the whole process of a specific healing event, such as the healing ritual or healing encounter in a certain setting; the process of decision making to seek health; the process of negotiation in the selection of a particular healing option from multiple health resources, and the interaction between or complementarity of these resources; the process of experiential change inside the body; and the mind of the healer as well as of the patient. These changes may occur during the healing event as well beyond the event itself. I also include in the scope of my study of healing processes the process in which socio-political control affects healing procedures and outcomes.

Effectiveness of healing

The terms ‘efficacy’ and ‘effectiveness’ are frequently used in medical literature in reference to the outcome of medical treatments. Seemingly similar in meaning, they actually express distinct ideas. Both efficacy and effectiveness assure that a treatment does more good than harm. Efficacy is the extent to which an intervention (technology, treatment, procedure, service, or program) has the expected benefit when delivered under optimal or ideal conditions. For instance, in a trial studying efficacy, bias is excluded as much as possible and concomitant medication and other co-interventions are avoided. A treatment is considered efficacious when it proves to be superior to a placebo or another treatment of known efficacy. It is essential to clearly state the populations and the outcomes for which efficacy is claimed. Effectiveness, on the other hand, is defined as the extent to which an intervention achieves its intended effects when delivered under more real life or everyday life situations, for example routine clinical care. Thus in a trial studying effectiveness, concomitant medication and other co-interventions might be carried out (Pittler and White 1999; Society for Prevention Research 2004).

Efficacy and effectiveness have become a recent topic of debate in Thailand, since in the national health service delivery both are used as a selection criterion for treatment interventions. However, attempts to measure the efficacy of healing interventions other than those deriving from modern biomedicine have been considered by critics of these attempts as philosophically and theoretically problematic (Villanueva-Russell 2005; Barry 2005; Borgerson 2005; Goldenberg 2006). It is argued that philosophically, biomedicine’s view of efficacy, which focuses on the removal of symptoms and diseases, is too reductionistic to evaluate treatments of other healing traditions that deal not only with the curing of diseases
but also with the affective, social, and spiritual well-being aspects of illness. Theoretically, the differences between knowledge of human anatomy and physiology, disease etiology, classification, and diagnosis in biomedicine and in other healing traditions call for different criteria for the evaluation of treatment outcomes and thus sets of definitions and measurements of these outcomes.

Shankar (1995) points out the distinction between modern and traditional approaches in knowledge verification. While modern experiments need to isolate a study object from its environmental context and limit confounding factors in order to measure the effects of varied controllable parameters (efficacy), the traditional approach attempts to examine a study object in its entirety together with its interlinkages and complexities (effectiveness).

This distinction in terms of the verification of knowledge within modern and traditional medicine refers to the different epistemological approaches that underlie effect evaluation in terms of either efficacy or effectiveness.¹

Lack of awareness of the difference between medical theory and epistemology, as used in modern and traditional medicine, can lead to contradiction. Adams et al. (2005) demonstrate this problem in a study of differences in efficacy and effectiveness interpretations between Tibetan medical doctors and biomedical doctors. In clinical studies of the treatment of growths in the uterus and treatments of symptoms associated with the Helicobacter pylori infection, the empirical evidence from Tibetan diagnostic procedures confirmed that the humoral imbalance had been corrected and the symptoms had disappeared. To the Tibetan medical doctors, the results were considered a good outcome and affirmation of the effectiveness of their healing methods. The empirical results from scientific tests — i.e. ultrasound and microbiological tests — attested the opposite, however. The underlying disorder was found to persist and thus indicated instead the inefficacy, as the biomedical doctors called it, of the Tibetan medical doctors’ methods. The study of Adams and colleagues calls into question the validity of applying an assessment of biomedical efficacy, which is rooted in a certain medical theory and epistemology, to evaluate the effectiveness of traditional medicine based on a different kind of theory and epistemology.

Based on these debates, it has been proposed that mere scientific proof of symptoms and disease removal is inadequate for understanding the effectiveness of traditional medicine (Waldram 2000). This current study assumes, therefore, that in order to explore the effectiveness of any healing practice in depth, one must focus on the medical theory and related knowledge that underpins the way in which healers and patients view health and illness. One should also pay attention to the meaning that healers and patients render to the core components of healing, which are supposed to promote its effectiveness. The local world which nurtures such knowledge and meaning should also be a focal point of study.

¹ Epistemological issues concern philosophical questions: What is knowledge (the nature and the sources of medical knowledge)? How does one obtain knowledge? How is knowledge justified?
Chapter I

Traditional medicine in Thailand: From past to present

The following sections briefly describe the origins and the present situation of traditional medicine in Thailand, as well as the problems faced in the development of traditional medicine and the study of the evaluation of its outcomes. It reveals the forces that have revitalized traditional medicine, the main approaches that inform the different ideas about its effectiveness, and the direction of its development within the Thai health system.

Heritage from the past

The origin of traditional medicine in Thailand is as vague as the origin of the Thai people. It is generally assumed that the history of traditional Thai medicine started in the Sukhothai period in the thirteenth century. A department of traditional medicine was later established at the court of the Kingdom of Siam in the fifteenth century during the early Ayutthaya period. However, healing practices can be traced back to at least the Dvaravadi period (seventh to eleventh centuries), which preceded the era of the Thai kingdoms (Thida 1995).

The old medical scriptures, like religious scriptures, were inscribed in Pali, the language of the sacred literature of Theravada Buddhism, an Indo-Aryan language originally developed in India. They were written in the Khom alphabet and then translated into Thai. When their contents are considered, one must conclude that to some extent they are related to traditions in India or Sri Lanka. Some scriptures refer to Buddha’s personal doctor Chiwaka Komaraphat and to the Indian Buddhist monk Mahathen Tamyae. One medical scripture is entitled Tamra Ya Langka or the Pharmacopoeia from Sri Lanka. A number of drug formulas are composed of plants alien to Thailand, and which refer to materia medica in the Ayurvedic pharmacopoeia. Some formulas such as Triphala and Trikratuk are Indian in origin. Even a sophisticated disease etiology, with disease categories based on wind (vata), fire (pitta), and phlegm (semha), refers to the three basic principles of energy or biological humor (tridosha) that comprise life according to Ayurvedic medicine. Buddhism has also strongly influenced these medical scriptures, but local knowledge is in general also present in these classical scriptures, like in the manuscripts of local healers.

Nowadays, the major classical textbooks of traditional Thai medicine include Tamra Phraosot Phra Narai (King Narai’s Pharmacopeia), Tamra Ya Silacharuek Wat Phrachetuphon (Phrachetuphon Temple’s Medical Inscriptions), Tamra Phaetsat Songkro (Textbook of Medicine for Assisting Patients), and Khamphi Phaet Phaen Boran (Ancient Medicine Scripture). With the exception of the latter, these scriptures were revived by the Siamese court in both the seventeenth and nineteenth centuries and are considered to cover the royal medical tradition. Apart from these classical scriptures, a vast number of scriptures are still found in local communities, especially in the houses of local healers and monasteries. In

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2 The Kingdom of Siam refers to a territory controlled by Thai ethnic groups that basically consisted of present day Thailand and some parts of its neighboring countries. Its history is divided into four periods: the Sukhothai period (1238-1351), Ayutthaya period (1351-1767), Thonburi period (1768-1782), and Bangkok period (1782-present). After the Second World War, the former name Siam was replaced by the current name Thailand.
general, in communities close to the center of the kingdom, medical knowledge attached to the royal tradition can be found, while in remote communities local traditions are more common.

**Revival of traditional Thai medicine**

As mentioned earlier, the continuation of the healing tradition in Thailand entered a crisis when the government adopted Western biomedicine as the mainstream health care modality for the country in the early twentieth century and abandoned the heritage of traditional healing. This lasted for almost a century, until the revival of traditional medicine in the 1980s. There are three different but parallel developments that explain this revival. The first is associated with the commercialization of health products and the Thai government’s export oriented economic policy. The second concerns the professionalization of traditional medicine and its integration into formal health services. The final development is based on the idea of community rights, and involves the revival of local healers’ role in communities.

**Commoditization of traditional medicine**

The commoditization of traditional Thai medicine is the inevitable consequence of the drive to increase its export value and satisfy the growing demand among the Thai middle class for traditional healing. In Thailand, the market for herbal medicine products in 2005, for instance, was valued at approximately 8.8 billion baht (220 million euro), according to a report by the Thai Farmers Bank Research Center (2005). If the value of herbal products in the form of dietary supplements and cosmetics are included, the figure reaches 48 billion baht (1.2 billion euro). The consumption of herbal products by Thai middle class people has been expanding by 20-30 percent annually in recent years, partly as a result what is a global trend of interest in natural health care, natural health promotion campaigns, and increasing awareness of the danger of synthetic chemical drugs.

Thai national policy on the development of herbal products has been guided by the prospect of and potential for trade and export, thus with an emphasis on research and development of such products. Medicinal plants that have a potential for being marketed for sale and export have been given top priority for scientific research. Some have been developed as herbal products in modern dosage forms to suit modern lifestyles. Herbal products for beauty and anti-aging, food supplements, as well as body tonics have become very popular among urban middle class Thai consumers.

This situation raised questions for me as a researcher, such as: Which sectors gain most from transforming certain traditional healing techniques and herbal drugs into commodities and services? And to what extent is the benefit generated from this commercialization invested in elementary research and development of traditional medicine knowledge?

The experience of Ayurvedic medicine in India shows that the commercial benefits from branded herbal products that are widely sold over the counter come at the cost of traditional drugs that are based on sophisticated herbal formulas. The use of traditional drugs prescribed by Ayurvedic practitioners is in decline because pharmaceutical firms no longer make them in
sufficient quantities. The proliferation of over-the-counter brands also undermines traditional practitioners because their expertise in diagnosis and tailor-made treatments is no longer required by consumers (Bode 2006). This also seems to be the case in Thailand, although a solid study on the matter has yet to be conducted. In fact, person-oriented remedies prescribed by Thai traditional practitioners have already become a rarity as the result of the decline in medical expertise of present day practitioners, most of whom lack apprenticeship experience. The situation hardly gives either practitioners or consumers any choice but to use ready-made herbal medicines produced by manufacturers or traditional clinics, and in the absence of a thorough examination of individual patients.

To ensure safety and promote consumer confidence, scientific evidence of efficacy and production standards have become requirements for herbal medicine products. Furthermore, registered herbal products can indicate only officially approved effects on their labels. Although many of these herbs were traditionally applied for much more varied purposes, the authorities consider such wide usage to have been based on false claims, as long as these applications are not scientifically proven. Calls from well educated consumers, biomedical practitioners, and academics have spurred policy makers to put the need for research on herbal products on the agenda of the national strategic plan for traditional Thai medicine development. In parallel with this development, Good Manufacturing Practice (GMP) has become a standard for the production of traditional medicine and herbal products that are marketed nationwide.

Traditional medicine revivalists have expressed doubts about the trend toward reliance on scientific research to prove the efficacy of traditional and herbal products. Among the questions they have raised are the following: How can a proof of efficacy that is developed from the perspective of biomedical disease theory be applied to traditional medicine products that are based on different disease theories? How can a proof of efficacy be conducted in the case of personalized healing, in which a tailor-made formula is needed? How can a proof of efficacy be designed for traditional drugs that require empowering through blessing rituals without deceiving the patients? These questions cannot be answered if traditional disease theory and its epistemology are not clearly understood.

**Institutionalization of traditional Thai medicine and its integration into formal health services**

The revival in Thailand of traditional medicine and the boom in herbal products and the spa industry have also produced a surge in the expansion of traditional medicine training and education. Since 1997, the number of newly licensed traditional medicine practitioners has dramatically increased (Yongsak 2006b). Most of them are well educated people from the middle class who are interested in self-care and who looked for opportunities in the health care business after the economic crisis of 1997. This trend produced a bandwagon effect, which is evidenced by the almost two dozen universities that opened bachelor degree programs in traditional Thai medicine in the past decade. In Northern Thailand, two universities in Chiang Rai have participated in this trend.
The major problem that these educational institutions face is the fact that traditional Thai medicine has remained to a large extent an obscure and incoherent field. To address this problem, a university that offers a program on folk medical knowledge will incorporate well researched folk healing knowledge and practices into traditional medicine training. Others have tried to develop traditional medical knowledge by applying their own theories or by taking a dual approach of teaching both Western medical subjects - anatomy, physiology, pathology, and diagnosis - and traditional medical knowledge as recorded in the classical texts. Nevertheless, training and research in all the programs are invariably grounded in biomedical science.

Some traditional medicine revivalists have expressed concern about the approach of these programs and have wondered whether the outcome of this patchwork of biomedical and traditional knowledge will become even more problematic if the differences in their philosophical foundations are not made clear. Might the disease theory and diagnostic procedures of biomedicine not possibly confuse the student, for example, or make him belittle traditional knowledge instead of increasing his understanding? How can insight into the interpretation of scientific evidence that stresses diseases and symptoms be extended to interpret the mental and social dimensions of health and illness as focused on in traditional practices? How can these programs help their students to recognize the limits of biomedical science when evaluating the effectiveness of traditional medicine? These questions have, however, not been addressed as critically as those concerning the modernization of dosage forms of traditional drugs or services.

The Thai National Health Security System was launched in 2001 to cover the 47 million people who were not enrolled in the two existing health care schemes, namely the Civil Servant Medical Benefit Scheme for public employees and the Social Security Scheme for private employees. Currently, the healthcare benefits of this scheme range from health prevention and health promotion to primary care and hospital care, and it includes a focus that ranges from common illnesses, traffic accidents, and renal replacement therapy, to access to antiretroviral therapy for HIV and AIDS patients. This universal health coverage scheme has given a big push to the integration of traditional medical practices into the biomedically dominated health care system. The current payment system for the universal health coverage scheme, which pays health service units in lump sums per capita has, however, been identified as one factor that has hindered the prescribing of herbal drugs and other traditional healing procedures. An additional payment system has been set up to enable health service units to provide standard traditional healing services, the quality of which should be guaranteed by clinical practice guidelines. It is believed that this standardization will be a tool not only for assuring the quality and effectiveness of traditional medical services, but also for limiting the over-utilization of non-medical services in the health security scheme, such as relaxation massage and traditional spa treatment.

In order to promote the utilization of herbal medicine in health care systems, the National List of Essential Medicines was formulated in 1999, and has been revised in 2006 and 2011. In the process of drug selection, the evidence of effectiveness from traditional use has been
taken into account (National Drug Committee 2006). However, both initiatives - the Thai National Health Security System and the National List of Essential Medicines - have raised a new set of questions: How can the evidence of the use of traditional medicine be developed beyond what is recorded in the classical texts? As for the proposed clinical practice guidelines - if there should be any at all - what kind of evidence is needed to confirm that the medicines or modalities will work effectively? How can the clinical experience of traditional healers be included as input into the development of the guidelines? To answer these questions, the evidence of effectiveness from a traditional perspective, as well as the embodied knowledge and day-to-day experience of traditional healers, need to be investigated.

Local healing by local healers

At the peak of the HIV/AIDS crisis in Thailand, enthusiastic cooperation among local health providers, NGOs, communities, and local healers led to the implementation of NGO proposals on holistic and alternative health care at many local health centers in Northern Thailand. Their purpose was to help people with HIV and AIDS to treat themselves and adjust their lifestyles through a combination of several practices, such as taking herbal concoctions and natural foods, practicing meditation and various mind-body exercises, avoiding prohibited foods, taking traditional drugs to find internal homeostasis, and treating HIV and AIDS related symptoms and diseases (Rangsan 2004). Applying traditional healing to HIV/AIDS patients, in combination with these holistic and alternative approaches as well as modern medicine, the local healers gradually learnt to acculturate to other modes of treatment and to the concept of holistic health.

The local healers’ participation in terms of healing people with HIV/AIDS in Northern Thai communities has from early on entailed the forming of networks. Proposals by the local healers’ network and their allies, arguing for community rights to apply local knowledge to manage community health care, were accepted as an important item on the national agenda in the health system reform movement (Komatra 2004; Yongsak 2006a). This means that local healers, who were once stigmatized as ‘quack’ doctors, actually succeeded for the first time to have their status legitimized as local healers who preserve local knowledge and adapt it, where needed, for the benefit of their relatives and neighbors in their local communities.

Many aspects of the experience of local knowledge in fighting HIV and AIDS have been explored by various authors and researchers, for instance the social movement of HIV/AIDS patients groups and networks (Chayan and Malee 1999; Thawat et al. 1999), the social movement of local healer networks (Yongsak 2006a), and the technical knowhow regarding indigenous and popular healing methods used by HIV and AIDS patients and local healers (Rangsan 2004; Sawing et al. 2006). However, some knowledge gaps have not been filled, especially from the perspective of local healers. For instance, in what manner has this kind of integration of medical and healing practices, as well as the empirical evidence that emerged during the HIV/AIDS crisis, affected healers’ perspectives on healing, or on effectiveness and ineffectiveness? What sorts of evidence are considered significant in their assessment of the
success of healing? To what extent does the underlying concept of health and illness of the local healers depart from the traditional medical texts? And to what extent has a biomedicalization of traditional medicine taken place, both during and since the peak of the HIV/AIDS epidemic in the 1990s?

The situation reviewed above indicates that applying biomedicine as an exemplar for the development of traditional medicine raises several questions. Most questions are related to the application of the concept of efficacy to measure the effects of local healing, whose basic characteristics fundamentally differ from biomedicine. The holistic concepts of health and illness, the experience-based knowledge system, the person-oriented approach of healing, the spiritual concern, and the medicines used are some of the most typical characteristics of local healing that are omitted from the present mainstream development of traditional medicine in Thailand. The situation is worsened when the study of traditional medicine by academics insists on focusing on proof of efficacy of medical procedures and medicines, without acknowledging the significance of their characteristics.

This thesis argues that to study the effects of local healing, the concepts of pluralism, local world and its moral aspects, healing process, and effectiveness - as presented above - have to play a role. Viewing healing as a process existing in the local world of healers and patients takes all components that can affect the healing outcome into account. This approach also serves to understand all aspects of the benefits of local healing, since the concepts of local world and healing process allow us to explore these aspects in a real life situation; aspects that range from personal and interpersonal to social changes; and from the physical, mental, and moral to the spiritual dimension of healing.

**Research objective and research questions**

This research studies local healing in Northern Thailand by focusing on HIV and AIDS as an example of a contemporary disease and illness. The objective of this research is to explain why local healing in Northern Thailand has been revived and how it has survived, adapted, and changed over time while serving the needs of local people.

This study tries to answer some of the questions mentioned above, especially those that are related to the effectiveness of healing. Therefore the main research questions are:

1) How is local healing practiced by healers and patients in resolving health problems related to HIV and AIDS in local communities?

2) What are the perspectives of local healers and patients on the effectiveness of local healing?

3) Based on the answers to the above two questions, how can clinical research that is appropriate to local healing be conducted?

**Research methodology**

This study was ethnographic in character. The fieldwork was carried out mainly in Chiang Mai, Northern Thailand, from February 2008 to May 2009. However, it was also extended to the nearby Lamphun province, where several of the HIV/AIDS patients involved in the
study lived. In addition, three further provinces were included in the study, one from Central Thailand, one from the Northeast, and one from the South, since some patients who were clients of the key informant healers resided in these areas. After the fieldwork, some additional data were gathered through contacts by mobile phone. I benefited also from contacts with healers who took part in a seminar, and from participating in a workshop and a community survey.

**The sampling of local healers and patients**

This study purposefully selected local healers in Chiang Mai who had experience in treating HIV/AIDS patients since the outbreak of the HIV/AIDS epidemic in 1992. These healers were expected to provide information about the way in which they and their communities had revived local healing to resolve health problems related to HIV and AIDS. For this purpose, I initially acquired a list of local healers from the Northnet Foundation, a non-governmental organization that works as a coordinating center for the development of folk healing in Northern Thailand. This helped me to preliminarily explore the treatment and practice situation of the local healers who have provided care to HIV/AIDS patients and who have been recognized as such by the local communities and among their peers.

After visiting ten local healers and conducting an interview with eight of them, I found that six of the healers had stopped practicing, while the other four were still practicing the healing of HIV/AIDS patients. The following are the names of these healers, into whose life worlds I managed to enter and in whose healing activities I intended to participate - and eventually did. All names presented are their real names; this is what the healers themselves wanted, since they expected that their healing activities would be described in a way that would not harm them.

1) Mo Boon Uppanan     Hang Dong district
2) Mo Somsak Kantimun   Mae On district
3) Mo Thatchai Thananchai  Hang Dong district
4) Mo Pinkaew Tannuan   Mae Taeng district

Since my study focuses on healer-patient interactions and the healing process, I had to trace HIV/AIDS patients from these four healers.

Thirteen patients from three healers were willing to be interviewed. From them, ten persons were patients of Mo Boon, two of Mo Somsak, and one person was a patient of Mo Thatchai. Of these patients, with four it was not possible to conduct a face-to-face interview. One person, though living in Chiang Mai, only allowed interviews via mobile phone; the others lived in other regions of the country – Central Thailand, the Northeast, and the South, and were thus also interviewed via mobile phone. I could not access the HIV/AIDS patients of Mo Pinkaew since he wanted to keep his patients’ identities secret.

Twenty-two other persons with HIV/AIDS, who were not patients of local healers, were also interviewed. Ten persons were volunteer leaders of two HIV/AIDS self-help groups; ten were people with HIV/AIDS whom I met when I conducted house calls; two were persons staying in the shelter for HIV/AIDS patients run by the Church of Christ in Chiang Mai.
Map 1. Thailand, Chiang Mai, and some districts referred to in this study
These twenty-two persons provided me with the opportunity to learn how they had faced formal health services, how they cared for themselves, and how they searched for alternative healing, including local healing.

All names of the patients in this study are fictitious in order to protect their identities and ensure confidentiality.

**Data collecting methods and engagement with the field**

Participant observation, in-depth interviews, and focus group discussions were the three main techniques I used to collect the data. These activities took place in the healing center belonging to a healer, the healers’ houses, the patients’ houses, the offices of HIV/AIDS self-help groups, an anonymous Red Cross HIV/AIDS clinic, and during travels to various activities, workshops, meetings, and exhibitions. Most interviews were conducted face-to-face. Some were conducted via mobile phone because of long distances and secrecy issues. With the permission of the interviewees, the interviews were almost always digitally audio recorded. Many events that I participated in provided data to analyze the underlying ideas that directed the healers and HIV/AIDS patients’ behaviors. Some of them are described in the following chapters.

**Gaining rapport and being familiar with the local world**

During the first stage of the fieldwork I observed and participated in several local events, including religious events in some communities and healing centers, in the Northern New Year event (wan pi mai mueang), and in the ritual of paying respect to the spirit of the healer teacher (pithi wai khru). In addition, to gain a good rapport with the healers, two further kinds of activities were conducted. First, on their request I helped the local healers to solve some problems for them. One healer, for example, had a problem with the funding of a project, which could have led to the loss of his minivan and the withdrawal of his grant. If this were to happen without a clear explanation, it would have given him a bad name (I will describe this story in detail in Chapter 6). Second, I participated in the activities of the Chiang Mai and the Northern folk healing network through seminars, exhibitions, demonstrations, and health promotions at district, provincial, regional, and national levels.

I was able to have an in-depth interview in the first month of my fieldwork with Mo Somsak because I already had a good rapport with him. In the second month of the fieldwork, I could start to interview by telephone his HIV/AIDS patients, who lived in other parts of the country.

Patients who wanted to keep their illness secret from others could only be interviewed face-to-face after the fourth month of the fieldwork. Secrecy was an issue that I was always concerned about during my contact with persons with HIV/AIDS. Due to HIV/AIDS-related stigma, persons with HIV/AIDS are wary of telling their diagnosis to persons whom they do not trust or are not familiar with. Some persons keep their HIV/AIDS status secret even to their family members. This issue will be explored further in Chapter 8. Time was therefore needed to gain first the trust of the local healers, in order for them to convince their patients
to cooperate. The healers had to be sure that I would cause no harm to them or their patients, neither mentally nor socially. With some HIV/AIDS patients I still could not approach them until the end of my fieldwork, because one healer refused to give me the contact addresses of his patients. Furthermore, some patients could not be contacted since the healer felt uneasy about telling them about the research.

During the course of the fieldwork I also joined in on such occasions as a temple celebration (ngan poi luang), the Northern healing wisdom festival (ngan khuang phaya) in Chiang Mai and Chiang Rai, the dissemination of knowledge about local healing through a radio program in which I participated twice as a speaker, massage training programs, meetings and seminars of the Chiang Mai and Northern local healer network, and funeral ceremonies of local healers in Chiang Mai, Chiang Rai, and Khon Kaen. Joining these events gave me the opportunity to gather numerous data regarding the meaning of things and procedures in the ritual process, the attitudes of healers towards their life worlds, the activities they conduct, their future plans, and the constraints that obstruct their aspirations.

Since most of the people with HIV/AIDS focused on in this study were women, I sometimes required the help of a female assistant to bridge the gap in communication and create a familiar relationship. In Thai culture, most women feel freer to talk with a woman than with a man, especially regarding issues related to sexual behavior or domestic affairs.

*Observing interactions in the healing process*

Since the interaction of healer and patient at the healer’s setting may provide significant data on the healing process, I focused on this feature in the initial phase of data collection. I had, however, only a few opportunities to observe this due to the fact that most of the patients were either secret cases or persons who resided in other provinces. Furthermore, given that, with the advent of ART, HIV/AIDS is shifting from a terminal to a chronic illness, and its symptoms are by now well defined, an interrogation of a patient by a healer that is primarily conducted by mobile phone can still obtain enough information in order to prescribe medicines, which can then be sent by mail. Frequent interactions at the healer’s setting thus seemed in most cases to be unnecessary. I could, however, observe the interactions between healers and patients at the houses of some HIV/AIDS patients when we conducted house calls. Additionally, the patients in Northern Thailand who sought the assistance of a healer for common illnesses could be observed and directly interviewed. This data compensates in part for the data that was inaccessible in the case of HIV/AIDS patients.

When collecting data at the healers’ own setting could not provide me with enough data about the present situation of persons with HIV/AIDS, I sought other possibilities that could offer me the opportunity to make contact with such persons. Among these were joining the house call activities of an HIV/AIDS self-help group that provides care, mental support, and suggestions for self-care. I was able to observe how the local healer and the volunteers dealt with HIV/AIDS patients who experienced side effects of antiretroviral drugs (ARVs), patients who became blind from Cytomegalovirus (a virus that is one of the most common
opportunistic infections among HIV/AIDS patients with a low immune status), a patient who had been abandoned by her family, one who was suffering from cancer, and another who had tried to commit suicide many times.

**Joining the activities of HIV/AIDS groups**

To observe the interactions between a local healer and HIV/AIDS self-help groups, I also conducted a focus group discussion. The group consisted of HIV/AIDS self-help group leaders, volunteers, a local healer, a coordinator from the Northnet Foundation, myself, and my assistant. Seventeen persons joined the discussion, which dealt with the situation of HIV/AIDS support groups in the nearby districts, their needs regarding local healing, and the activities that should be undertaken to serve these needs.

I also joined a rally by persons with HIV/AIDS in Chiang Mai to urge UNAIDS and the Thai government to stop the ‘war on drugs,’ to reduce the harm for drug users, to provide universal access to health care for marginalized people - such as persons with HIV/AIDS, transgender persons, migrant workers, and minority ethnic groups - and to have more concern for their rights to access health care. This event gave me an exemplary picture of the people associated with the HIV and AIDS movement in present day Northern Thailand.

I also participated in a Thai and Italian Red Cross training of 40-50 HIV/AIDS patients. Furthermore, I observed the monthly meeting of an HIV/AIDS self-help group at a district hospital on the occasion of World AIDS Day, in which a group of elders was engaged together with persons with HIV/AIDS.

I also observed the role of a leader of an HIV/AIDS self-help group who was working as a support giver in a shelter for HIV/AIDS patients run by the Church of Christ in Chiang Mai. On this occasion I met two non-Thai persons with HIV/AIDS: one was Tai Yai (a Tai ethnic group residing in the Shan state of Burma) and the other a Chinese immigrant. Both had lived in Thailand for a long time, but had no access to Thai health security. This gap made the role of the shelter necessary.

**Learning the need for healing alternatives**

When the client of a local healer wanted to get access to a confidential blood test, I brought him, accompanied by his healer, to an anonymous Red Cross clinic for persons with HIV/AIDS in Chiang Mai. This event not only allowed me access to an anonymous clinic but also gave me the chance to listen attentively to the interaction between the patient and clinic staff regarding the result of the HIV blood test.

To learn more about the attempts of HIV/AIDS patients to seek alternative treatment, I once took an HIV patient, who suffered from chronic headaches, was almost blind, and had great difficulty walking, to a hospital for her weekly acupuncture treatment. I also arranged for her to have a meeting with a local healer there. She was then treated with a course of traditional medicine provided by another local healer. Although she could not continue the treatment due to the problem of distance, through this interaction I learned about the limitations of healing across a large area, and healing with a distance between healer and patient (even when the healing is given free of charge).


**Interviewing resource persons**

Along with the healers and people with HIV/AIDS, I talked with other people who were interested in the treatment of HIV and AIDS by herbal medicine, such as a researcher at the Social Research Institute of Chiang Mai University, a professor in biochemistry at Chiang Mai University, the dean of the School of Traditional and Alternative Medicine of Chiangrai Rajabhat University, the former dean of the Faculty of Oriental Medicine of Rangsit University, and a staff member of the AIDS division of the Saraphi Hospital. These conversations were conducted to learn from these experts about the situation of herbal medicine utilization and drug trials in the 2000s, and their opinion about the effects and impacts caused by these interventions.

**Research material**

This thesis is based on a variety of research materials, including research articles, news from the media, and a description of the patenting process regarding herbal medicines treating HIV and AIDS; pamphlets produced by the healers; reports on HIV and AIDS epidemiology in Thailand; pictures and videos regarding the healing activities of the healers; and a report of the Northnet Foundation regarding indigenous knowledge on treating HIV and AIDS.

Field notes were the main ethnographic material of this thesis. I kept three different kinds of field notes. First, there were notes I took during interviews or observations. These notes were roughly taken with some drawings, diagrams of kinship relations, timelines, maps, the plan of a deserted temple, and the contact addresses of key persons. The second type of notes described elaborately all data from my interviews and all observations in chronological order. The validity of the text of this data was always rechecked with my digital recordings, as well as with the still pictures and video images I took during most events. The third kind of notes was derived from the second, and constituted an arrangement of the data according to each key informant.

During my fieldwork, 176 digital audio files were recorded, and 3,035 pictures and 472 video clips were taken. All digital voice recordings, pictures, and videos were classified into categories to make them accessible any time I needed them.

**Data analysis**

Data analysis was conducted parallel to and after data collection. All data was analyzed based on the theoretical perspective used in this study. Any event, interpersonal interaction, and narrative was viewed within the local world of the healers and patients; a world that is influenced by macro level social forces. The analysis aimed to search for cultural conditions, social contexts, and historical backgrounds that influenced the local world of healers and patients and facilitated the revival of local healing in the community. The analysis also looked at the internal components that structure the local world of healers and patients. It tried to explore how these components nurture the emic point of view and enable a meaningful practice, negotiation, and contestation between the healers and patients. The objective of these analyses was to search for the legitimizing context of local healing – the circumstances
that can revitalize the creativity of local healing and maximize its effectiveness. It intends also to clarify the process that can lead to effectiveness of healing.

**Ethical considerations**

This ethnographic study adhered to the following rules:

*No deception.* The researcher introduced himself as a student in a doctoral program to all persons involved in the fieldwork, regardless of whether they had any contact before the study.

*Voluntary participation.* After being informed about the nature and objectives of the study, each key informant was asked for his or her consent to participate in the project. The informants were told that they could terminate their participation at any time. ‘Informed consent’ was not officially sought due to the cultural consideration that many Thai people feel inhibited when asked to sign a paper to commit themselves. Thus, implicit or passive consent, as demonstrated by the participant’s willingness to answer questions and take his or her time to complete the interview, were considered sufficient.

*No harm to the participant.* The participants were assured that the process and the results of the study or any piece of information that they contributed, would do no harm nor pose any risk to them.

*Anonymity and confidentiality.* Any private or sensitive information of the participants was kept anonymous and confidential. In addition, I asked permission from the informants before starting to audio record the interviews, and informed them of their right to put ‘off the record’ part or all of the information that they had given.

**Outline of the thesis**

This thesis is presented in nine chapters. The eight chapters that follow this introductory chapter contain the results of the literature study, the research findings, interpretive analysis, the generalizing interpretation, and a conclusive synthesis.

Chapter 2 sketches the origin and historical development of Northern Thai society and its healing tradition. It highlights the multi-ethnic character of this society and the marks this has put on past and current healing practices. It accentuates the relative autonomy of local communities, which facilitated the evolution of a social system that made people largely self-reliant in meeting their basic needs, including health needs, and in the organization of community life. People nevertheless had a common belief system that formed the legitimizing context in which local healing traditions were embedded. In more recent history, fundamental changes were introduced by the colonial powers and the Thai nation state. One of these changes was the introduction and expansion of Western medicine in the region, at the expense of local healing. Describing various aspects of the latter change, the chapter lastly presents the HIV/AIDS crisis in the country as an event that provided an opportunity for communities to once again resort to self-reliance - including self-care - and led to the revival of traditional medicine.

Chapter 3 describes how the local healers focused on in this study have formulated
their explanations of HIV and AIDS. They have managed to utilize a variety of knowledge resources in dealing with the disease. The search for a medical theory and practices for the treatment of HIV and AIDS can be viewed as an example of the adaptability of local healers in serving the changing health needs of local people. It shows also that the outcome can be evaluated in different ways, dependent on the theory used.

Chapter 4 presents the healing process as a process of transformation of various kinds of meaning, including changes in the meaning that the local people render to the healer, to the disease, and to the healing setting. Change in the meaning of life is another element that contributes to an effective healing process; it can help patients to transcend their own suffering through religious and social practices, such as thinking with mindfulness and showing concern for others.

Chapter 5 presents a case study in which various aspects of the meaning attribution by healers and patients to medicines and their effects are introduced. These different aspects - the sacralization of medicines, the naming of medicines, and associations between bodily sensations and the working of medicines - are then elaborated in greater detail in the following sections. In the final section, under the heading ‘The symbolic power of medicines,’ I discuss the findings that my study has generated on the workings and effects of medicines, as perceived by patients and healers.

Chapter 6 focuses on the local moral world that enables a local healer to continue with his healing practice in a moral way, as promoted by the healing tradition he adheres to. The chapter indicates that whichever context has gradually undermined a healer and created his moral breakdown, and no matter how he remakes his moral life in a changing society, his moral experience always refers to the local moral world, of which merit and the sacred entities are a part. The healer’s effort to uphold the local moral world is evidence of its significance in his healing tradition.

The desirable effects of the moral aspect of the healing process are described in Chapter 7. This chapter demonstrates that sensitivity to the divided local world serves as an internal starting point of humanized healing. This chapter complements the previous one by focusing on the role of morality in the healing process as it unfolds in practice. It examines in particular the causal connections that healers and patients make between morality, as applied by them in the healing process, and the outcome of this process. I argue that trust related to faith, the power of virtue, and merit are the core components of morality applied in the healing process, which contribute to the moral outcome that can foster and facilitate the effectiveness of healing.

Chapter 8 explores the adaptability of local healers and patients in dealing with the issue of confidentiality. While the maintenance of secrecy regarding a patient’s HIV positive status and treatment by local healers does in many cases contribute in a positive way to a patient’s well being, it may also have negative effects on a patient’s health, as this chapter will show. It shows that the effectiveness of local healing and traditional drugs in dealing with secrecy can be attributed to the former’s flexibility and the latter’s absence of bodily appearance-related side effects.
Chapter 9 addresses the limitation of two clinical trials conducted in Thailand to evaluate the efficacy of traditional drugs for the treatment of HIV/AIDS patients. The perspective of local healers on clinical trials is subsequently presented.

Finally, in Chapter 10 I draw on the various research findings presented in the previous chapters to give summarizing answers to this study’s research questions.
Chapter II

Origin and historical development of Lanna society and its healing tradition
This chapter provides the necessary historical background to the study. It begins with a sketch of the important historical situation of Northern Thailand, which will help to clarify its multi-ethnic character and the nature of local healing in the area. Although little documentation on the origin of local healing practices exists, it can with good reason be assumed that healing in Northern Thailand – an area that people now prefer to call by its traditional name of Lanna – was shaped by the movements and migrations of different ethnic groups more than eight centuries ago. This multi-ethnic origin is still traceable in contemporary local healing practices, with different ethnic groups specializing in specific healing skills or methods. We will therefore begin with a short description of the political and social developments that, since about the fourteenth century, have formed Lanna society. The second section describes the characteristic outlook of local communities in the area. Historically, communities in Lanna could be described as strong and tightly knit; not loosely structured as has been described for Central Thailand.\(^1\) They had a great measure of autonomy with a strong sense of self-reliance in many aspects of community life. Traditionally, villagers tended to seek cooperation within the community and with other communities for solutions when confronted with particular problems. Certain aspects of such characteristics are still present in Lanna communities today.

When in the nineteenth century colonial powers tried to expand and establish their influence, Western medicine was introduced as a completely different form of healing. Its influence on Lanna medicine will be described in a separate section that follows. The final section explains how, at the end of the twentieth century, Lanna local healing was confronted with an unanticipated threat and challenge, the HIV/AIDS epidemic or AIDS crisis, whose epicenter was located in Northern Thailand. Several healers felt the need to help combat this threat. This period therefore receives great emphasis in this thesis, and the information and material gathered during the fieldwork was focused on this intense crisis.

**The multi-ethnic origin of Lanna society**

Before the presence of Tai ethnic groups\(^2\) in the area now known as Thailand, many other ethnic groups, such as the Lawa, Kha, Mon, and Yang, were residing there (Chayan 2006). The legend of Chiang Saen states that somewhere in the past a Tai ethnic group, which had been residing in the south of China, moved to this region and collaborated with the Lawa to establish Wiang Yonok (or the City of Yonok) and other cities in the Kok basin (nowadays located in Chiang Saen district of Chiang Rai province) (Saratsawadi 2008: 47). The legend

\(^{1}\) Embree (1950) described the social system of Central Thailand as loosely structured. In his view, Thai culture could be characterized by individualistic behavior, and compared with Japanese and Vietnamese society, he observed a lack of regularity, discipline, regimentation, neatness, and lasting obligations in Thai life.

\(^{2}\) Tai refers to the population groups that speak a common proto-Tai language. Subgroups of Tai mostly reside in South China, the Shan state of Burma, North Vietnam, Assam of India, Laos, and Thailand. Thai, or formerly Siamese, are a subgroup of Tai. Thai refers to people who live in Central and Southern Thailand. Nowadays, aside from Tai ethnic groups, many non-Tai tribal groups dwell in Northern Thailand, such as Lawa, Yang (Karen), Akha, Lahu, Lisu, Hmong, and Yao.
of Chiang Mai tells of Lawa Changkarat, who was the first king of the city state of Ngoen Yang (Chiang Saen), and was succeeded by twenty-four kings. Phaya Mangrai (r. 1259-1317), the twenty-fifth king of the city state of Ngoen Yang, decided upon – and succeeded in – uniting the divided cities in the region. Phaya Mangrai established the new capital in the city of Chiang Rai in 1262. From there he extended his power southward to the Ping River basin. Ten years later, he founded the city of Fang and successfully incorporated the old Mon cities of Hariphunchai (Lamphun) and Khelang Nakhon (Lampang), major centers at that time. In 1296, Phaya Mangrai founded Chiang Mai as the new capital of the basin, between the Ping River and the Suthep Mountain. The power of the kingdom reached its peak when it brought other city states in the Phrae basin, Nan basin, and some parts of the Khong basin and Salawin basin, under its control. This kingdom was, from the thirteenth to the eighteenth century, named the Kingdom of Lanna.

The legend of Chiang Mai tells that the political system of the dynasty of King Mangrai (1296-1558) was based on the panna agricultural system. A panna was an area of land that comprised all the farms that belonged to the same irrigation network (Pornpilai and Aroonrat 2003: 31). The ruler used it as a manpower control mechanism since all farmers had to subordinate themselves to one panna in order to obtain their ration of water for farming. Each city in the kingdom contained many panna. For example, Chiang Rai had thirty-two panna, Phayao thirty-six, Chiang Saen sixty-five, and Fang five. Throughout the kingdom, many panna were organized to enlist tributary labor and collect tax, as well as to provide food reserves and conscripts in times of war. The term lanna, literally ‘million rice fields,’ was derived from this political system and became the name for the kingdom (Saratsawadi 2008: 25, 196).

The period between 1355 and 1525, from the reign of Phaya Keu Na to that of Phaya Kaeo, is often called the Golden Age of the Kingdom of Lanna. During the reign of Phaya Tilokaraj (r. 1442-1487), Theravada Buddhism, which was adopted from the Kingdom of Sukhothai in the south of Chiang Mai, reached its peak and led to intellectual and cultural prosperity. The Eighth Buddhist Council, set up to review the Tripitaka (the Buddhist canon), was held in Chiang Mai in 1477. During the reign of Phaya Kaeo, Buddhist literature prospered. Scholarly Buddhist monks composed many texts in Pali, the formal language of Buddhism. Architecture, sculpture, painting, and Buddhist arts were also in full bloom (Saratsawadi 2008: 159-171).

The power of the Mangrai Dynasty declined gradually until the period of Phra Mekuthi, the sixteenth and final king of the Kingdom of Lanna. In 1558, Chiang Mai was occupied by the Burmese troops of King Bayinnaung from Toungoo and became a vassal state of Burma for the next 216 years. The legend of Chiang Mai attributes this decline to a lack of respect for local traditions. This was due to the king and his nobility, who came from another city in the kingdom and performed inauspicious and inappropriate conduct that violated local traditions.

3 Theravada Buddhism is one of the main schools of Buddhism. It is relatively conservative and believes that it has preserved the original teachings of the Buddha and the religious practices as they were performed in the Buddha’s era. Now it is widespread in the countries of mainland Southeast Asia and Sri Lanka.
As a vassal state of Burma, Chiang Mai was required to pay special taxes and an annual tribute consisting of two small trees made of gold and silver, plus costly gifts of goods and slaves. In times of war, it had to provide military conscripts to Burma. In certain periods, such as during the attacks of the Burmese, almost the entire population of Chiang Mai was forced to relocate to Ava in Burma. The rest fled into the jungle and let Chiang Mai become a deserted city, overgrown by the surrounding fields.

Burma’s harsh treatment of Chiang Mai, as well as its use of the city as a base from which to draft recruits and procure supplies for its wars with Siam, initiated regular rebellions. In
1774, Phraya Chaban, a chief bureaucrat of Chiang Mai, and Chao Kawila, the son of the ruler of Lampang, rebelled. After their failed attempt, they requested military assistance from the Siamese forces and successfully drove the Burmese out of Chiang Mai later that year. From that time onwards, Chiang Mai became a vassal state of Siam.

In 1782, the year of the establishment of Bangkok as the new capital of the Kingdom of Siam, Chao Kawila was appointed by King Rama I of Siam as the ruler of Chiang Mai. Chao Kawila, as the first to reign in the Chao Jet Ton Dynasty, started to rebuild the city by letting in local people from the forests and bringing other Tai people from nearby towns to settle there. Among them were Tai Yai, Tai Khuen, and Tai Lue from the Shan area (now a part of Burma) and Sipsong Panna (now Chinese territory). This period is known as the age of ‘collecting the vegetables into the basket, collecting the people into the city’ (kep phak sai sa, kep kha sai mueang) (Saratsawadi 2008: 319). In this process, Chiang Mai became an increasingly multi-ethnic community.

Chao Kawila revitalized local traditions which had once prospered during the dynasty of Mangrai. As a vassal state of Siam, the rulers of Chiang Mai and the other principle cities in Lanna were able to govern the cities autonomously according to their local traditions and laws, though they had to pay annual tributes and a certain amount of fixed taxes, as well as attend the royal ceremony of the Oath of Allegiance (thu nam phiphat satcha) in Bangkok. Moreover, Bangkok had the right to request other tributes, especially teak and other local valuables, which were needed for important ceremonies or for the construction of temples and palaces. In times of warfare, the kingdom was forced to conscript troops and send them to Bangkok. Lanna would, on the other hand, receive some necessities in return, for example ammunition, tin, sulfur, and glass (Saratsawadi 2008: 360-364).

During the reign of King Rama V (r. 1868-1910), Britain, which had established control over Burma, tried to expand its influence over Lanna. This forced Siam to change its policy towards the region. A new administrative system for all Lanna city states was established to centralize power. This led to a gradual reduction in the power and influence of the rulers of Chiang Mai and its city states. The new changes had huge effects, not only for the rulers and the nobility, but also for the ordinary people (Tej 1977). The introduction of a new taxation system, which required payment in money instead of supply of labor or delivery of agricultural and forest products, dissatisfied the people. The situation worsened when officials from the central administration occasionally demanded labor from the local population without payment. This resulted in political uprisings in Chiang Mai and the principle city of Phrae, with the support of local rulers. However, Bangkok managed, heavy handedly, to subdue the rebellions and punish the local ruler of Phrae (Saratsawadi 2008: 457-462).

The turmoil in Chiang Mai and Phrae made Siam aware of the need to establish a sense of unity and nationalism among the people of Lanna. The reforms to create a modern nation state, which started during the reign of King Rama V, were concerned particularly with this issue. Infrastructural, educational, cultural, as well as health reforms were the succeeding measures that gave Chiang Mai the status of a province of Thailand. Nowadays, Chiang Mai has not only lost its status as capital of a kingdom, but many aspects of its identity,
whether political, economic, social, educational, religious, or cultural, have also changed (Saratsawadi 2008: 462), a development deplored by many local scholars (Thanet 2009). Through exploration of the local healing tradition, however, unique principles and practices are still visible, despite the strong domination of Western medicine promoted by the modern Siamese nation state. Also evident are many aspects of community life, which have their origin in Lanna communities, and which have been revived in conjunction with the revival of traditional healing.

**Main characteristics of local communities**

Within the geography of lofty mountain ranges alternated with river basins, the people in Lanna chose to settle their habitats along the basins; the city states of the Lanna Kingdom were also localized here. These basins include the Chiang Mai-Lamphun basin, Kok basin, Lampang basin, Phayao basin, Phrae basin, and Nan basin. Mountains formed the natural boundaries demarcating the territory of each city. Even though these cities fell under the Kingdom of Lanna, of which Chiang Mai was the main center, they were nevertheless independent. They had their own rulers, who were succeeded by their descendants for several generations.

Now, as in the past, the tightly knit social relations and autonomous organizations in Lanna’s communities make mutual help among villagers and collaboration for special events possible. The autonomy of community organizations also facilitates the turning to self-reliance in terms of care by making use of local resources available within a community. It will become evident that when local communities began to face the challenge of HIV and AIDS in the late twentieth century, and when this characteristic of autonomy and self-reliance has been revitalized, it created a legitimizing context for local healing as well as facilitating the effectiveness of healing. This is a subject of the following chapters.

Before Chiang Mai’s inclusion into the modern nation state, the rulers of Chiang Mai and the other principle cities in Lanna only got involved in the lives of villagers in times of war or when their labor was required. People in general, and especially those who resided in remote villages, were otherwise almost independent of the local rulers. These ordinary villagers (phrai ban) were not obligated to be registered as clients of patrons or rulers like the people living in towns (phrai mueang), the latter of whom had to fulfill town corvée (involuntary, often unpaid labor). This system differed from the Kingdom of Siam, in which clients were much more strictly controlled by their patrons and the state. Therefore, during this time, most rural villagers in Northern Thailand were freer to manage their collective life than those living in towns or cities (Chatthip and Pornpilai 1998), as was evident in the way in which community life was organized at a local level into various independent divisions.

The organization of the community system in Northern Thailand was based on three divisions: the so-called domestic division (muat ban), religious division (muat wat), and irrigation division (muat mueang fai). The leaders of these divisions were respectively the kae ban, kae wat, and kae mueang fai. They were all seniors who were capable in their field and were respected by the villagers (Chatthip and Pornpilai 1998: 7).
The domestic division (muat ban) was a system that involved settling domestic conflicts, protecting the community against violations, assuring the security of the village, managing duties during community events and occasional celebrations, and collecting money for community purposes. The religious division (muat wat) was responsible for the relationship between villagers and the temple, for conducting annual religious events, arranging the offering of daily foods to the monks, and collecting money donated for religious objectives. The irrigation division (muat mueang fai) dealt with the organization of the irrigation systems within the communities. This included building and repairing canal weirs, digging water canals, allocating water to the fields, punishing persons who violated the rules of the irrigation society, and holding offering ceremonies to spirits guarding water from the mountains (phi khun nam) and spirits guarding the dikes (phi fai) (Chatthip and Pornpilai 1998: 7-15, 26-27).

This community-based system in Northern Thailand was gradually superseded by the local organizations of the modern Thai nation state. The domestic division was replaced by the local administration organization, under the supervision of the central government. The Royal Irrigation Department’s local unit took over the irrigation division. Only the religious division was not interfered with by the National Office of Buddhism, although the abbot of the village temple was required to be appointed by the Lord Abbot of the province.

The long lasting system that creates and reinforces relations between people from different villages through religious events is called hua wat. When an important religious event is held in a temple, other temples in the same hua wat will be invited. The associated temples will agreeably send monks and villagers to attend the event. Donations will also be collected to help the host temple (Pornpilai and Aroonrat 2003: 130-131).

Poi luang is the most important community religious event. It mobilizes money and manpower resources from villages in the same hua wat to celebrate a new temple or a new building in a particular village. Each village will come to join the event with a money tree (khau tan), whereby banknotes are attached to split bamboo branches and a joyful procession is held. It is also the time for traditional music and shows. People from other villages come to visit their relations in the host village. Each home serves plenty of food and beverages to its guests (Chatchawan 1999: 15). The cooperation between and within communities is an important characteristic of Lanna villages. We will encounter this characteristic again in the detailed descriptions of healing practices in the following chapters.

The heritage of Lanna healing

The traditional law of the Mangrai dynasty states that a ‘herbal healer’ is counted as one among the ten craftsmen (phrai mueang) who deserve to be respected and should not be killed (Aroonrat 1977). Although we can only speculate about the nature of healing before the introduction of Buddhism and Brahmanism, it is certain that many healing practices and rituals that are now seemingly Buddhist or Brahmanistic have a much older animistic origin. The rulers of Lanna did not provide any medical services to the population. This was seen as the role of Buddhist monks and local healers who studied medical knowledge from scriptures and learned it from senior healers.
Illustration 1. A money tree procession
There is, however, evidence that in 1424, in the period of Phaya Sam Fang Kaen, a group of monks from Chiang Mai visited Sri Lanka and studied Buddhism for six years. When they returned, they established a new Buddhist sect at the Pa Daeng temple of Chiang Mai, but there is no evidence that at that time medical scriptures from Sri Lanka were being imported to Chiang Mai (Thanet 2009: 79). This differs from the area of Siam, where a medical scripture about Thai medicine exists, namely *Khamphi Worayokkhasan*, which was translated from Sri Lanka’s Pali into Thai. There are, however, some Lanna medical formulas that can be associated with Sri Lanka, such as the *ya wiset langka* (special drug from Sri Lanka) and the *ya ayu watthana wiset* (special drug for rejuvenation), which are known to originate from Lanka Thawip (the Thai name for Sri Lanka in the past).

Since Lanna was (and still is) a multi-ethnic state or society, there were multiple healing practices available in the region. Nowadays, many of these practices have simply been adopted and included in Lanna medicine without much concern for their origin. In some cases, healing techniques and medical formulae can still be traced to their origins, such as a style of Burmese massage called *ao man*, a Burmese drug to treat disorders after childbirth (*ya lom phit duean phama*), and the great red Burmese drug (*ya daeng luang phama*), the latter of which is a treatment for wind disease (*ya lom chiang tung*) and has its origin in Chiang Tung in the Shan state.

Throughout history, cultural exchange in Northern Thailand among the Tai ethnic groups, and between them and their neighbors, has brought about trade, political occupation, and relocation. Clashes among these ethnic groups based on cultural conflicts were quite rare due to the fact that these ethnic groups had many values in common. All Tai groups believed in spirits (*phi*), Brahmanism, and Buddhism, and possessed similar languages, cultures, and traditions. Only hill tribe people in the region also believed in their own spirits. In what follows, I will describe the common characteristics of the Lanna belief system, which is mostly found among the Tai Yonok, the major Tai ethnic group in Lanna.

**Common beliefs and healing practices in Lanna**

In this section I present the ideas that underlie the practices of local healing in Lanna communities. Healing procedures that are still conducted in the present day are subsequently described. In the present, as well as in the past, the belief in spirits (*phi*) is found all over Lanna, especially evil spirits, such as the spirit of a woman who has died during childbirth (*phi phrai*) and which haunts a weak person in order to eat the raw meat or internal organs of the host. Healing rituals are needed to suppress and purge this malign spirit. The evil spirit that resides in the place where wild animals come to eat salt earth (*phi pong*) is another, and it can attack the knee joints of the victim, who will then need specific indigenous healing to cure it. Ancestral spirits (*phi pu ya*) and guardian spirits, such as the house guardian spirit (*phi chao ban*) and temple guardian spirit (*phi suea wat*), also need rituals whereby these spirits are worshipped or proffered merit. The latter rituals are conducted when people assume that the ancestral or guardian spirits are dissatisfied with disunion among their descendants or with the improper behavior of their descendants (Anan 1992).
Khuet, which refers to prohibitive rules concerning actions which may result in bringing bad luck to an individual or the community, is another belief that is commonly found in Lanna. A person who does not observe khuet risks bringing calamity upon himself, his family, or community, unless a rite of undoing khuet (kae khuet) is performed (Davis 1984: 285). Disregard of khuet may directly affect the health of an individual or community. For example, burning the corpse of a person who has died from leprosy with pustules (pen tum pen huean), severe abscess (fi hai), abnormal collection of tissue under the skin (fi san buam phong), or a chronic skin disease with vesicles (maheng tum fai) will cause smoke that harms the people of the community (Khomnet 2001: 140). Khuet may be considered a local moral code since it aims to control the behavior of local people by keeping them away from what is socially prohibited.

Khwan is an indigenous concept regarding an abstract entity that governs each part of one’s body. Khwan maintains the will power of a person and brings about prosperity and well being in life (Anake 2005: 33). A person’s khwan will be lost when that particular person is in a bad situation or experiences misfortune (khro), such as having an accident or being harmed. A person who has lost his khwan will feel sad, depressed, or will be easily frightened, which may lead to physical illness or death. A rite of calling khwan (hong khwan) is undertaken to revitalize and reunite the body and mind-soul (khwan) of the patient. In addition, according to astrological calculations in the time of khro, a person may be required to wipe out khro (pat khro), diminish khro (sado khro), or send away khro (song khro). Once khro is alleviated, a rite of calling khwan can be conducted (Malee 1998; Yingyong 2003; Rangsan 2004). According to Chatthip and Pornpilai (1998: 257), after the death of a person, that person’s khwan will be divided into four parts. The first part resides in the home to protect the offspring, the second stays in the grave, the third is somewhere in the interspace between heaven and earth, and the last part lives with the Sky God (thaen) in heaven.

Lanna astrology, which is based on Brahministic cosmology, is also an important pillar of disease diagnosis in the Lanna healing tradition. According to Lanna astrology, personal health corresponds to the fate (duang chata) of the individual, which alternates regularly according to birth date and age. Bad fate may lead to bad khro, which risks danger or illness. Every year, specialists in Lanna astrology work out the calendar and provide consultation to serve the people of Northern Thailand. Healers always use the Lanna calendar to determine the date for collecting medicinal plants and performing healings. They avoid treating patients on inauspicious days, which, according to their beliefs, will bring unsatisfactory results. The idea of omen is another tool used to describe the factors that affect the results of healing. As told by some healers who participated in this study, failure of a healing will be the result if the first visit of the patient occurs when the healer is sleeping, eating, or absent. It is also an ominous sign if, during a visit to the patient’s home, the healer meets a monk, a crying child, or a funeral ceremony.

Saiyasat (literally the knowledge of ignorance, a negative term used for animistic and Brahmanistic beliefs) appears in most aspects of life in Lanna culture, including health and illness. Saiyasat can be used for either benevolent or malevolent purposes. When a person
gets sick and shows symptoms such as speaking incoherently, mental instability, or having unidentified pain, black magic (khun sai) is believed to be the cause of the illness. The victim is required to undergo a treatment from a healer who corrects the black magic (mo kae khun sai).

In addition to animism and Brahmanism, Buddhism also plays a crucial role in local healing. The Buddhist concept of karma not only guides the thinking and way of life of Lanna people, it also affects how people decide to manage their illness. Karma literally means action or doing. Any kind of intentional action, whether physical, verbal, or mental, is regarded as karma (Keyes and Daniel 1983). In its ultimate sense, karma means all moral and immoral volition. Involuntary, unintentional, or unconscious actions do not constitute karma. In its popular sense, karma is the result of our own past actions and our own present deeds. Healers in present day Lanna divide karma into two parts: present karma and past karma. Present karma is the result of deeds regarding intrapersonal and interpersonal relationships in this life; past karma is the product of one’s past deeds in previous existences. Violation of prohibitive rules (khuet) and improper conduct towards the ancestral spirits are interpreted as bad present karma. Genetic diseases, congenital disabilities, insanity, and severe accidents are sometimes considered the consequences of past karma (Yingyong 2003). Karma has greatly influenced the idea of morality among Lanna people. Bad karma is believed to be the source of a bad life, while good karma has the opposite effect.

That (dhatu in Pali and Sanskrit), the basic element of the human body according to Buddhism, also influences the medicinal healing practices of all Tai ethnic groups. The theory of that and drugs to normalize the inner elements (ya that) complement – like in the Thai healing tradition – the principle of healing with a more rational approach to gaining harmony inside the body, as well as between the body and its surrounding environment.

A great variety of procedures are documented among the healers in present day Lanna (Malee 1998; Yingyong 2003; Rangsan 2004). These include various mixtures of medicinal plant preparations, used internally and externally, which already appear in numerous medical formulae inscribed in ancient scriptures. These formulae are unique, since most of their ingredients are parts of medicinal plants growing in Northern Thailand. However, some formulae are composed of materia medica from other countries, which are also common in Thai and Ayurvedic medical formulas. Ground or crushed medicine (ya fon), in which medicinal materials are abraded into a powder, is a unique preparation of Lanna medicine. These medicines may contain dry roots, rhizomes, barks, woods, fruits of specific plants, the fangs and horns of wild animals, shells, and other medicinal materials, mixed according to a certain formula and used for specific illness symptoms. In the old days, the Lanna people were familiar with household remedies made of ground medicine, which were used to cure acute illnesses such as those caused by eating the wrong food (kin phit), postpartum syndrome (lom phit duean), fever, convulsive fever, chicken pox, herpes zoster, abscess, vomiting, and so on. Such medicines can be quickly prepared: the soaked medicinal materials are ground with sandstone and mixed with water to be readily used.

Other than pharmaceutical treatment, physical therapeutic procedures in Lanna medicine
are widely used for the alleviation of wind, joint, and bone diseases. Examples of this treatment are: a form of massage called *ao en*; a physical treatment of tapping away the tension in muscles and tendons with special wooden instruments (*tok sen*); a massage in which a healer warms his feet on hot charcoal before pressing them on a client’s body (*yam khang*); a technique to expel poisonous illness by rubbing betel leaves, a knife, or a wild animal’s canine tooth dipped in a herbal solution on the affected person’s body, while chanting mantras (*chet haek*); a technique to extract poison in case of poisonous fever and pain by touching the client’s body with a boiled egg (*chop phit*); and a technique to heal a broken bone with mantras, medicinal oil, and bamboo splints (*khwak sui*). Some of these techniques have been used in modern Lanna style spas as exotic alternative medicine practices to attract Western tourists and holistic therapists.

According to Yingyong (2003), the various healing rituals of the Lanna tradition can be classified into five categories, according to their purpose. The first are rites for foretelling. This includes all kinds of astrological procedures and explanations of illness given by mediums. The second are rites for expelling bad things, such as sending away bad luck (*song khro*), worshipping with candles (*bucha thian*), sprinkling holy water (*rot nam mon*), withdrawing *khuet* (*thon khuet*), and so on. The third are rites for building will power, such as sending offerings to the Sky God in Tai myth (*song pu ya thaen*), calling out *khwan* (*hong khwan*), extending fate (*suep chata*), and so on. The fourth are rites for consciousness development and awareness of death, such as the rite for a person who is assumed dead (*bang sukun dip*), the giving of a particular sermon regarding the story of a frugal millionaire who was suffering in hell (*thet maha wibak*), and asking for forgiveness from the three gems of Buddhism, namely the Buddha, his teaching, and his disciples (*suma kaeo thang sam*). The fifth are rites for well being and fortune, such as worshipping the angels of four directions (*khuen thao thang si*), sprinkling water on the Buddha’s relics (*song nam phra that*), and offering food to ancestors and the dead who used to be enemies (*tan khan khao*).

In the old days, most healers in Lanna were male since all ancient scriptures and manuscripts were inscribed in the local alphabet, which only persons who had been ordained could read – and these were only men. Yet females have played important roles as midwives (*mae chang*), angels (*thep*), or spirit mediums (*ma khi*) of the spirits of late local rulers who were heroes or well respected (*phi chao nai*). During the past few decades, many women have enrolled in Thai traditional medicine and massage training courses provided by local health offices or colleges of traditional medicine.

Healing in old Lanna was not considered a career or occupation, since healing itself was not conceived of as an income generating activity. Instead, it was viewed as a moral undertaking. A statement that represents clearly the status of local healing in the old days is that ‘medicines and healing are things that patients should ask from the healer without being hindered by any costs’ (*ya kho, mo wan*). Even though the practice of healing was not meant to generate income, people in Lanna did set up a system of reciprocity to maintain the healing tradition. Money, labor, and material rewards, as well as high status, were things that clients and communities have always used to support their healers. Evidence of such practices that
remain until the present day is the rite of expressing gratitude (dam hua). It is always held on local New Year’s event or at the start of the Buddhist Lent, when patients and clients come to the house of a healer to pay respect, bless the healer, and offer food and utensils.

The introduction and expansion of Western medicine

Western medicine was first introduced in Northern Thailand by American Presbyterian missionaries. The first of these missionaries who came to the region was Daniel McGilvary. Along with preaching the gospel, McGilvary, although not a medical doctor, dispensed free quinine to treat patients during a malaria epidemic. The effectiveness of the missionary medicine enabled this modern medication to spread widely. The demand for quinine was so overwhelming that he had to order more. He also treated goiter, a disease no local healer was able to treat, with Potassium Iodide. Again, this cure made him more famous than any healer before. McGilvary was also very interested in small pox inoculation and vaccination, since in some villages this epidemic could be devastating, taking the lives of all children. As McGilvary noted in his book, the promotion of this new technique attracted all generations of villagers, and they came to see him especially for vaccinations (McGilvary 1982: 15-17).

However, before McGilvary could do his medical work, he encountered several difficulties in his evangelistic work in Chiang Mai. This was due to problems created by his first follower, Nan Inta, who was a favorite of Chao Kawilorot, then the ruler of Chiang Mai. By proving that a solar eclipse happens according to God’s natural laws rather than being occasionally caused by the voracious monster of the sun, McGilvary was able to convince Nan Inta to become a Christian. Later, a servant of Chao Kawilorot and a local healer were also converted. This led the ruler to become discontent, as he saw the conversions as a new threat to his rule based on the fear of a new power center called into existence by the missionaries. Observing the Sabbath also frustrated the ruler since it limited the time in which he could claim labor power from his subjects (Prasit n.d.). The execution of the two local Christians in 1869, by order of Chao Kawilorot, suppressed missionary work in the area for nearly a decade. It was only after the ‘Proclamation of Religious Toleration’ from the central government, which gave Lanna people the right to convert, that McGilvary could make a number of exploratory tours to expand his evangelistic mission.

The missionary medicine that was practiced alongside the evangelistic work succeeded in putting forward these new healing methods. In 1904, Dr. James McKean, another American missionary, set up a local laboratory to produce the small pox vaccine. He trained his staff, who were then sent to work in remote villages. In 1908, he established the Chiang Mai Leper Asylum with the support of the central government and Chao Inthawarorot Suriyawong, the seventh ruler of Chiang Mai. The asylum worked out well. It turned into ‘a show piece of humanitarian mission work,’ since it could help a number of lepers who had up till then been forsaken and despised by a society that only let them survive in miserable conditions (Swanson 1995).

The mission strategy in Chiang Mai assumed initially that if the missionaries could convince the people of the validity of science, the truth of science would attract them and
confirm the superior truth of Christianity. This was the application of the so-called ‘Baconian evangelism,’ which used scientific information and theories to validate the truth of the Christian religion. McGilvary viewed the relationship between Christianity and science as intimately connected, like twin sisters or a mother and daughter. He stated that ‘they are both revelations of God, the one in His word, the other in His works’ (Swanson 2003: 104). He believed that the truth of Western science would result in the conversions of Northern Thai people, who would discover the falsity of Buddhism: ‘Some of the simplest truths of western science, when taught to the adult overthrow his system of idolatry, when to the young they can no longer embrace it’ (McGilvary quoted in Swanson 2003: 105). For him, Western medicines and medical procedures were Baconian evangelism in another guise.

McGilvary used Western medicine to support his evangelistic works in two ways. First, he utilized medicine as a theoretical way of constructing the truth of the scientific perspective in contrast to traditional Northern Thai cosmology. Second, he employed medical care as a practical way of obtaining the sympathy and trust of the local people, with the hope that they would finally convert to Christianity. However, after having invested a lot of attention on Baconian evangelism, McGilvary concluded that this assumption did not bear out in practice. He found that people made their decision about conversion on the basis of political, personal, and other factors that were not related to Baconian evangelism. It also appeared that the local people saw the relationship between medicine and Christianity in a different way. They converted to Christianity based on a feeling of gratitude or of relief, or due to the discovery that the Christian God is a new guardian spirit with more power than other animistic spirits (Swanson 2003).

Presbyterian missionaries managed to convert quite a few people to Christianity in the course of their encounters with missionary medicine. Most of the people who converted to Christianity were socially marginalized, i.e. the poor, the ill, lepers, hill tribe people, and those accused of being ancestral spirits of the maternal lineage that had become malevolent (phi ka). Some weaknesses of the Western missionaries, however, accounted for the relatively slow growth of Christianity in Thailand, such as the lack of understanding of Thai culture, ineffective communication in transferring meaning across cultures, and a disregard for indigenous buildings, forms, or music, which alienated the Christians from Thai society. Moreover, their aggressive approach was opposed to the Thai disposition of meekness (Lange n.d.).

Nevertheless, missionary medicine had a major impact on medical care in Northern Thailand until the 1930s. Nowadays, the McCormick Hospital, established in 1920 by American missionaries in the city of Chiang Mai, is a lasting testimony to their influence. During the period of missionary medicine, traditional medicine, spiritual cults, and Buddhism seemed to be the enemy of the newcomers. The missionaries used medicine as a tool for undermining Northern Thai beliefs about the supernatural causes of illness. They rejected the belief that karma is the root of illness, and rather taught and verified that illnesses were caused by germs and other natural causes. They also proclaimed that the power of God always overcomes everything and surmounts all evil spirits. God is the great doctor who is capable of curing.
Furthermore, they taught the doctrine that the human body is created and given by God, and that it therefore deserves to be preserved and cured with scientific medicine. This doctrine had to counter the Buddha’s teaching, which the missionaries interpreted as the idea that ill and suffering bodies should be approached with indifference, since bodies are not permanent, cause suffering, and are an illusion (Prasit 1996; Swanson 2003: 105). The Buddha’s teaching relevant to this issue is that of the three signs (trai lakhana): impermanence (anicca), state of conflict (dukkha), and not-self (anatta). From a Buddhist perspective, however, the precise understanding of this teaching helps patients to deal appropriately with their illness rather than letting it worsen (Payutto 2007).

**State medical services and the medical school**

After the establishment in 1888 of Siriraj Hospital, the first hospital in Bangkok, it took nearly half a century before a state hospital in Chiang Mai was set up. Changes in public health undertaken by the central government occurred after the 1932 coup, which transformed the absolute monarchy into a constitutional monarchy. Expanding health care to the larger population, in accordance with the democratic principle of equity, was one of the promises of the coup leaders. However, this principle later turned out to be a strategy for building up Siam, the earlier name for Thailand, into a great nation state comparable to the Western super powers (Chatichai and Komatra 2011). The regional hospitals in the towns around the border with French Indochina were first established. The hospital of Chiang Mai City then followed in the 1940s. A psychiatric hospital established in 1938 in Lampang was moved to Chiang Mai in 1947.

In 1956, the United States Operations Mission (USOM) granted the Thai government funds to establish a medical school in Chiang Mai. Two years later, in affiliation with a medical school in Bangkok, the first medical class with 65 students materialized. After the foundation of Chiang Mai University in 1964, the medical school and the hospital of Chiang Mai City were transferred to the university. The Faculty of Medicine of Chiang Mai University was the first regional medical school in Thailand.

Aside from providing medical services, the provincial public health office was set up and entrusted to manage sanitation, disease prevention and control, and also legal control of medical practices and the sale of medicines. The Art of Healing Control Act, which had been carried out by the central government since 1936, was rigorously implemented in the region after the establishment of the provincial public health office. From the 1950s to the 1980s, some local healers in Chiang Mai were charged as quack doctors (Injai 2000: 56). Many of them quit their healing practice due to legal problems.

When a primary health care policy was implemented in Chiang Mai in the 1980s, most healers were obviously not recruited as village health volunteers. The local healers felt that the public health officers and the village health workers had a bad attitude towards them because they had not followed any formal training and as a consequence only possessed outdated knowledge. However, in some cases, local healers were invited to give the village health volunteers information about the use of medicinal plants (ibid.: 51-52).
The local healers in Chiang Mai that I focused on in this study often said that after Western medicine became the mainstream health care system, the people who sought local healing were those who had been previously treated with various medicines in the hospitals but with no effect (*khī sak hong ya* or, literally, had been discarded by the hospital). These might be persons who need rituals or specific medicine for local diseases for which Western medicine seems to be ineffective. The healers objected to the bureaucratized, commercialized, and fragmented characteristics of Western medicine, which also led to a number of dissatisfied clients (ibid.: 52-53). The role of local healers became prominent once again at the beginning of the HIV/AIDS epidemic, when no Western drugs were available to treat the virus.

**The AIDS crisis in Northern Thailand**

The AIDS crisis has represented a unique challenge but also an exceptional threat to healers in Northern Thailand. Since time immemorial, Northern Thai society had not been plagued by any such devastating disease, which has cost the lives of so many victims and left modern doctors and most traditional healers completely helpless. This particular incident will be the focus of this thesis, as a way of examining the experiences of local healers who have engaged in the AIDS crisis.

The first AIDS case in Thailand was reported in 1984; this was a homosexual male living in Bangkok. In the late 1980s, it was reported that the first wave of the HIV/AIDS epidemic developed among men who had sex with men (MSM). Subsequently, the virus spread rapidly to intravenous drug users, and to commercial female sex workers and their male clients. Then it spread to women in the general population, namely the wives and girlfriends of these sex workers’ male clients (Weniger et al. 1991). In 1988, a heterosexual man in San Sai district was reported as the first AIDS case in Chiang Mai. All the latter cases were female sex workers. In 1989, 44 percent of female sex workers in Chiang Mai were found to be HIV positive. Many of them moved to other provinces. From here, HIV and AIDS spread throughout the six provinces of Northern Thailand. In 1994, of a total of 18,409 AIDS patients in Thailand, 7,493 lived in the North. The prevalence rate was 4.8 times higher than the country’s overall rate. In 1999, the cumulative number of AIDS patients and deaths resulting from AIDS in the six provinces of Northern Thailand was 51,032 and 13,323 cases respectively, while the total numbers for the country were 155,954 and 35,200 cases respectively (Division of Epidemiology 1999).

Figures 1 and 2 show that the HIV/AIDS epidemic in Chiang Mai started in 1988. It became a crisis in 1993, when the numbers of newly registered HIV and AIDS patients and of those who had died from AIDS dramatically increased. The numbers reached their peak in 1996. The numbers were still high until 1999, but have since continuously declined. According to these data, one can thus say that the period of the ‘AIDS crisis’ ran from 1993 to 1999. This corresponds to the information given by the healers in this study, who said that it was during this period that they had to fight HIV/AIDS in the communities most vigorously. Most of the healers started their HIV/AIDS healing activities in 1993, the first year of the AIDS crisis.
The fight against AIDS

Before 1990, the Chiang Mai Provincial Public Health Office began its campaign against AIDS by focusing on three prohibitions: do not visit prostitutes, do not be promiscuous, and do not use drugs. The officials were, however, unsuccessful in attempting to persuade the public to believe that the threat of AIDS was real. In the early 1990s, when AIDS cases became known to the public, the mass media scared people with horrible pictures of AIDS...
patients in their terminal stage of illness, and with the idea that AIDS is a deadly disease. This caused fear of AIDS among the public and resulted in a panic response. People responded to persons with HIV and AIDS in negative ways: they did not talk to them, did not sell things to them or buy from them, did not want to share a car with them, did not eat or drink with them, and refused to join the funeral of a person who had died of AIDS. Instead, they took part in gossip and defamation. Because of these negative social reactions, persons with HIV kept their illness secret, even from their family members. Due to stigma, they also did not dare to seek treatment for opportunistic infections in hospitals. When the symptoms were so apparent that they could no longer hide the truth, these patients were forced to live separately from their other family members; some families expelled the ill person and left them to face their misery alone (Yingyong 1999: 51, 104-105).

From 1993 to 1994, more pregnant women, newborn babies, and housewives were reported as being HIV positive. Many infants died from AIDS. Furthermore, the number of widows of husbands who had died from AIDS increased. More appropriate information about HIV/AIDS began to be disseminated to the public. Local performances, creative learning activities, and volunteers were the main means for reaching out to target groups, whether sex workers, youth, or villagers. AIDS was seen as a social problem that needed action from all sectors. The first HIV and AIDS self-help group, named the Thursday Group, was organized at the Chiang Mai Thai Red Cross, in order for HIV positive people to help one another release pressure and exchange experiences. At a temple in Doi Saket district, more than 70 widows set up a self-help group under the patronage of the abbot. They revealed themselves through a popular television program and attracted wide audiences, including an Indian Thai in Bangkok, who later provided funds for a foundation to help people with HIV and AIDS (Seri 1996: 58-59). It was at this juncture that local healer groups in many districts were set up to exchange experiences and search for ways of healing HIV and AIDS. However, discrimination still persisted. The mass media criticized the hospitals that failed to help AIDS patients. Due to the absence of treatment within the formal health care service, some local healers took advantage by offering treatment with traditional medicines, but at a high price (Yingyong 1999: 54).

In 1994, an important event in the confrontation between biomedicine and local healing took place. A number of newspapers reported on a miraculous decoction against HIV and AIDS that was being dispensed by an ‘angel doctor’ in Chiang Mai. The reports attracted many HIV and AIDS patients from Chiang Mai, neighboring provinces, and from other parts of the country. Every day, a large number of HIV and AIDS patients came by local transport to the healer’s office. These unusual visits caused serious traffic jams in the city and frustrated the city dwellers. Additionally, the popularity of this ‘quack doctor’ irritated medical officers. On February 23, 1994, the Office of Provincial Public Health charged the angel healer with deception, and of producing and dispensing medicine without a medical license.

In response to this charge against the healer, numerous HIV and AIDS patients petitioned the Prime Minister and the governor of Chiang Mai to let the provision of the decoction continue until good antiviral drugs had been developed (Bangkok Post February 28, 1994;
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Matichon February 27, March 1 and 2, 1994). The negotiation proved successful. The authorities allowed further production and dispensation of the decoction, but the healer was not allowed to advertise or sell the medicine in any way.

This case made the government aware of the urgency of HIV and AIDS in the Northern region, which was perceived as a situation even worse than losing a war (Yingyong 1999: 7). It led in 1995 to the setting up of the Regional Directing Center for Fighting AIDS. Subsequently, the provincial, district, and sub-district operational centers aimed to coordinate all resources from the government, private sector, volunteer organizations, and communities to fight the battle against HIV and AIDS.

From 1995 to 1996, AIDS became the primary cause of death among people in Chiang Mai. More people with HIV and AIDS revealed themselves and more self-help groups were formed with the assistance of district hospitals, sub-district health centers, and NGOs. Many activities were created to support people with HIV and AIDS who joined these groups, such as meditation practices, self-care training, and the promotion of additional income generating activities. The role of some HIV and AIDS self-help groups was acknowledged not only at community level but also at the national and international levels. The representatives of HIV and AIDS self-help groups raised their voices in many boards and working groups. However, in places where AIDS was not widespread, discrimination and prejudice were often still seen. For example, in many places a blood test was required when applying for a job or before an ordination, and in some cases it was required in order for a person to simply continue in his job, or even for persons who wanted to be a member of the village cremation service. Some children were forced to leave school due to the HIV infection of their parents. Commercial sex workers had to change their venue of operation from brothels to pubs, bars, karaoke and massage houses, as well as apartments. Adolescents became the new risk group since unsafe casual sex remained prevalent among them, and furthermore because students and youths were preferred by commercial sex workers because of the belief that they were free of HIV (ibid: 55-56, 87).

The Northnet Foundation was one of the NGOs concerned about the problem of HIV and AIDS. It had a unique approach of seeking cooperation with local healers. In 1996, the Northnet Foundation, supported by the European Commission, started a project to promote holistic health care for people with HIV and AIDS in Chiang Mai. The project supported three holistic health centers in Fang Hospital, Mae Hoi Ngoen Health Center, and the Folk Healing Center of Ban Denchai. In coordination with Mae On district hospital, the project also allowed local healers to operate in the hospital and urged local healers around San Kamphaeng and Mae On districts to form a group, called the Pancha Sila Club, which was the first local healers group organized by a local hospital in Chiang Mai. Aside from facilitating the exchange of experiences and supporting the networking of local healers, Northnet also provided protection for local healers who had cared for HIV and AIDS patients against charges of illegal practices. The Chiang Mai governor was invited to open the Thai Medicine Village at the house and the center of the local healers who played an important role in HIV and AIDS healing (Yongsak 2006a).
The dramatic increase in the number of HIV and AIDS self-help groups was the result of AIDS programs conducted by both governmental and non-governmental organizations. Although the establishment of many groups was aimed at receiving funds from the government rather than at mutual help and support, some of the groups have been able to survive and maintain their activities until now. In 2009, there were 72 HIV and AIDS self-help groups in Chiang Mai. Most groups were affiliated with district hospitals or community health centers. Aside from activities such as making house calls, offering counseling and social support, and promoting self-care, some groups joined political and social movements organized by the national NGO Coalition on AIDS and the Regional Network of People with HIV and AIDS. Examples of their work include the campaign for universal access to antiretroviral drugs (ARVs); support for the ARV compulsory license policy of the Thai government according to the TRIPS agreement; the campaign for a harm reduction policy; the request for health services for marginalized groups; and the campaign against practices that discriminate against and stigmatize people with HIV and AIDS and other disadvantaged minorities.

The introduction of the antiretroviral program

In 1996 it became clear that progress in the treatment of HIV and AIDS was being realized. In the following years, more and more countries were able to reduce AIDS from an acute fatal disease to a chronic disease. In Thailand in 1995, small steps in antiretroviral therapy (ART) were being taken, which continued to advance during 1996. A serious research program on ART was conducted in 2000. Then a great leap came about in 2004, when the Thai government declared its commitment to the ultimate goal of universal access to ART under the National Access to Antiretroviral Program for People living with HIV and AIDS (NAPHA) (Sanchai et al. 2006; World Health Organization Regional Office for South-East Asia 2007). At the end of 2004, the total number of patients being treated through NAPHA was 58,133, which exceeded the target (Figure 3; World Health Organization Regional Office for South-East Asia 2007). Thailand became a country that had achieved a rapid expansion of ART coverage (World Health Organization Regional Office for South-East Asia 2007). In 2004, 4.7 percent of the HIV and AIDS patients in the whole country came from Chiang Mai. The expansion of NAPHA in Chiang Mai is demonstrated in figure 4.

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4 The TRIPS agreement (Agreement on Trade-Related Aspects of Intellectual Property Rights) is an international agreement regarding the minimum standards for intellectual property protection applied to members of the World Trade Organization (WTO).

5 Harm reduction is a set of practical strategies designed to reduce the harmful consequences of drug use and other high risk activities. It is proposed as an approach to complement the more conventional ones of supply and demand reduction.
In 2007, ART was included in the benefit package of the Thai National Health Security system. The benefit package also includes medical history; physical and laboratory examination (HIV antibody testing); voluntary counseling and testing; drugs to treat opportunistic infections, other related illnesses, and the side effects of ARVs; follow-up laboratory examinations such as a complete blood count and chemistry; CD4 counts (twice a year); viral load testing (once a year); resistance testing (once a year); and referral to other health care services.

Recently, the Adults and Adolescents Committee of the Thai National HIV Guidelines Working Group issued a new practice guideline (Somnuek et al. 2010). A relevant recommendation was the initiation of ART before a CD4 count of less than 350 cells/mm³.
This was based on the evidence that through ART, patients could achieve an improved immune status that would be adequate to prevent morbidity and mortality from opportunistic infections. Another recommendation was the removal of d4T (Stavudine) from the preferred first regimen due to its high rate of toxicities. As a consequence, some would feel more comfortable to use ARVs, since they would no longer be anxious about the appearance-associated side effects caused by d4T. According to this new guideline, many more HIV and AIDS patients would be included in the national ART program.

Conclusion
Northern Thailand developed its unique culture through the course of generations and in the context of a mixture of different ethnic groups. Even though this region was occupied by Burma and later by Siam for a long time, communities there nevertheless maintained their strong sense of self-reliance. Local culture, founded on animism, Brahmanism, and Buddhism, was a nurturing environment for the prosperity and diversity of local healing in the communities. Missionary medicine and the nation state, which have, to a certain extent, affected the local way of life of these communities, have fundamentally eroded the legitimacy of indigenous healing with their respective claims of scientific validity and advancement of modernity. Legal control represents the concrete success of the state’s modern Western medicine over indigenous healing. It put many local healers under the charge of being quack doctors, while at the same time the educational policy of cultural assimilation followed by the central government prevented healers’ descendants from continuing their healing tradition.

The primary health care policy in the 1970s was the pilot attempt that led to the revival of the use of medicinal plants in the communities. However, due to the attachment to scientific evidence and health bureaucracy, the policy implementation confined itself to the use of single medicinal plants. Local healers who took the decision to treat untreatable patients became an essential health resource, while the HIV/AIDS epidemic frightened the neighbors of these healers. The situation also opened up an opportunity for local healers to commoditize their medicines amidst the prevalent feelings of hopelessness. However, the struggle of the HIV and AIDS self-help groups to help the local healer who was arrested after dispensing a decoction of traditional medicine (the ‘angel doctor’ described above), was the starting point that urged every sector in society to reconsider not only the seriousness of the situation but also the possible roles of traditional medicine. With the cooperation of NGOs and local community hospitals, some local healers could organize their network and exchange their experiences in caring for HIV and AIDS patients. In this way, they were protected against the enforcement of the law.

The great leap that came with the national provision of ART in Thailand was the result of the capacity of the Government Pharmaceutical Organization (GPO) to produce a cocktail of ARV drugs as well as the policy of compulsory licensing, the latter of which enabled the production of cheap generic ARVs and the use of patented ARVs at a reasonable price. Because of these measures, the principle of equal access to ART – which was pushed by HIV and AIDS advocates in civil society and the government – could be implemented successfully.
Since then, Thailand has been studied as a case of a developing country that has an effective ART program.

The introduction of ART marks the end of the urgency of the AIDS crisis. It also greatly changed the roles of local healers regarding HIV and AIDS. The disease lost its life threatening character and the hospitals started to offer ART free of charge, which no local healer could afford to do. Other concerns, however, keep patients worrying. Although the ART program has managed to save many HIV and AIDS patients, some questions remain: Can new ARVs be developed in time to substitute the old ARVs to which the virus has become resistant? Do new ARVs present more serious side effects than the previous ones and can they lead to deterioration of the functioning of the whole body? Can the state absorb the high expenses of new ARVs? Does the greater concern for drug interactions between ARVs and herbal medicine obstruct alternative means of self-healing? These ARV related worries also raise the question of whether there is space for the development of alternative forms of healing for HIV and AIDS. These questions will be posed again in the following chapters and answered on the basis of the experience of local healers and their patients. To start with, the next chapter will explore the healers’ theories of HIV and AIDS.
Chapter III

Local healers’ search for a disease theory of and healing methods for HIV and AIDS
This chapter focuses on the search by local healers in Chang Mai over the last two decades for a theory to explain the causation and course of HIV and AIDS as a newly emerging disease, and for methods to treat it. The healers went back to traditional medical scriptures and tried to connect their experiences with this new disease with what was written in these scriptures, as well as with the knowledge that had been orally transmitted to them by their predecessors. This is the method they applied in identifying, testing, and verifying causes and healing methods for the disease diagnosed by biomedicine as HIV and AIDS. The healers’ approach shows their flexibility in dealing with the new situation caused by a threatening disease for which biomedicine had no satisfactory answer. It also demonstrates how, when a disease theory different from that of biomedicine is applied, a different view on what is a good outcome of healing emerges.

The chapter starts with the debate that has taken place among local healers in Chiang Mai over the question of whether HIV and AIDS is indeed a new disease. It then elaborates in detail on the theoretical hypothesis proposed by one of the key healers in my sample, and compares this hypothesis with what is written in the medical scriptures of the Thai royal tradition. The outcome of this comparison will form the framework for a potential traditional medical theory of HIV and AIDS. The practices of other healers are subsequently synthesized into the theoretical framework of this disease theory, as are their principles of treatment. In the final part of the chapter, indications of what a good outcome is in relation to these principles of treatment are presented.

**AIDS: A new disease?**

AIDS is considered a new disease in the scientific world, since the virus that causes it – HIV – is different from other kinds of viruses that have previously afflicted human beings. HIV has the potential to completely destroy the human immune system, which is the body’s defense against infectious organisms and other invaders. The disease is life threatening and as yet incurable. In contrast to the biomedical consensus regarding HIV and AIDS, local healers do not fully agree about the cause of the disease, how it should be classified, and whether it should be counted as a new disease.

Whether AIDS is a new disease or not has been a controversial issue among the local healers in Chiang Mai since the moment it entered their local world around 1992. Most healers initially learned about the disease from information disseminated by the Ministry of Public Health and the public media. They also came into contact with frightened and hopeless HIV and AIDS patients who were searching for a cure, and who conveyed to them the idea that AIDS is a new and incurable disease.

The controversial issue regarding HIV and AIDS among the local healers is whether it is a kind of muttakhuet disease. Let me describe how the local healers in my study sample explained such a disease.

Muttakhuet comprises two words: mutta, which is a Pali word that literally means urine, and khuet, a Northern Thai word which means bad or wrong. Muttakhuet is a disease category comparable to that of venereal diseases or sexually transmitted diseases in biomedicine. The
Chapter III

most common *muttakhuet* disease is *nong nai* (literally, inside abscess, or gonorrhea). Given the fact that the local meaning of *khuet* has moral implications, a person who becomes sick from *muttakhuet* will be despised by people in the community, and will be accused of being a sinful person who has practiced licentious sexual behavior. This cultural meaning has unintentionally played a role in producing and reproducing the social stigmatization of HIV positive persons during the HIV/AIDS epidemic (see Chapter 8).

The Northern medical scriptures contain many traditional drug formulas for the treatment of *muttakhuet*. It is strongly believed that a person who has recovered from gonorrhea after the use of traditional drugs will not become re-infected, even if they have further sexual contact with someone with gonorrhea. The explanation for this is that after the use of the appropriate traditional drugs, the body will develop *phum* to fight against the ‘germ’ that causes gonorrhea. *Phum* in this context refers to the capability of the body to tolerate pathogens, allergic agents, and toxic agents. The notions of *phum* and germ, as used by the Northern local healers, might have been influenced by the idea of immunity (*phum khum kan rok*), which has been adopted from biomedical science. The difference is that according to the local ideas, *phum* is the outcome of a normalization of the inner elements of the body, namely earth, water, wind, and fire. It can be said that a mechanism that is used in local healing to treat *muttakhuet* diseases consists of finding normalization of the inner elements. These ideas have influenced the behavior of local people towards venereal diseases and HIV and AIDS in a certain way, which I will describe further in Chapter 5.

A local scholar and healer who has his own clinic and a Thai massage school in Hang Dong district explained to me that he sees AIDS as a type of *muttakhuet*. He believes that the traditional drugs and symptomatic treatments that he has derived from old medical manuscripts have the potential to heal HIV and AIDS patients. However, since his private clinic is located in the center of Hang Dong district and he does not have a special space available for the healing of HIV and AIDS patients – which would be necessary in order to avoid disturbing his general patients and Thai massage students – he has had no opportunity to further develop his experience.

Mo Somsak and Mo Boon, two key local healers in this study, mentioned on the contrary that AIDS is a new disease and differs from *muttakhuet*. Mo Somsak based this statement on his attempt to use traditional drugs for the treatment of *fi mamuang* (a type of *muttakhuet*) to treat HIV/AIDS patients, but with no positive outcome. Mo Boon followed the advice of his father, a famous local healer in the region, and was in the same way not concerned about *muttakhuet*.

Like Mo Somsak, Mo Thatchai agreed with the idea that AIDS is a new disease, since he could not find reference to the disease in the old medical manuscripts. Neither did he get a good result when he used traditional drugs for the treatment of gonorrhea. He observed the signs and symptoms of HIV and AIDS patients and concluded that itching, dry skin, a yellow face, a dull forehead, and becoming thin resembled the symptoms of a kidney disorder induced by bad blood. When he applied medicines for a blood disorder, the good results were obvious.
Only Mo Pinkaew, the local healer in this study with the longest experience, insisted that AIDS is a re-emerging disease. He gave the disease the local term of *khang muttakhuet*, which is a type of *muttakhuet* related to blood disorder. According to the ideas of Mo Pinkaew, if one treats a disease with traditional drugs, the disease must be explained on the basis of traditional disease theory.

I would like to note here that even though there is no consensus among the local healers about the question of whether AIDS is a new or a re-emerging disease, or whether AIDS is a type of *muttakhuet*, most healers were inclined to agree with the assumption that AIDS is associated with a blood disorder. This agreement can be formulated more clearly when we consider how the healers treat HIV and AIDS.

**Khang: The origin of AIDS**

In November 2008, I joined the funeral ceremony of a local healer in Chiang Rai. At the event I met Mo Pinkaew, a well known Northern local healer, who had ideas about AIDS that were different from the other local healers. Meeting him by chance at that funeral ceremony gave me the opportunity to learn that he was practicing the healing of HIV and AIDS patients, and I was able to make a first appointment with him at his house for the following month.

**Mo Pinkaew from Mae Taeng**

I had met Mo Pinkaew before, for the first time, in 1999 at a Regional Convention on Culture and Health held in Chiang Rai. He was invited as a panel speaker on the issue of new challenges in local healing. In 2003, I met him again in Bangkok when I acted, according to the Healing Art Act 1999, as a member of the professional committee on traditional Thai medicine. Mo Pinkaew was a member of the sub-committee that was tasked with revising the handbook of traditional medicine. Yet on this occasion I had no chance to talk with him about his healing activities. The interview at his house in 2008 was therefore my first opportunity to get to know him better.

Mae Taeng district, where Mo Pinkaew lives, is situated about thirty kilometers north of central Chiang Mai. Tourist information is focused on the fascinations of elephant riding in the valley near the Mae Taeng River. I met Mo Pinkaew in his three story shop-house near the main road. The building is situated opposite a hotel and nearby is a branch of an international superstore and a local fresh market. The plate above the door announcing ‘The Traditional Thai Medicine Club’ assured me that this was the place I was searching for.

When I arrived at his residence, Mo Pinkaew was taking care of a mother who, after childbirth, was suffering from ‘after childbirth disorder’ (*lom phit duean*). She was so

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1. *Lom phit duean* is a local disease and refers to a syndrome that often occurs in mothers after childbirth when they ingest improper foods (*kin phit*) or smell the wrong odors (*sap phit*). Symptoms may range from pale and yellow skin, weakness, dizziness, anorexia, and insomnia, to unconsciousness or mania. It also happens in older women who did not receive proper care after labor. In the latter case, the symptoms may include headache, dizziness, vomiting, diarrhea, chills, numbness in hands and feet, absent mindedness, grumbling, and mania.
dizzy and weak that she could not walk. Accompanied by her husband and relatives, she had taken the traditional drugs prescribed by Mo Pinkaew a short while before I arrived, and was awaiting the outcome of the treatment.

After some greetings, Mo Pinkaew and I took a seat on a set of teakwood chairs in front of two office tables which separated the reception area from the workspace. I noticed a desktop computer on a table inside the office. On top of the office tables stood a certificate and two pictures related to his honorary Master degree in traditional Thai medicine which had been conferred to him by Chiang Rai Rajaphat University in 2006. One picture portrayed him in academic gown; the other was of him receiving the degree from the Thai Crown Prince. Behind my chair was the other part of the building, where two wooden counters formed a triangle. The glass on top and on the side of the counters showed many of Mo Pinkaew’s medicinal products that were offered for sale. Five certificates from local organizations that acknowledged these herbal products were also placed there.

Our conversation started with Mo Pinkaew giving his opinion about developing education for and passing down the knowledge system of traditional healers. He indicated that the major problem in developing traditional medicine was the rarity of contemporary healers with the knowledge and practices of the ancient healers. Most healers, he said, did not use the traditional treatment principles nor did they have much practical experience in treating patients. In their teaching they passed this problem down to the next generation, and in this way it became a never ending problem.

Mo Pinkaew also repeatedly insisted during the interview that the traditional drug formulas from reliable medical scriptures were still useful in treating many current diseases. In his opinion there are three traditional medical textbooks that are reliable, namely the Tamra Phaetsat Songkhro, Tamra Phaetsat Songkhro Wat Phrachetuphon, and Khamphi Phaet Phaen Boran. The other textbooks are problematic due to the incompleteness of the inscriptions or because they have been influenced by the interests of donors. He suggested that there are many problems that lead to the ineffectiveness of traditional drugs. First, many past healers only passed down the complete drug formulas to their own descendants or to persons whom they trusted. These secret formulas might not be inscribed in the texts, or if they are inscribed, many might be incomplete or written in cryptic form. Second, local healers of later generations cannot analyze drug formulas properly. They only know which traditional drug they should use for which particular illness or disease, conforming to the practices of their ancestors; however, they have no deeper knowledge of the etiology of illness and disease or of the drugs used for treatment. Third, some healers formulate the properties of traditional drugs according to the outcomes of scientific research of medicinal plants without referring to their own medical manuscripts. According to Mo Pinkaew, this is not the proper way to characterize the properties of traditional drugs.

Mo Pinkaew was confident in the value of ancient knowledge, which was intensely demonstrated during our conversation about diseases and treatments. He often said that ‘it is presented in the ancient texts, but we, the later generations, don’t know about its implications.’ This opinion will be further illuminated when we consider it in the light of
Mo Pinkaew’s education and healing background. The following information about this background is extracted from three interviews that I conducted at his house and at his traditional pharmaceutical factory, as well as from a previous study done by one of his students (Thawatchai 1999).

Mo Pinkaew is 65 years old. He belongs to the ninth generation of a local healer lineage in Chiang Mai. His paternal ancestors were royal elephant trainers, while his maternal ancestors were the major patrons of Wat Lok Moli, a Buddhist temple in central Chiang Mai. Around 10 kilometers from his residence is his traditional pharmaceutical factory located in his home village, which he set up in 2000. Mo Pinkaew started to practice healing at a young age, thus his experience in healing – both secular and sacred forms – covers more than 40 years. In 2001 he received a national license in Thai traditional pharmacy. He is respected as an expert traditional healer and as such has been appointed as a committee member on many traditional medicine boards, both at regional and national level.

When Mo Pinkaew was young he learned much traditional mystical and medical knowledge from his uncle. He can write in the old script and read Northern mystical and medical manuscripts, which have been passed down to him through the generations. At the age of nineteen, he learned from a healer in Phrao district the practice of sak muek – a traditional practice of making a tattoo, which is believed to make the skin impenetrable and invulnerable. He was trained in meditation in order to search for underground treasures² and in hypnotization by a healer in Phitsanulok province. He also learned from an abbot in Mae Taeng about incantation, shamanic healing, and traditional drugs. In addition, a healer in San Pa Sak taught him about traditional bone setting.

When Mo Pinkaew was 35 years old, he was ordained as a monk for one year in a temple in Central Thailand to study a kind of Buddhist meditation and local healing from a respected and experienced monk. He then conducted the Buddhist ascetic practice of traveling alone to deserted places in the provinces of Central Thailand. These experiences have made him an expert in teaching this form of meditation; some monks even come to study under his guidance.

At the age of forty, Mo Pinkaew learned from a Karen healer in Mae Hong Son province about magic spells and chet haek – a local healing practice to treat the poisoning caused by evil spirits or the ingestion of improper foods. He believes that this hill tribe group has preserved the authentic Karen spiritual practices.

Aside from local healing, Mo Pinkaew was, at the age of nineteen, trained in giving injections and normal saline infusions by an American medical doctor in Chiang Mai University Hospital. This doctor wanted to treat Mo Pinkaew’s cleft palate abroad, but his mother did not give permission. Despite the fact that he received no treatment, his contact with Western medical technology in the medical school fuelled Mo Pinkaew’s curiosity. With

² In ancient times, during a war people needed to hide valuable things underground. After the war, however, these treasures might become lost. With the help of a person who has a highly concentrated mind and has learned the ancient practice of looking for underground treasures (du sombat tai din), the exact location of the underground treasure can be discovered.
the support of an acquaintance who was familiar with the doctor, Mo Pinkaew gained the opportunity to learn how to make injections, a skill which he later used to complement his local healing. He also learned about modern medications from the handbooks of pharmaceutical companies. This informal learning influenced his perception of diseases. I will describe this later when I discuss Mo Pinkaew’s disease theory, in which he has integrated the germ theory of biomedicine with traditional medical theory.

For many years, Mo Pinkaew practiced as a local healer in his home village. The various illnesses among the inhabitants of the subsistence agriculture villages around his home offered him an abundance of case studies. He became a master of spiritual healing in Mae Taeng. People in the villages in the neighborhood were in awe of his mystic powers. He said:

My factory does not need any guards; no one dares to enter my factory at an improper time because everybody knows that there are some spirits protecting this place from intruders.

The life history of Mo Pinkaew shows that to become a competent local healer he had to learn from a variety of knowledge sources. In having such a wide variety of knowledge, a local healer like Mo Pinkaew will not be easily embarrassed. This learning style arms the healer with knowledge that can deal effectively with a variety of health problems in the community. Moreover, it provides the healer with several tools to solve a problem in different ways. Mo Pinkaew compared healing with sculpture. A pretty sculpture is not achieved by using only one kind of instrument. Healing, therefore, should not limit itself to one kind of knowledge, one approach or one technique. This characteristic was evidenced by other local healers in this study as well. From a wider social perspective, local healers like Mo Pinkaew are the product of a multi-ethnic society in which a variety of healing sources is simultaneously present, and out of which each healer independently selects the sources he will use.

**HIV, AIDS, and khang**

It was in 1982 that Mo Pinkaew treated for the first time a disease with symptoms that later became recognized as those of AIDS; his second time came in 1992. He defined AIDS from 1992 onwards as a re-emerging disease. He gave this disease the local term of *khang muttakhuet* and classified it into two types. The first type is caused by white blood cells eating red blood cells, causing a yellow body, scaly skin, and a high CD4 count. The second type is caused by red blood cells eating white blood cells, causing a thin body, papules, dark skin, and a low CD4 count. In both types the patient will have a positive HIV blood test. In addition, Mo Pinkaew divides AIDS according to the infecting germ: a so-called male and female germ. He explained that a couple that became infected by the same sexual germ would not die until they had sexual intercourse with somebody with the other sexual germ. This idea came from his observations in clinical experience. He found that some couples were still alive and without symptoms even though their blood tests were positive. But after one partner had sexual intercourse with somebody who was not his or her spouse and who was HIV positive, it could aggravate the illness and lead later on to death.
Both of the ideas I have described above were based on data that Mo Pinkaew received from patients who had sought treatment from modern medicine before they met him. This kind of clinical explanation does not have any roots in traditional disease theory nor does it affect the technique for treating diseases. What it does reveal is how a modern diagnosis and the results of laboratory examinations such as HIV blood testing, CD4 counts, or viral load testing, have been reinterpreted by a local healer in a way that differs from medical science. The idea of Mo Pinkaew that is based on traditional medicine theory is that every disease is innate, and it will appear when we eat the wrong diet. Formulated in other words, an incorrect diet can aggravate diseases, all of which are congenital. In brief, this idea focuses on diet as a trigger of disease, and khang as the root of all diseases, because it is inherent since one is born.

**Khang/sang in medical texts**

*Khang* is a local word that corresponds to *sang* in the *Phra Khamphi Pathomchinda* (the scripture of child development and childhood diseases).[^3] According to this scripture, every infant has a certain birth *sang* that depends on his/her day of birth. There are seven types of *sang* associated with the particular days of the week. Each *sang* may lead to a particular illness in an infant. For example, an infant born on a Monday has water *sang* (*sang nam*) as its innate *sang*. This infant is likely to become sick from water that causes fever, an illness that has certain symptoms such as sharp apex like nodules on the tongue, difficulty in sucking milk and water, and vomiting something that looks like rice cleansing water.

*Sang* affects the health of a child from two to five years old, and is related to the particular type of *sang* relevant to that child. After the period of *sang*, the disease determinant shifts to *tan chon*. *Tan chon* is the result of changes in a child’s diet. Eating unfamiliar foods facilitates the development of various pathogenic worms or parasites (*kimichat*) in the body of the child in this period.[^4] These pathogenic worms reside in the body of humans and may at any time cause various illnesses and diseases.

If a child who has become sick from a certain *sang* is not treated properly in the period of *tan chon*, then some pathogenic worm may cause a certain illness. For example, a child born on Monday will become ill from a pathogenic worm named *santathat*. The symptoms are a cool body, incessant flatulence, bleeding, and urine like rice cleansing water. If this child is not treated properly at this time, he or she will become ill from a certain kind of *ritsiduang*.

[^3]: The *Phra Khamphi Pathomchinda* is the most elaborate medical scripture among Thai traditional medicine textbooks. In order to capture the idea of *sang*, I have had to simplify the information about its signs and symptoms into a brief description, and have omitted a discussion of what is associated with it and what can aggravate the illness. For further detail see Mulholland (1988).

[^4]: According to the *Phra Khamphi Pathomchinda*, there are eighty types of *kimichat* in various parts of the body, i.e. stomach, brain, bone, spleen, heart, blood, bile, phlegm, eye socket, lymph, liver, belly, liquid fat, hard fat, anus, lung, small and large intestine, lower part of the body, hair, nose, tongue, under the nails of the fingers and foot, muscle, tendon, and throat. Each type of *kimichat* resides in one particular body part.
disease later in life, at the age of 30 or 40. *Ritsiduang* is the name for the category of diseases that all have protruding tissues in common; these protruding tissues can grow in one of the nine orifices of the body, namely eyes, ears, nose, mouth, skin, anus, and urethra.

In the *Phra Khamphi Pathomchinda*, an abundance of internally and topically used medicines is available for various kinds of *sang* and related diseases. Before the coming of antibiotics, Thai infants and children were accustomed to treatment with these traditional drugs. When a child was ill, his or her grandfather would use the clean tip of his finger to touch a mixture of the drug with water, lemon juice, or liquor and smear it on the child’s throat, tongue, soft palate, or inner side of the cheek where the nodules, sores, or colored coatings were located. For internal medication, there were several traditional drugs for specific purposes, such as treating particular *sang*, purging general *sang*, purging parasites, and treating stool with mucous or blood, and so on.

![Figure 5](image.png)

**Figure 5.** The disease theory formulated in Thai traditional scriptures of child development and childhood diseases and the interpretation by Mo Pinkaew

**Khang, kimichat, incorrect diet, and HIV**

According to Mo Pinkaew, *sang* and *khang* are the basis of all diseases. The difference between *sang* and *khang* is, however, that *sang* refers to certain diseases in the child, while *khang* covers diseases in adults that are the result of improper *sang* treatment. A person
who can treat sang can treat all diseases. Khang relates to heat in the body, which emerges when the body becomes overheated. Khang in the nose will cause nose bleeding. Khang that emerges in the liver will cause the presence of blood in the feces and a foul odor of blood in the mouth when coughing. Khang in the kidney causes a yellow body and edema of the hands and legs. The heat of khang may induce ulcers in the throat or stomach and can further develop into cancer. To prevent diseases associated with khang, every child should take traditional drugs to purge the khang. This drug has to be administered at the proper time according to the lunar calendar. If an adult is ill from a disease associated with khang, he or she has to be symptomatically treated.

Mo Pinkaew broadly interpreted kimichat as small and minute pathogenic organisms, including all viruses and bacteria. These pathogenic organisms might continue to reside in the body if they were not purged completely in the periods of sang and tan chon. When somebody who has these pathogenic organisms in his body grows up as an adult, that person is likely to become ill anytime he or she feels weak. The most important trigger for the violence of these pathogenic organisms is the ingestion of improper food.

Kimichat, when activated by an incorrect diet, especially strongly sweet and fatty foods, can result in a number of diseases, such as ritsiduang – ritsiduang chamuk (ritsiduang in the nose), ritsiduang ta (trachoma), and ritsiduang thawan (hemorrhoids) – pradong (skin disease with hot itching), tap khaeng (cirrhosis), san, and mareng (cancer or chronic sore). All of these diseases have their own root in particular organs; for instance, the root of ritsiduang chamuk is in the brain and the root of ritsiduang thawan is in the area of the xiphoid process (the lower part of the breastbone). In traditional treatment, one has to cut off these roots by using particular ya tat rak (drugs cutting the root). Mo Pinkaew claimed that this knowledge appears only in Northern medical manuscripts, and that nobody learns about it anymore. This lack of knowledge has led to inaccuracies and thus inadequacies in the effectiveness of local healing.

Regarding HIV and AIDS, Mo Pinkaew applied the concept of khang and proposed that the virus was a kind of kimichat that resides in a person. It is activated after the ingestion of improper food, i.e. raw meat or fish, or liquor. The HIV that is so triggered can then do harm to humans and spread through sexual intercourse or blood contact. He also remarked that he had experienced that a person who was likely to become infected with HIV had, before becoming infected, had a dream in which he or she had sexual intercourse with someone. This particular dream was a prophetic sign of the disease. Mo Pinkaew argued, however, that this disease is curable, just like cancer and other khang diseases, if one takes the right medicine.

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5 According to Northern Thai disease classification, san is a category of disease. Its common symptom is having a hard lump under the skin, which begins as very small and then gradually enlarges. If persons who have san ingest the wrong foods (such as ripe jack fruit and meat) they will develop cancer.

6 In Thai traditional medical knowledge there are prophetic signs of some severe illnesses. For instance, a person who has dreamt of a round shape of white light running out of his or her body – the sign of deficiency of the element of wind – will die in four days if not treated properly.
Khang muttakhuet phrai kin lueat
In some HIV and AIDS patients, Mo Pinkaew diagnosed *khang muttakhuet phrai kin lueat*, when this kind of *khang* not only involved sexual intercourse and blood disorder but also *phrai* or evil spirit. *Phrai*, which often takes possession of vulnerable persons, subsequently destroys the blood (*kin lueat*) of an HIV patient and turns him or her into a greedy person as soon as that person is not watched over by other persons. Persons who are possessed by *phrai* like to eat raw animal meat at night. Medication alone cannot cure this problem; ritual healing should also be applied.

HIV positive might not be HIV or AIDS
Although Mo Pinkaew accepted the results of laboratory blood testing as an essential tool to diagnosing HIV and AIDS, in some cases he rejected the diagnosis ‘HIV infected,’ regardless of whether the HIV blood test was positive. For instance, he had a patient who had a lump on his neck, which became bigger and bigger, while the patient became gradually more skinny. The HIV blood test was positive, but the situation of the patient worsened after he took ARVs. When that patient sought care from Mo Pinkaew, he was diagnosed by Mo Pinkaew as having *san khanthamala* instead of AIDS. The patient’s recovery from his disease after treatment of *san* with traditional drugs confirmed to Mo Pinkaew that his diagnosis was correct. Mo Pinkaew said that the germs that caused AIDS and *san khanthamala* were nearly the same, so the blood tests of both diseases were in the same way positive.

The unrecognized disease theory of AIDS
Unlike Mo Pinkaew, the other local healers did not associate HIV and AIDS with *khang*, although most of them accepted that *khang* is the origin of all diseases and that an improper diet aggravates HIV and AIDS. Mo Pinkaew was aware of the fact that his theory would not be accepted by other local healers and medical doctors, academics, and health authorities. When he participates in joint seminars with such persons, he prefers to keep his opinions to himself. Throughout the interviews I had with him, Mo Pinkaew complained occasionally about the inferior status of local healers:

> Nowadays, we, local healers, cannot treat HIV and AIDS openly and we cannot reveal the evidence that we can cure it because the health authorities assured the public that HIV and AIDS are incurable. Most local healers do not dare to treat it because they are afraid to be arrested.

For Mo Pinkaew, the dominant biomedical discourse offers no opportunity to formulate models of disease theory and treatment alternative to those of biomedicine. Speaking from his experience he told me:

> I used to cooperate with disease control authorities in helping HIV and AIDS patients. But after having received a list of my patients from me, these

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7 *San khanthamala* is a sort of *san* disease. It develops in the form of lumps along the tendons of the neck. If a lump is broken, it becomes rotten. If a lump falls down, germs will enter into the blood circulation. This *san* is severe and deadly unless the right treatment is followed.
authorities prohibited my patients to take traditional drugs or else the patient would not get his monthly support money. Since then, I ceased to cooperate with the health authorities.

This altercation with the health authorities led to Mo Pinkaew changing his practice of keeping patient medical records up to date; because he had no license as a doctor of traditional medicine, they could form evidence against him and lead to his arrest. When I asked to interview some of his patients, I got the response that this would be impossible, for two reasons: on the one hand, this was because of the absence of medical records; on the other hand, it was due to the problem of the social stigma attached to persons with HIV. These problems were an obstacle not only for me as a researcher but also for other HIV patients who lack the opportunity to learn from the healing experiences of these anonymous persons.

One may ask how practical the disease theory, as developed by Mo Pinkaew, is, since it cannot be affirmed by any case studies. This lack of confirmation is a limitation of this study. It results from the difficulty in gaining access to the HIV patients of Mo Pinkaew. However, by exploring the principles of treatment in the next part of this chapter, we can explore how Mo Pinkaew’s theory relates to what is practiced by other local healers.

Principles of treatment

Even though Mo Pinkaew described HIV and AIDS on the basis of khang, a theory on which he differed from other local healers, the principles of the treatment he conducted were similar to those of the others. Mo Pinkaew affirmed that merely by normalizing the four inner elements, through the use of traditional drugs according to traditional texts and conducting symptomatic treatment, the HIV illness could be cured. The following are the treatment principles that I have synthesized from the knowledge that I gathered from all of the local healers who participated in this study.

Symptomatic treatment

As HIV can destroy the immunity of its host, HIV patients who have a low CD4 count occasionally fall ill from opportunistic infections caused by pathogenic bacteria, viruses, fungi, and protozoa, while many patients also suffer from food allergies. The most frequent symptoms of these infections and allergies are diarrhea, fever, skin papules, itching, headache, dizziness, loss of appetite, insomnia, paleness, and loss of weight.

These initial symptoms – which often appear randomly and subsequently become chronic – are noticeable abnormalities. They make persons with HIV aware that they need care and healing. All local healers were concerned with all the symptoms from which HIV patients suffered. Some searched for medicines in their old manuscripts in order to heal a symptom and

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8 According to the Thai Art of Healing Act 1999, there are four branches and corresponding licenses of traditional Thai medicine: medicine, pharmacy, midwifery, and massage. Mo Pinkaew had only passed the national licensing examination in pharmacy, so in terms of treatment he only had the legal right to dispense, formulate, manufacture, and sell traditional drugs.
learned from their patients which medicine worked for which symptom and which medicine did not work. Others used the medicines that were passed down from their ancestors and managed to alleviate the troubling symptoms.

Mo Boon learned from his father how to conduct symptomatic treatment. The pattern of his treatment always included traditional drugs such as *ya daeng luang* for fever, *ya daeng noi* for headache, *ya dam* for skin papules, *ya kae kin phit* for dizziness and diarrhea from ingesting improper food, *ya fok lueat* for loss of appetite and paleness, and *ya tom pot* for lung infection. Mo Somsak used traditional drugs, for example *ya kae kin phit* for dizziness and diarrhea from ingesting improper food and *ya bamrung rang kai* for loss of appetite and paleness. Mo Thananchai had experience in the treatment of HIV patients who suffered from fungal infections in the brain, with the symptoms of strong headache, dizziness, and blurred vision.

The HIV-related opportunistic conditions that, according to the local healers, respond well to traditional drugs are herpes simplex, herpes zoster, and oral thrush. The conditions that are difficult to treat with traditional drugs and are life threatening are tuberculosis and Cryptococcus meningitis (a fungal infection of the membranes covering the brain).

**Normalizing inner elements (prap that)**

In Northern traditional medicine and traditional Thai medicine, *that* represents the inner elements of the human body. It has been taught from generation to generation that human beings are composed of four elements (*that si*): the elements of earth (*that din*), water (*that nam*), wind (*that lom*), and fire (*that fai*). These four elements work together to maintain the functions of body and mind. If any element becomes abnormal, it will disturb this harmonious functioning and cause illness. Traditional Thai medical textbooks elaborate on the abnormalities related to the four elements in various manners. In Northern traditional medicine there is an additional *that* beyond the four elements; this is the element of air (*akatsa that* or *that phra chao*).

According to Mo Boon, his father had taught him about the relationship between striking characteristics of patients and the abnormalities of inner elements. If somebody who walks into the consultation moves stiffly, it will indicate an abnormality of the element of earth. If he has an edema, it will be an abnormality of the element of water. Having excretions from the eyes and eye pain will be an abnormality of the element of wind. If he feels hot after sitting for a while, it will indicate an abnormality of the element of fire. Mo Boon used *ya dam* – a drug to cure *khang*, and which was once used by his father for small pox fever – in order to cure abnormalities of the blood, since blood is composed of both the elements water and wind, as well as *ya fok lueat* – a drug to cleanse blood – to cure decreased and thinned blood.

Unlike Mo Boon, Mo Somsak learned about the four inner elements in a traditional Thai medicine class. He thought that HIV possibly disturbs the functioning of the four elements, therefore normalizing them would likely help HIV and AIDS patients to return to a normal state. First he tried *ya benchakun*, which is generally known as a drug to nourish the four inner
Local healers’ search for a disease theory of and healing methods for HIV and AIDS

elements. The results were not as expected, because the hot quality of the drug aggravated diarrhea. Then he searched in his medical scriptures for another drug that had a neutral quality. Among the ten drug items from the manuscripts that normalized inner elements, he found only two that had formulas with a neutral quality. He chose the one for which he could find the complete materia medica and called it *ya prap that*. The second trial was satisfactory; the patients became healthy, developed a good appetite, good sleep, and a fine complexion. Mo Somsak has continued to use this drug as his major medication until today. After this success, he sought for drugs to nourish blood (*ya bamrung lueat*) from his manuscripts and has used them as a supplement.

Since Mo Pinkaew indicated that HIV and AIDS is a blood disorder, he treats it with the drug to create blood (*ya sang lueat*) and the drug to create lymph (*ya sang nam lueang*). However, he pointed out that to normalize the four elements, a healer needs to examine the symptoms of the patient to find out which inner element is the cause of the abnormality, so that the healer can adjust the drug appropriately.

Like Mo Pinkaew and Mo Somsak, Mo Thananchai, who stated that HIV and AIDS leads to bad blood, uses a drug to normalize inner elements, drugs to nourish blood, and drugs to create blood in order to treat his HIV patients.

From what I have described above, we may conclude that all local healers use traditional drugs to correct the blood disorder caused by HIV, either by cleansing the blood, nourishing the blood, or creating new blood. This evidence firmly confirms the assumption that, from the perspective of the local healers, AIDS is associated with a blood disorder.

**Killing germs (kha chuea)**

Seeing that AIDS is caused by a germ, Mo Pinkaew chose a formula from a traditional textbook, the materia medica of which have anti germ properties. This practice goes against the classical perspective that there is no concept of germs or germ killing drugs in traditional Thai medicine. As his life history suggests, we may assume that the influence of biomedicine accounts for this adaptation.

Mo Boon found out with the help of his father that the hottest drug from the manuscript – the drug containing pungent materia medica as a major part of its formula – which was named the drug to cure blood *khang* (*ya khang lueat*), and a traditional drug that he obtained from a manuscript of Khruba Khaopi, were effective in treating his first generation of HIV patients. Since then, he has changed the name of both drugs to ‘the drug to kill germs’ (*ya kha chuea*) because his HIV patients all know that the disease is an infectious one, but that there is no (biomedical) drug that can kill the germ that causes it. It appeared that the name ‘drug to kill germs’ satisfied these hopeless patients better than the old names. I will discuss the significance of the names of the drugs for HIV patients in Chapter 5.

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9 Khruba is the title that Northern Thai people confer on monks, usually of old age, who are highly venerated for their sanctity and personal charisma (Tambiah 1984: 295).

10 Mo Boon told that he found the manuscript of Khruba Khaopi in Nong Chang temple and that it contains the following text: ‘In the future, there will be an incurable disease, this drug can cure it: …’.
Excreting toxin, excreting germs (khap phit, khap chuea)
Toxin (phit) in the traditional concept is the result of many agents. Poisonous food may have toxin, which leads to acute diarrhea, vomiting, dizziness, and so on. Poisonous drugs may cause acute heart failure, hematuria (red blood cells in the urine), and hematemesis (vomiting of blood), and so on. Some diseases may produce toxin that causes high fever, pain, inflammation, and papules, or round spots with a dark red, blue, or black color on the skin. In traditional Thai medicine, a medical scripture named Phra Khamphi Takkasila exists which describes these poisonous fevers (khai phit) and black fevers (khai kan). They are mainly associated with viral and bacterial infections.11 The mechanism of drug treatment in this scripture includes pushing out the febrile toxin (kratung phit khai) and externally applying decoction (prasa phew phai nok). The objectives of the treatment are to accelerate the process of disease development, to push the febrile toxin from the inside to the outside, and to prevent the febrile toxin from spreading to the internal organs.

Since Mo Somsak considers HIV and AIDS to be a poisonous disease, he used to treat it with a drug comprised of five valuable roots (ya kaew ha duang), to which the Phra Khamphi Takkasila refers as a major drug to push out febrile toxin. However, this drug did not work. He discovered later that a traditional drug named ‘the great drug to excrete poison’ (ya pit pak luang), which is described in one of his own scriptures, was effective. This drug is mainly composed of materia medica which possess diuretic and tonic effects. He ranked this drug as essential for HIV patients. When somebody was in a critical condition (e.g. with a low CD4 count), he advised them to immediately take this drug in a double or triple dose.

Mo Pinkaew focuses his treatment on the excretion of HIV instead of its toxin. Before excreting HIV, however, he needs to separate HIV from the blood by the use of the drug to cleanse blood (ya sa lueat). The drug to excrete germs (ya khap chuea) is then administered to excrete HIV gradually through the urine.

Dietary control (kam kin)
Kam kin is a local health concept mostly applied to pregnant women, mothers after childbirth, patients with fever, and weak patients. It is based on the fact that the blood and wind in the bodies of such patients are likely to lose their function; ingesting certain foods may aggravate blood and wind and has a negative effect on the fetus or the infant during breastfeeding. It is often necessary, therefore, to control the diet by omitting prohibited foods (ahan salaeng). A grandmother will teach a new mother what kind of foods may harm her or her baby, and what kind of foods she should eat in order to facilitate labor and breastfeeding.

Mo Somsak learned more about prohibited foods when he treated his HIV positive nephew. His nephew had used traditional drugs for symptomatic treatment and to nourish his body. During the treatment he was not allowed to eat meat, which is in general a prohibited food. After one year of treatment, his nephew became healthy once again and resumed his work.

11 Examples of viral and bacterial infections in Phra Khamphi Takkasila are khai wat noi (cold), khai wat yai (influeza), khai ok hat (measles), khai raksat (typhoid fever), khai ngu sawat (herpes zoster), khai e-suk e-sai (chicken pox), khai fai lam thung (erysipelas), and so on.
as a house painter. One day the house owner invited him after work to join a dinner where grilled meat and liquor were served. These foods suddenly harmed him with hematochezia (the passing of bloody stools). Ten days later, he died.

This event taught Mo Somsak that liquor is also a prohibited food and that his nephew had not completely recovered from HIV and AIDS. He learned from this case, and from his second HIV patient, that he had to observe more strictly which foods fall within the range of prohibition for persons with HIV. Putting together a list of such foods, which he gave to me on a full A4 page, was an attempt by Mo Somsak and his HIV patients to collect data about prohibited foods. It was similar to the lists of prohibited foods of other local healers and HIV self-help groups. Meat, buffalo meat, farm chickens, fish without scales, snapping turtle, seafood, bamboo shoots, mushrooms, insecticide-contaminated vegetables and fruits, strong sweet fruits, coconut juice, carbonated water, fermented foods and beverages, caffeinated beverages, and raw foods are at the top of their lists.

Mo Pinkaew apparently insisted on the crucial importance of forbidding some foods that can aggravate the disease of khang. Sweet, fatty, and raw flesh foods are the best nourishment for pathogenic worms associated with khang. He judged the ingestion of prohibited foods as essential in the etiology of diseases, so all of his HIV patients are required to omit prohibited foods from their diet alongside taking medication.

Once an HIV patient has become sick after ingesting prohibited foods, all local healers treat him or her with a drug to cure the ingestion of improper food (ya kae kin phit). Each local healer has his own drug for this purpose. According to Mo Somsak, ya kae ha ton (literally, drug comprised of five plants), which is generally used for mothers who become ill after childbirth from ingesting prohibited foods, was ineffective among HIV patients. He had to search his manuscript for another drug to cure the ingestion of improper food in order to gain a good result.

Some foods and herbs that are recommended by the local healers and HIV self-help groups are locally familiar, for example: phlu khao (Houttuynia cordata Thunb.), mara khinok (Momordica charantia L.), pheka (Oroxylum indicum Vent.), buabok (Centella asiatica Urban.), thao sakhan (Piper interruptum Opiz.), boraphet (Tinospora crispa L.), marum (Moringa loeifera Lam.), fathalaichon (Andrographis paniculata Wall ex Ness.), samothai (Terminalia Chebula Retz.), and kaphrao (Ocimum sanctum L.). Recent scientific research reveals that these herbs possess compounds that have certain pharmacological qualities such as promoting immunity, stimulating digestion and appetite, and reducing flatulence. Nutrients in these plants may contribute to slowing the progression of HIV and enhancing the immune response to the virus (Bodeker et al. 2006). Some plants were cultivated and disseminated by Mo Boon to enable persons with HIV to plant them in their kitchen gardens.

Aside from prohibited foods, certain smells (sap phit) can also aggravate HIV and AIDS. A female HIV patient of Mo Boon, who did not recover after being treated with local healing as well as with ARVs, was suspected to have smelled the goods she sold, which had a strong odor of squid and seafood. Another HIV patient mentioned spray paint. Her husband suddenly had a strong headache and convulsions after he had sprayed an old motorcycle; three days...
later he died in hospital from a fungal infection in his brain. Among persons with HIV, it is believed that the solvent in spray paint can push the growth of fungi in the nervous system. *Nam pu*, a popular fermented food made from local crabs, is not only prohibited because of its ingredients; its smell can also jeopardize HIV patients. An HIV patient of Mo Somsak in Chiang Rai got immediately convulsions after he smelled the odor of cooked *nam pu*, which was blown from the kitchen of a neighbor. Two days later, he passed away.

**Living conditions (kam yu)**
Regulations on living conditions, *kam yu*, are in part also borrowed from practices relating to pregnant women and mothers after childbirth. Hygiene and rest are the living conditions that are most important as far as the local healers and persons with HIV are concerned. Mo Boon often advised his HIV patients to cleanse their bodies with an antiseptic soap, alum, and then to apply a solution of *ya dam* (drug to normalize blood and wind) to reduce skin papules. Washing the mouth with a diluted salt solution was recommended to those who had oral thrush. Boiled water was also preferred as drinking water. Before raw vegetables and fruits are eaten, they should be washed with potassium permanganate or baking soda. I tracked the living conditions of an HIV patient who suffered from chronic abdominal pain and was diagnosed by a medical doctor as having a parasitic disease. I found that she was washing her raw vegetables and fruits with water from a dim well, which might be contaminated with pathogenic protozoa. In addition, she could not follow the advice to take complete rest when her CD4 count was low. Her poor living conditions were also the local healers’ explanation for the ineffectiveness of the healing.

**Detach oneself from something that causes suffering (kan plong)**
When most HIV patients learned for the first time about their positive HIV blood test, they tended to become anxious about the consequences they would have to face. Social stigmatization, a feeling of having sinned, and family burdens were the main concerns that led to hopelessness and an early death for many HIV and AIDS patients. When they were not able to cope properly with these negative impacts, a good healing result might be not expected.

Each local healer had a different method to solve their patients’ suffering. In some cases, the advice to follow rituals like *song khro* (the ritual to send away bad things after a person has experienced a bad situation that leads to unexpected results) might help. Persuasive counseling with empathy was also performed to strengthen a patient’s will to survive within the family that the patient loves. Meditation – a tool to concentrate the mind, practiced by both local healers and HIV self-help groups – was proven effective in avoiding becoming engrossed in self-involvement. Mo Boon applied local proverbs (*kham ba kao*) and Northern Thai teachings of ancient scholars to arouse mindful thinking among persons with HIV, in order to resolve their suffering from a confused mind.

These techniques are all directed towards detaching the sufferers from the thing that makes them suffer. The results are a release from suffering. This process of release from suffering is locally known as *kan plong*. I will describe this issue in greater detail in Chapter 4.
Reducing the side effects of antiretroviral medication

The need to find effective ways to control ARV-related side effects is a very common concern among people with HIV and AIDS around the world; for instance, Pawluch et al. (2000: 258) observed this concern among people in south central Ontario. This current study confirms that this is also true for some Thai people living with HIV, and it is also evident from the experience of local healers.

No local healer rejected ARV medication if the patient decided to start this drug regimen under the supervision of a medical doctor, since some patients wanted to reduce the burden of their healing costs. But if both local healers and patients in this study had a choice, then they would prioritize traditional drugs. In recent years, the side effects of ARVs have been the most important concern that has led new HIV patients to look for alternative medications. Patients who try to hide their infection in particular fear the redistribution of body fat (lipodystrophy), which is a side effect of D4T in cocktail drugs that reshapes physical appearance causing hollow eyes, sunken cheeks, a protruded mouth, skinny arms and legs, but a big belly. These manifestations have become the new stereotype of HIV patients treated with ARVs. To avoid this side effect, some patients have therefore turned to traditional drugs from local healers. I will elaborate further on this concern in Chapter 8.

For HIV patients who are on ARV medication, another demand has emerged, namely the need to mitigate the side effects of ARVs. Local healers like Mo Boon and Mo Somsak were challenged by this new situation. Mo Boon, for example, encouraged his patients to take ya dam to normalize blood and wind and ya fok lueat to cleanse the blood alongside ARVs. He compared this with growing plants. Chemical fertilizers can stimulate the rapid growth of plants but they destroy the soil. Organic fertilizer fills this gap by both nourishing the soil and sustaining the growth of plants. Operating in a similar way to organic fertilizer, normalizing blood and wind and nourishing the blood can therefore reduce the side effects of ARVs. For patients who complain about the high level of serum cholesterol induced by ARVs, Mo Boon prescribes a drug to reduce lipids. Mo Somsak said that he would like to learn more about ARVs and their side effects before deciding on how to treat them.

The innovation of local healing for the purpose of mitigating ARV side effects is a new challenge to local healers that is still in its infancy. More efforts have to be made, both by healers and patients, to prove the effectiveness of traditional drugs in reducing the side effects of ARVs, and to identify any drug interactions that occur. Such efforts should also address the concerns of biomedical health practitioners, who uniformly prohibit the use of traditional drugs in conjunction with ARVs since they believe that such concurrent use is detrimental to the health of patients and therefore to the working of the ARVs (Kang’ethe 2009: 90).

Summary

The traditional drugs listed above are summarized according to each healer in Table 1.
<table>
<thead>
<tr>
<th>Healers</th>
<th>Traditional drugs</th>
<th>Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mo Boon</td>
<td>ya kha cheua 1 (ya khang lueat) ya kha cheua 2</td>
<td>To kill germs</td>
</tr>
<tr>
<td></td>
<td>ya dam</td>
<td>To normalize blood and wind, cure bad blood and wind, external use for skin papules</td>
</tr>
<tr>
<td></td>
<td>ya fok lueat (ya lom 80)</td>
<td>To cleanse blood, create blood, cure decreased and thinned blood, weakness, loss of appetite and paleness</td>
</tr>
<tr>
<td></td>
<td>ya daeng luang</td>
<td>For fever, cure decreased and thinned blood</td>
</tr>
<tr>
<td></td>
<td>ya daeng noi</td>
<td>For headache, dizziness, fainting</td>
</tr>
<tr>
<td></td>
<td>ya kae kin phit</td>
<td>For dizziness and diarrhea from ingesting improper food</td>
</tr>
<tr>
<td>Mo Pinkaew</td>
<td>ya prap that</td>
<td>To normalize the inner elements of the body</td>
</tr>
<tr>
<td></td>
<td>ya sang lueat</td>
<td>To create blood</td>
</tr>
<tr>
<td></td>
<td>ya sang nam lueang</td>
<td>To create lymph</td>
</tr>
<tr>
<td></td>
<td>ya sa lueat</td>
<td>To separate germs from blood</td>
</tr>
<tr>
<td></td>
<td>ya khap chuea</td>
<td>To excrete germs</td>
</tr>
<tr>
<td></td>
<td>ya kae kin phit</td>
<td>For dizziness and diarrhea from ingesting improper food</td>
</tr>
<tr>
<td>Mo Somsak</td>
<td>ya prap that (ya pok that)</td>
<td>To normalize inner elements of the body</td>
</tr>
<tr>
<td></td>
<td>ya bamrung lueat (ya paeng lueat)</td>
<td>To nourish blood and body</td>
</tr>
<tr>
<td></td>
<td>ya bamrung rang kai</td>
<td>For loss of appetite and paleness</td>
</tr>
<tr>
<td></td>
<td>ya pit pak luang</td>
<td>To excrete toxin</td>
</tr>
<tr>
<td></td>
<td>ya kae kin phit</td>
<td>For dizziness and diarrhea from ingesting improper food</td>
</tr>
<tr>
<td>Mo Thanachai</td>
<td>ya prap that</td>
<td>To normalize inner elements of the body</td>
</tr>
<tr>
<td></td>
<td>ya bamrung lueat</td>
<td>To nourish blood</td>
</tr>
<tr>
<td></td>
<td>ya sang lueat</td>
<td>To create blood</td>
</tr>
<tr>
<td></td>
<td>ya kae chuea ra</td>
<td>For fungal infection</td>
</tr>
<tr>
<td></td>
<td>ya kae puat hua</td>
<td>For headache</td>
</tr>
<tr>
<td></td>
<td>ya kae kin phit</td>
<td>For dizziness and diarrhea from ingesting improper food</td>
</tr>
</tbody>
</table>

Table 1. Traditional drugs used in the treatment of HIV and AIDS by the four local healers in Chiang Mai

From these principles of treatment we can conclude that all local healers were aware of the significance of diet for the aggravation of disease. This is probably related to the concept of khang, which states that poor diet facilitates the development of various pathogenic worms in the body. So when a disease of khang breaks out, the first measure one has to take is to omit prohibited foods. If the disease destroys the normal state of the inner elements, normalization of the inner elements is the essential treatment. If symptoms caused by a toxin are apparent, medication for purging such a toxin should be applied. If the pathogenic worms that produce
such a toxin cannot be eradicated by the normal body mechanism, then medication for excreting or killing the pathogenic worms is considered essential.

This shows that even though the local healers (with the exception of Mo Pinkaew) did not connect the principles of their treatment directly to the concept of *khang*, we can trace their practices back to the same theory. I myself tend to believe that if we provide local healers with an opportunity to revise and verify their knowledge together in a clinical setting, they would manage to develop a consensus regarding a traditional disease theory for HIV and AIDS.

**Indications of a good outcome**

Although HIV and AIDS is incurable in the eyes of medical science, local healing always keeps the opportunity open for a complete cure. The question is how to prove this. Mo Pinkaew insisted that HIV and AIDS patients could be cured within two years, and that the permanent effectiveness of his healing of HIV and AIDS was proven by modern blood testing, whereby the results of blood tests changed from positive to negative. The problem is that his patients who have recovered from HIV and AIDS did not want to reveal themselves because of the consequences of being stigmatized. The conviction that a complete cure is possible may sound exaggerated from the perspective of medical science, but it should not be ignored or dismissed until an opportunity for proof arises that is not biased by a difference in discipline and theory.

As a researcher who has a background in medical science, I am eager to prove whether or not a CD4 count or the result of an HIV blood test have improved, because this is a convenient way to communicate with the biomedical and health authorities. Why is there such a lack of evidence for whether local healing really works, obtained by comparing the pre-test and post-test situation?

The case of an HIV patient of Mo Boon could answer part of this question. This patient was convinced that she had been suffering from HIV and AIDS. She had run the risk of becoming infected with HIV when she had a secret sexual relationship with her husband’s friend over a period of three years, a man who later died from AIDS. Her initial symptoms were also associated with HIV infection: fever, severe chronic diarrhea, anorexia, loss of weight, weakness, and dark skin. She continuously took traditional drugs for twelve years and most of her symptoms disappeared in the third year. To end the doubt, I persuaded her to take a blood test at the Chiang Mai Thai Red Cross anonymous clinic. It was surprising to learn that her HIV blood test was negative. To my regret, however, I was not able to find any scientific evidence to show that she had been HIV positive twelve years ago. Why? This is because of the problem of social stigma attached to HIV and AIDS. She had not dared to go to the nearby hospital to test for HIV. This case cautioned me that in practice there are some limitations in terms of acquiring complete evidence from laboratory tests. I will return to this patient in Chapters 5 and 8.

My interest in the positive or negative results of HIV blood tests may be compared to the interests of Mo Somsak during the first phase of his healing trajectory for HIV and
AIDS patients. Since most HIV patients wanted to purge the HIV from their bodies, his initial attention in the early days was therefore directed towards killing HIV. After learning more about the principles of local healing, however, he started to focus instead on how to prolong the life of patients and how they can live healthily with HIV. This shift in his healing objectives rendered the presence of HIV less significant and allowed him to emphasize the indications of an outcome that corresponds to the principles of local healing.

Five indications of a good outcome can be summarized from the practices of all the local healers and patients. The first indication is the inner sense of a patient of a positive initial outcome, which is based on a form of self-evaluation. For Mo Pinkaew, the sense of refreshment of the mind is the important primary outcome. It is like a dehydrated plant that is soaked with water. This sense of refreshment is perceived within one hour of taking the drugs. Some patients also felt hungry and thirsty. After this, the illness gradually retreats. Mo Boon also underscored this aspect of the outcome and noted that his early outcome objectives were only focused on ill persons rather than on healthy persons.

The second indication is the recovery from illness symptoms such as diarrhea, headache, dizziness, weakness, and so on. This outcome may appear after one week, three months, or one year (in the case of a headache from a fungal infection in the brain). Patients can conduct self-evaluation of this outcome as well. Mostly, it is related to the effect of symptomatic treatment.

The third indication is an improvement of appearance. A fine complexion and weight gain are the most important indications that strengthen the confidence of HIV patients who had been feeling bad due to HIV and AIDS. Having dark skin and being skinny are stereotypes of AIDS patients, thus a pinky skin, bright face and eyes, and a well nourished body are the visual signs of recovery from HIV and AIDS. According to the concept of inner elements, these signs are related to a normal function of blood and wind in the body. It can be said that this positive outcome is mostly the effect of a normalization of the inner elements.

The fourth indication is the ability to tolerate foods that in the past worsened the illness. For Mo Somsak and some of his HIV patients, this outcome of gradual improvement was an indication of an improvement in immunity. Even though it was not clear how immunity is associated with the inner elements, Mo Somsak believed that by trying to find traditional drugs to improve immunity, the persons with HIV had no longer to care about prohibited foods and could eat the same foods as when they were healthy.

The final indication is the restoration of daily life abilities, which is the comprehensive outcome of the healing. As the ultimate aim of the healing of Mo Somsak is for a person to live healthily with HIV, this indication involves the ability to work as usual and to conduct daily routines regardless of one’s HIV status.

An HIV patient from Saraphi district claimed that a CD4 count, which is an indicator of medical science to evaluate the outcome of ARV medication, is not a good indicator of improvement or well being. A CD4 count always fluctuates because it is influenced by many factors. If a person is overly concerned about the CD4 count, he/she will be stressed by it. It is better to observe oneself and watch one’s own health. This notion of listening to one’s
own senses and feelings is compatible with the principles of local healing and deserves more attention.

From the perspectives of the healers and patients, these indications of a good outcome are what they expect to gain from a good healing procedure. These indications are based on the principles of treatment that are derived from what has developed into a local disease theory, and they differ greatly from the principles of treatment as defined by biomedicine. As described above, the indications of a good outcome focus on the patient’s perception of his/her own bodily sensations, physical appearance, as well as psychological and physical functioning in daily activities, rather than on what is detected by scientific instruments. This shows that a different disease theory can lead to different indications of a good outcome. This point of view should be included in the assessment of the effectiveness of local healing.

**Conclusion**

When AIDS started to threaten the life of Northern Thai villagers, local healers in Chiang Mai learned to find ways to deal with the deadly disease through their attempts to effectively treat it. They gathered information about the disease from the mass media, public health authorities, and their patients. Then they went back to their medical scriptures and the knowledge that had been orally transmitted to them by their ancestors. They conducted trials of the selected medicines and developed explanations of the disease from these trials. This demonstrates how local healing is still alive, and how local healers are capable of gathering a variety of local knowledge sources when dealing with a new threatening disease.

While the disease explanations and healing methods developed by these local healers are rooted in local disease theory, they are at the same time adapted to the new knowledge that they have received from biomedicine. Apart from the specific explanations, their general ideas about the disease which underlie the principles of their treatment are influenced by both local and modern notions. That is to say that the importance of normalizing the inner elements and the control of diet, for example, are local in nature, while the fight against germs is a new idea. These syncretized ideas about the disease direct the way in which the healers define the indications of a good outcome and evaluate the effectiveness of healing.
Chapter IV

Meaning transformations as a key aspect of healing
The previous chapter focused on the development of a disease theory and healing methods for HIV and AIDS by local healers in Chiang Mai. This chapter complements the previous one by exploring how cultural meanings contribute to the effectiveness of the healing process in the case of HIV and AIDS. The first section of the chapter presents the transformative process that turned an ordinary villager into a meritorious healer and an abandoned temple into an HIV/AIDS healing center. The second section demonstrates how the ability of this healer to arrange the healing process resulted in a change in the meaning that local villagers attribute to HIV/AIDS. A disease that was initially considered a death sentence became a manageable condition that one can survive through the joint efforts of healer, patient, and community. An important aspect of this survival is the collective shift in the typical dramatic tone associated with HIV and AIDS. The third section examines various aspects of Buddhist teachings that this healer conveys to his patients, and which have made this transcendence possible. The core of these teachings is the necessary shift that one must make in the scheme of meaning that one attributes to life. Lastly, the chapter discusses how the various changes in the meanings attributed to HIV, AIDS, suffering, and life in general, contribute to the effectiveness of this process.

Transformation of a healer: Mo Boon from Ban Denchai

I have chosen in this chapter to focus in particular on meaning transformation in the life and healing practice of Mo Boon because of the importance he attaches to the merits of local sacred beings. Like other healers that feature in this book, Mo Boon acknowledges this merit in relation to the effectiveness of the healing; but in contrast to the other healers, this merit also played a role in his transformation from an ordinary villager into a healer.

I met Mo Boon for the first time during my early fieldwork phase in 2006. Since then, my regular visits made me familiar with Mo Boon, not only as a healer but also as a person. I conducted in depth interviews with him and observed his daily life, his healing activities, as well as his religious performances on holy days. When I first met him he was living in a small wooden house close to a bigger building, the latter of which was the house he had built for his parents from his own savings. Next to his parents’ house were the houses of his eldest son and elder brother. Even though his own house was very small, he used the back part of it, which was around five square meters, as the healing space where he took care of his patients. In this room was a wooden cabinet in which some ten transparent plastic bottles filled with traditional drugs were kept. When I recall my observations of Mo Boon’s practice, one particular patient comes vividly to mind. He was a man who suffered from san – the disease that presents a hard lump under the skin as the common symptom. I remember well the comfortable and honest character of the relationship between Mo Boon and his patient.

During my second fieldwork period in 2008, the physical environment around Mo Boon’s residence had changed somewhat: there was a new concrete house, and a healing center between the house of his eldest son and that of his elder brother had been built. Mo Boon, however, still continued his ordinary life and kept on serving the community as a local healer. Numerous visits provided me with abundant occasions to become acquainted with and closely
observe his conduct. This allowed me to learn more about his life, his moral experiences, and to explore the thoughts behind his conduct.

**Boon’s life as an ordinary villager**

Boon’s childhood and adolescence was similar to most villagers in remote rural communities who are deprived of the opportunity for higher education. He attended a nearby school until grade four, at which time he had to quit schooling in order to help his family. His father had thirteen children and not enough money to support education for all of them. Boon helped on his father’s garlic farm and plowed rice fields. His hard work earned him enough to build a house for his parents. After he got married, he moved with his wife into a rice barn near his parents’ house. On his wedding day, he asked for a blessing of prosperity in front of the Buddha statue in the local monastery. Boon received the blessing he had asked for in the form of a son in the first year of his marriage. Not having his own land, he rented a rice field to farm, and had to give half of his harvest to the landlord. After a few years of hard work, he had saved enough money to buy two rice plots. Later, he bought a rice threshing machine, through which he earned extra income by renting it to local farmers. Within one year his whole investment had been returned. Three years of hard work had brought his family a good life and he could now build his first house near that of his parents.

**The AIDS crisis and the transformation of a healer**

In 1992, two years after his second son was born, the HIV/AIDS epidemic appeared in Boon’s community. An undeniable panic broke out among the villagers about this deadly disease, which did not pass unnoticed by Boon. People were dying and there was nothing one could do. Instead of being horrified, he thought that the villagers should seek solutions before the disease spread to their offspring. He decided to do whatever he could to help stop the disease. So, at the age of 35, Boon started to talk to the villagers about HIV and AIDS and distributed information he had picked up from the radio and the public health office. Despite his good intentions, nobody listened to him. Feeling rejected and discouraged, Boon no longer wanted to do anything. Desperate, he gave up all hope. He went to the farm with his wife but the only thing he did was sit, look about himself aimlessly, and cry. He sold his house for a low price and returned to live at the rice barn. He also put up a sign to offer his land for sale; luckily, no one was interested. He turned his back on the community and did not talk to anyone for a period of two months. But the idea of stopping HIV and AIDS and helping those who were affected still preoccupied him and held the attention of his unconscious mind.

Then the critical turning point came in Boon’s life. Despite being a healthy man, one day, all of a sudden, he fainted and remained unconscious for five days. Rumors abounded that he had become possessed by an evil spirit (*phi ba*). A spirit medium, however, told his family...

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1 In the following sections about his earlier life, I refer to Mo Boon simply as Boon, since this describes the time before he achieved his status as a healer within the community; after that I refer to him as Mo Boon (which means ‘Doctor Boon’).
that he had been inhabited by a Buddhist saint or Orahant (Orahant khao sing). When he regained consciousness, he felt reborn, with a new soul in his old body and a new vision of his life. It was now clear to him what had gone wrong with his previous attempt to change the villagers’ response to HIV and AIDS:

The villagers did not listen to me because I was never ordained. So I thought I should not say anything anymore. When I stopped talking, they said I went crazy. I wondered why they listen to monks and also give them money. I started to understand that words were not enough. Talking could work with young people, but for adults I needed to live an exemplary life.

Boon realized that it would be impossible to persuade his neighbors to help persons with HIV and AIDS in the community unless he was ordained. However, as he was married and had two sons, he could not leave his family to enter monkhood. After conferring with his parents and his wife, he decided to dress in white and stay every night for three months in a nearby Nong Chang temple to study the Buddha’s teachings (dharma) and practice meditation.

In Buddhist culture, lay people often dress themselves in white clothes and stay in a temple on a Buddhist holy day or during the Buddhist lent (phansa) to engage in religious practices. They pay their respects to the Buddha while listening to dharma, reciting mantras, observing the religious precepts, and practicing meditation. The white color of their clothes represents the purity of the physical, verbal, and mental state that they intend to conduct. Boon followed the eight precepts, which included sexual and other forms of sensual abstinence. He seriously undertook meditative practice in accordance with a local Buddhist manuscript he found in Nong Chang temple, a meditative practice called samathi kao than, or meditation of the nine bases. Boon practiced mindfulness by concentrating on his breathing; he breathed in and prayed bud then breathed out and prayed dho. He practiced control of his mind by focusing his concentration on the nine bases located within his body: the first base is in the middle of the belly, then one moves to the second base in the middle of the chest, then to the throat, the mouth, the nose, the eyes, the ears, the crown of the head, the inner part of the brain, back to the crown of the head, the ears, and finally the forehead.

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2 Phansa is the Buddhist lent, a period of three months during which all monks have to stay in a temple, study dharma, and avoid all unnecessary travel.

3 A mantra is a word or phrase repeated by a priest, healer, or a person who performs a ritual and other religious practices. Each mantra is considered effective in producing change for a specific purpose. Buddhist mantras are formulated by a compilation of words that are viewed as being at the heart of Buddhist teaching. Reciting mantras is therefore a way to remind a person of the Buddhist teachings.

4 The precepts in Buddhist tradition are commitments to abstain from doing things that are considered obstacles in one’s progress towards spiritual development. The five basic precepts for all Buddhists consist of abstaining from harming living beings, stealing, sexual misconduct, lying, and intoxication. For a person who wants to practice meditation, eight precepts are recommended. In addition to the basic five, one must refrain from: eating at forbidden times; dancing, singing, listening to music, going to see entertainment, wearing garlands, using perfumes, and decorating the body with cosmetics; and lying on a high or luxurious sleeping place (this latter precept is extended to abstinence from all sexual activity).

5 Bud-dho means Buddha or the Enlightened One.
Through this kind of practice, Boon claimed that his mind became more subtle and could perceive the existence of the two invisible worlds, namely heaven and hell. Boon could see neighbors who had passed away, and was able to know beforehand that someone in a certain house would die in the near future. No one in the village, however, yet believed the knowledge he had acquired. This did not deter him from his practice. He simply observed his extrasensory perception and waited to see whether the event that he had foreseen would happen. He realized that his mind had been transformed into a new state, its qualities shown through his delightful and powerful enthusiasm in helping others.

In Buddhist tradition, a person who is ordained and who follows the proper conduct in accordance with the way of the Buddha’s teachings is respected by local villagers as a *khon suk* (literally a ‘ripe’ person). While in Northern Thailand practicing monks are addressed with the term *tu*, the respect for other ‘ripe’ persons is expressed with the term *noi* (for a person who ordained as a novice) or *nan* (for a person who used to be a monk). The terms *noi* and *nan* also connote the sense of an educated person or a local scholar. Although Boon never had the opportunity to be officially ordained, because of his attendance to meditative practice and his observance of the Buddha’s teachings, the villagers did respect him to some extent as a ‘ripe’ person.

Aside from his spiritual practice, Boon always reminded himself of what he had learned from his father when he was a child. His father, who was a healer, had often sent him out on errands to a store in Lamphun province to buy medicinal herbs. He had also accompanied his father to treat patients at their homes. Never before did he imagine that he would follow the role of healer that his father and grandfather had fulfilled in their time. Nevertheless, he did follow in their footsteps. Boon also became the third generation of local healers that had to deal with a deadly disease. His grandfather and his father both had to cope with the outbreak of deadly epidemics in Chiang Mai: his grandfather, who came from Burma and had married a local woman, was a local healer during the time of a smallpox outbreak in the 1940s; his father was a local healer in the time of a cholera epidemic in the 1960s. Both generations had saved many lives in the region. Boon thought that HIV/AIDS, smallpox, and cholera had many things in common, whether in their life threatening character, in their sudden outbreak, or in the limitations of the medicine available to control them. He reasoned that the traditional drugs that his father and grandfather had used in their time might be able to save the lives of many persons with HIV in his time.

Eagerly, Boon started to learn traditional medical knowledge and practices with his father during the daytime. His father taught him how to diagnose diseases, how to prepare the traditional drugs he himself was familiar with, and how to use them for different diseases. As Boon had been familiar with local healing since he was young, he was able to learn these skills within a few months. Apart from the traditional drugs that had been used in his father’s and grandfather’s time, Boon had to seek additional medicines. With the assistance of his father, he searched through his father’s manuscripts for specific drugs to cure HIV/AIDS. They found a potent drug for *khang lueat*, a blood disease not dissimilar to AIDS. In a manuscript written by Khruba Khaopi and kept in Nong Chang temple, Boon also found a
drug for future incurable diseases, which could possibly be used for the treatment of AIDS. He prepared these traditional drugs, put them in cardboard boxes, and placed them on the glass altar of the Buddha statue in Nong Chang temple for three months.

In the meantime, Boon managed to persuade the elders who often visited the temple to help persons who were affected by HIV and AIDS. He told them that helping such persons was a great deed of merit making; simply by offering moral support they could reduce these people’s suffering. Given the fact that the elders were respected by the villagers, their positive response to his proposal had a rippling effect and created a wider positive influence in the community.

In the period of his intensive meditative practice, Boon had a dream. In this dream, a monk came to visit him and said, ‘For a long time I have come to you, but you were asleep. Why didn’t you come earlier? I’ve been waiting.’ The monk led him to a mountain where he could see a beautiful white pearl colored relic of the Buddha, to which he paid his respects. Boon told his dream to an elder at the temple and described the monk of his dream in detail. The elder said that this monk might be the highly revered Khruba Siwichai and encouraged him to pay homage to this late monk at the Phrathat Doi Suthep temple. Boon persuaded the villagers to join him, and they traveled in two pick-up trucks to visit the temple. When he reached the foothill of Doi Suthep (Suthep Mountain), he saw the statues of three monks in a pavilion. He asked the driver to stop the car and went into the pavilion. He found that the middle statue, the statue of Khruba Siwichai, was like the monk in his dream. He paid his respects and said that he had come to see Khruba Siwichai, as was told to him in his dream. After Boon had walked throughout the Phrathat Doi Suthep temple and was preparing to leave, a monk came to him and, holding out a one foot tall statue of Khruba Siwichai in his hand, said, ‘Take this statue and worship it, it will help the sick.’ Boon was puzzled about why this monk would give the statue to him and how he seemed to know that he was healing patients. He connected this incident to a story his father had once told him about how his grandfather had used to provide treatment to Khruba Siwichai when he was ill.

On the day that Boon completed his three month study and retreat at Nong Chang temple, he went to see and pay his respects to the abbot. As an offering to the abbot, he brought with him flowers, incense sticks, and a candle in a silver bowl. As he was leaving and was about to pass the temple gate, the leaf of a sacred pho tree fell right into the bowl he was carrying. He felt bewildered and went back to the abbot and asked for his advice and interpretation. The abbot said that Boon would become a resort for people; he should therefore determine to

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6 Khruba Siwichai was a Buddhist monk who lived from 1878 to 1938. His moral teachings were based on the Northern traditional style of Buddhism, which was appreciated by most Northern people during the revolutionary period of the inclusion of the North into the Kingdom of Siam.
7 Phrathat Doi Suthep temple is the spiritual center of Chiang Mai and was reconstructed under the direction of Khruba Siwichai. It is located near the summit of Doi Suthep (Suthep Mountain), a sacred mountain according to Northern Thai cosmology (see Swearer et al. 2004).
8 The Sacred Fig Tree or pho (Ficus religiosa Linn.) is considered auspicious since it was the tree under which the Buddha meditated and attained Enlightenment.
do good things with all his heart. The abbot also gave him some puzzling advice: ‘Having a fortune or not having a fortune will bring suffering. Having fame or not having fame means suffering.’ Boon pondered over these words for a few days. He concluded that what the abbot had advised him was to walk the middle way. He made a vow to dedicate his life to helping people without aiming for material return or fame, since both could lead to misery.

**Analyzing the transformative process**

The story of Mo Boon tells us of how an ordinary person transformed himself into a local healer in a context that needed an urgent response to the HIV/AIDS epidemic. Although he was born into a family of local healers, his potential as a healer was initially not recognized by his fellow villagers, since he was just an ordinary man like many others; he had only a basic educational background and worked as a poor farmer. In order to be converted from his ordinary status as a villager into a healer capable of dealing with deadly disease, a transformative process was required. In his case, in contrast to many other healers, his transformation was not only brought about through an apprenticeship to other healers and the accumulation of experience in treating patients. This process would have taken time in which his aged father would have had to play a major role. It turned out that this was not to be the case. Mo Boon’s transformation occurred through the construction of a new reality around him. By dressing in white and practicing meditation in an abandoned temple, he was transformed from a ‘raw’ into a ‘cooked’ person, a ripe or matured man. He also became a trustworthy man, who not only came from a family of local healers that had fought epidemic diseases in the past, but was also a man whose symbolic association to the most powerful local saint had endowed him with a special power to fight HIV and AIDS.

Although the transformation in the case of Mo Boon was intrapsychic and personally experienced, its shared symbolic significance gave it a social impact. Every event in the process of his transformation was meaningful, not only to Mo Boon himself but also to the community as a whole. In Thai and local history, when the country encounters misery, people have always expected help from someone who possesses great merit. In Northern Thailand, this meritorious person is called *ton bun*. Khruba Siwichai was a *ton bun* well recognized by local people. Mo Boon’s emphasis on merit making and his association with Khruba Siwichai through the symbolic signs described above therefore produced not only a meaningful experience for himself but also a narrative meaningful for the community as a whole. This social experience was significant to the community, especially at the time of the unprecedented threat of a dreadful new disease. The villagers came to realize this threat and the potential response to it offered by Mo Boon even more when Mo Boon, in the process of becoming a healer and at the beginning of setting up his mission in practice, established a healing setting in the community.
Transforming an abandoned temple into an HIV healing center

In 1993, when Mo Boon started his mission by treating the HIV/AIDS patients in the village at the Nong Chang temple, word of mouth quickly spread around. Soon, so many patients came to see him at Nong Chang temple that Mo Boon was afraid that it would bother the elder villagers who came to the temple to meditate. He consulted the temple committee and asked for permission to use the area of the abandoned temple near his home as a healing center. Some villagers opposed the idea, fearing that having two temples so close to one another would cause a division of faith among the people. Mo Boon handled this sensitive issue by inviting a district monk to be his adviser and by promising the abbot that he would not turn the area into a new temple.

In the meantime, he put up an announcement at Nong Chang temple that he would conduct a trial healing session to treat volunteer HIV/AIDS patients free of charge for three months. At first, patients in the village were interested in coming, but their spouses were against it, and nobody joined the project. Later, seven HIV patients from other villages volunteered to receive Mo Boon’s free treatment.

With donations from people in the region and the cooperation of the community, a healing center was built in the abandoned temple, and the trial project commenced. After the three month trial, Mo Boon found that his traditional drugs were effective. As he said, ‘The fever was gone. There was no papule anymore.’ But he also found that he had to work very hard, spending the nights looking after his patients at the temple and the days preparing the medicines and working at his longan tree plantation, and so could spend little time with his family. Since the inpatient center had exhausted him, he decided to change it to an outpatient center; patients would stay at their own homes and come to see him once a week on Buddhist Sunday.

The news of the satisfactory results of the trial spread quickly through word of mouth. The villagers started to call him ‘Mo Boon’ (Doctor Boon). Over thirty HIV/AIDS patients a week came to the healing center from Chiang Mai and neighboring provinces. The expense of providing the treatment soared with the increasing number of patients; however, he and the healing center committee were able to manage it. The center was supported by donations from individuals and fees from patients who could afford to pay, as well as by financial support from the Disease Control Department, which had sent its officials to observe the center on its opening day. The subsidy from the Department of Disease Control was spent on medicines for deprived patients. It also helped to procure tools and utensils that could enable persons with HIV to earn an income: Mo Boon invested in sewing machines for persons with HIV to make hats and in a candle molding tool for them to make mosquito repelling candles. The donations from villagers were spent on building concrete structures and on other tangible investments, such as pavilions, water tanks, an herbal steam room, massage room, football field, and electricity in the toilets.
Illustration 2. The HIV healing center at the deserted temple of Ban Denchai in 1994. Left: Mo Boon and his HIV patients. Right: Mo Boon’s father and the villagers who constructed the wooden houses for HIV patients.

Illustration 3. Ceremony to invite the statue of Khruba Siwichai to reside in the shrine hall
Aside from investing in this new infrastructure, Mo Boon organized a special event to install another statue of Khruba Siwichai in the healing center. As can be noticed from the pictures, many villagers participated in this event. The statue was set near a statue of the Buddha that was the principal image of the healing center’s wihan (the building within a temple complex where the Buddha image is located).
In 1995, the Northnet Foundation, a non-governmental organization working with HIV and AIDS in Chiang Mai, came to support Mo Boon’s work and facilitated an exchange of experiences among the local healers who were treating HIV and AIDS. In Hang Dong district they organized a healer group named the ‘Chatura Sila Group’ and Mo Boon was selected as the vice leader. In 1996, the story of Mo Boon was published in a chapter of a book, entitled *Twenty-three experiences of AIDS in Northern Thailand*, which was supported by UNICEF and UNAIDS (Seri 1996). Since then the healing center has become a site for study tours, with visitors from both within the country and abroad. Mo Boon has also participated and shared his experiences in several meetings and conferences on HIV and AIDS, including the XV International AIDS Conference held in Bangkok in 2004.

In 2002, Mo Boon’s healing activities in the deserted temple could no longer continue, since the villagers had invited a monk to reside regularly at the place and wanted to develop it into a fully functioning temple. Mo Boon moved the healing center to his own house, which is where I met him during my first period of fieldwork.

*Transforming a space into a place of healing: An analysis*

It is evident from the story of Mo Boon that healing HIV/AIDS patients in Northern Thailand is not only an affair between the healer and the patients, but is also a communal affair; it is a process that belongs to the community. The transformation of an abandoned temple into a healing center was realized by converting the place into a site for merit making. It made villagers feel comfortable donating money and contributing to the construction and administration of the center. Moreover, support from many organizations outside the community also changed the healing center into a place of public interest that could serve more comprehensive needs of persons with HIV and AIDS. For HIV positive persons, the healing center was a place of hope where they could access the healing provided by Mo Boon’s traditional drugs to revive their lives. The center was meaningfully named ‘The Rehabilitation Center for New Life’ (*Sun Fuen Fu Puea Chiwit Mai*).

*The transformation of AIDS from a fatal into a treatable disease*

From the story of Mo Boon, as told above, we can easily see that the contribution of local healers to the fight against HIV and AIDS in Northern Thailand is about more than saving a certain number of lives. It constitutes a change in the meaning that people attribute to HIV and AIDS. I would like to emphasize the fact that the local healers in Chiang Mai, including Mo Boon, were the very first category of people to insist that AIDS is a treatable disease and that persons with HIV can live healthily if they use traditional drugs and conduct a proper

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9 It is a pity that after the new temple of Denchai was established, the whole infrastructure of the healing center was demolished. Only the Buddha and Kruba Siwichai statues were kept in the building of the new temple. In addition, as I could observe at the opening day of the new wihan, many people from Bangkok (some of whom were owners of or stars from a television channel), who had donated money for the construction of the temple, had not been informed about the history of the temple’s site; it seemed as if the temple had been developed from nothing.
life. This persistent call from local healers was instrumental in changing society’s view of AIDS as a disease.

It should be noted that at that time when Mo Boon first began treating HIV/AIDS patients, there were no antiretroviral drugs (ARVs) available in the hospitals. The standard treatment was based on symptomatic care, and many HIV positive patients died rapidly after succumbing to opportunistic infections. In this atmosphere, it was said that AIDS was an untreatable disease and persons with HIV felt hopeless. Numerous reports stated that many HIV positive persons died not long after the revelation of their positive blood test results due to despair and loss of hope. The message that AIDS was a controllable and treatable disease can therefore be seen as a transformative experience for hopeless and helpless patients.

Yada, a woman with HIV from a nearby province who had been seeking care from Mo Boon at the healing center since 1997, was one of these patients who had experienced such a transformation. She recounted for me the story that Mo Boon had told her during one of their encounters. She told me that Mo Boon had died for five days and, in this state, he came to see many things in heaven. Then he was reborn and was offered the good medicines to heal persons with HIV and AIDS. Accompanied by her parents and young daughter, Yada joined the activities in the deserted temple every second Buddhist holy day. In addition to receiving the traditional drugs, she dressed in white, paid her respects to the Buddha’s image, recited Buddhist mantras, practiced meditation, and talked with Mo Boon. He always encouraged her not to lose hope and to keep taking the traditional drugs as long as she could. She believed that she has survived because of the help of Mo Boon, while her friends who did not follow this healing path have all passed away.

Illustration 4. Inside the shrine hall. Left: The statues of the Buddha and Khruba Siwichai inside the shrine hall. Right: The activities in the hall, i.e. praying, practicing meditation, and dispensing medicines.

One could argue that giving hope to people with HIV is similar to deceiving persons out of self-interest. This is true in some cases. As I learned from many persons with HIV, some healers do try to make a profit through selling herbal medicines with the claim that they would cure HIV/AIDS. A police general and a pharmacist claimed that they had discovered a medicine to treat HIV/AIDS and dispensed this medicine for free at the Chiang Mai sports
Meaning transformations as a key aspect of healing

stadium. But all of these alternatives were ultimately denounced by people in the community since those peddling them conducted their treatments with dishonest intentions and their medicines had no effect.

Mo Boon is different. For one thing, from the beginning of his healing activities he separated himself from any monetary involvement. The financial management of the healing center was placed in the hands of a group of respected elders in the community. This transparency caused him to be recognized not only by the community but also by the HIV groups and NGOs operating in Chiang Mai and Lamphun, local and national government organizations, and local administrative organizations. At least two chapters in two books have been written by academics who admired Mo Boon for his works at the deserted temple (Seris 1996; Rangsansan 2004).

For Mo Boon, the only thing he had to prove was whether the HIV/AIDS patients recovered from their illness and remained healthy after treatment with his local healing. The initial three month free trial was therefore conducted to prove this. Although it was a difficult task to take care of the seven inpatients during the three month trial, along with his other routine work to earn a livelihood, the experiment eventually bore fruit. The satisfying result, which was apparent to the villagers, was persuasive to change the perception of HIV and AIDS among the villagers and among the patients themselves.

Apart from the trial, Mo Boon and his staff organized events in which the villagers in the surrounding communities participated, such as thot pha pa (a religious event which is held to offer essential necessities to monks), collecting money for the buildings and infrastructure at the deserted temple, and holding an event to celebrate the hall shrine. These events were opportunities for Mo Boon to inform the villagers about the success of the healing, and for the villagers to share the merit of their contributions. Through these social experiences, the meaning that villagers gave to HIV and AIDS was gradually transformed. AIDS became increasingly viewed as a treatable disease; people with HIV should not be discriminated against; and the community felt itself capable of solving the problems of HIV and AIDS with its own local wisdom and methods. The success in fighting against HIV and AIDS in Ban Denchai was therefore the triumph of a community, among many communities that were challenged by HIV and AIDS in Northern Thailand, in which local healing played an important role.

Transcending emotional distress

HIV/AIDS does not only affect the physical body, it also produces emotional distress. This distress may be due to the expectation that the sick person will die and will have to part with his or her loved ones at an early age, or to being stigmatized as a deviant person and being discriminated against by his or her family, workplace, or community. Emotional distress can be expressed in feelings of confusion, fear, despair, depression, anger, or other forms of psychological suffering (Farmer and Kleinman 1989; Lyketsos et al. 1993; Penchan 1994). As long as this suffering is not relieved, it is, in the perspective of the local healers, difficult to treat a patient’s physical ills or achieve a sustainable treatment outcome. Below I explore
the various ways in which Mo Boon and his patients deal with the emotional suffering due to HIV and AIDS.

**The use of proverbs, metaphors, and pictures**

Most of Mo Boon’s patients who seek his care come to him with grief and anxiety. Mo Boon stated that his healing strategy is to detach them from their emotional distress before treating them with medicines. Mo Boon makes heavy use of traditional wisdom as expressed in the local proverbs (*kam ba kao*) he learnt from his father and in the metaphors people are traditionally familiar with. In addition, Mo Boon uses pictures of patients who have recovered through his healing as a means of encouraging and giving hope to others.

The concept of *phaya* (or *panya* in Pali) underlies Mo Boon’s teaching about emotional detachment to his patients. *Phaya* refers to intellectual, insightful, and deep existential understanding expressed in the form of proverbs. In Buddhism, somebody who has supreme *phaya* has an understanding of everything, including each event as it occurs, and is able to detach himself entirely from hatred, greed, and ignorance. Such a person can liberate himself from selfishness and devote his life to the service of others out of goodness. In a more sophisticated sense, *phaya* is the outcome of an intrapsychic change which occurs during the enlightenment process and causes revelation of the ultimate truth.

In his educational brochure for persons with HIV, Mo Boon does not only mention his knowledge about the use of medicinal plants to heal common illnesses, but also includes some local proverbs, for example: ‘To become rich one has to creep. If you run you have no success. To sit on the altar you have to behave well.’ (*Khao mi hue kan, khao nan hue lan, krai nang thaen man sang khwam di.*) These proverbs mean that those who want to be rich have to be industrious and do it little by little; that those who do something in a hurry will fail; and that those who want to have a respected position in society have to behave with politeness. Mo Boon explained to me that being a patient person and doing good things for others are necessary characteristics of those who want to achieve success in any business. In the same manner, persons with HIV who expect a good outcome from the healing have to be patient and should be satisfied with the results they gain, little by little. Furthermore, they have to help other persons once they have recovered.

Mo Boon reminded patients that believing others without firm evidence was akin to following a blind person or asking for fire from somebody with blurred vision (*ta bot nam thang, ta fang nam fai*); it will only led to more trouble. The blind person here is a metaphor for someone who is ignorant. In other words, the saying says that one should follow the teaching or advice of a person who has *phaya*, so that one will not get into trouble. Another local proverb that Mo Boon often uses is: ‘If we are afraid of death, it will come close to us; we should therefore not have fear for it’ (*Klua lam chang tai, ai lam chang tao*).

Mo Boon also developed a lesson to motivate his HIV/AIDS patients to pay more attention to the significance of the Buddha’s teachings – *dharma* – for their illness. Patients who come to him with grief and anxiety usually wish a quick recovery. Mo Boon commonly responds to this using a visual example. He takes two earthenware pots, one he has filled with water and
the other one which is empty. He asks the patient to open the lid and look inside both pots. Then he asks which pot is the most beautiful. He explains that those without dharma in their hearts are like the pot without water; ants and insects live inside this pot and its surface does not feel nice. Persons with dharma in their minds are like the pot filled with water; its surface is nice because of the moisture. Therefore, if one wants to become a nice pot that offers no space to ants and insects, one needs to protect oneself by having dharma in one’s heart.

Mo Boon always emphasizes that everyone has to die sooner or later. He explained that he himself may die sooner from a car accident than someone will die from HIV, since he often travels to the city to buy the ingredients required for his traditional medicines. As human beings, we are born without material possessions, and we will all leave this world with empty hands. Only our good deeds remain and they make our minds noble. So let us be satisfied with what we are and what we possess. The aim of this simple teaching can be summarized with the local word plong (literally, to cut it off), which means to detach oneself from something that makes one suffer. When one truly understands the essence of life, one can, according to the Buddha’s teaching, detach oneself from that thing or event.

Yada, the HIV patient I presented above, told me that Mo Boon had taught her to detach herself from the fear of death. This was not an easy task since she was 26 years old and had to support her family after her husband had passed away from AIDS, leaving her with her two year-old daughter. After she went to see Mo Boon, listened to his teachings, practiced meditation, and took traditional drugs, she vowed to herself that she had to stay alive for her parents and her daughter, no matter what her neighbors said or how they looked down on her daughter. She insisted that she was still alive because of Mo Boon’s teachings and medicines. Some persons who had once said that she would soon die due to her HIV status had since passed away, yet Yada she was alive and had survived her HIV infection for more than twelve years. Furthermore, she had no fear of dying. She just wanted to look after her daughter until she finished her education so that she would have a good future.

Mo Boon aroused in his patients the hope of recovering from their illness by showing them pictures of his past healing activities and by talking about other HIV patients who had come to him in a serious condition but were finally healed and were able to live a healthy life. Saichai, a 30 year-old local merchant from Lamphun province, had been infected with HIV by her husband three years prior. She told me that before visiting Mo Boon, she was depressed and worried about her life and family. Seeking care from a hospital could only help her to improve her physical health, and since she had to conceal her illness from others, she had no one to talk with apart from her sister-in-law. When she and her sister-in-law went to see Mo Boon, she did not only receive medicines. The teachings and pictures in the healing center presented by Mo Boon created a feeling of comfort and made her aware that she was not the only one who was HIV positive. She started to realize that other persons with HIV could live joyfully if they stopped eating prohibited foods and took their medicines regularly. Saichai believed in Mo Boon because he was a kind person and had a humorous and comfortable way of talking.
Chapter IV

In sum, the traditional practices of Mo Boon in relieving the emotional suffering of patients are based on the teachings of Buddhism, both in local forms such as proverbs and metaphors, and in modern forms such as photographic representation. Even though these practices seem to deal with cognitive understanding, they encompass Mo Boon’s personal feelings of concern and the sense of good teachings from the old days. These practices, which are typically conducted by local scholars and those who are considered persons to resort to in matters of spirituality in communities, therefore affect patients’ understanding of how they will be able to detach themselves from emotional suffering.

Religious practices

In Thai Buddhist culture, a popular word to represent the meaning of death is *sin bun* (to run out of merit). A religious practice that is believed to offer the possibility to prolong life is making merit. In the case of a severe illness that can no longer be treated by medications, this religious practice is the last possible healing procedure that may have effect. The following story presents the efforts of a patient of Mo Boon to cope with her fear of death and her concern about her children through her engagement with religious practices.

On the morning of a June day in 2008, I accompanied Mo Boon and an NGO worker on a visit to Surang, a middle class woman living with HIV in the sub-district of Nong Tong. I had met Surang once before when she came to Mo Boon’s house on Northern New Year’s Day, a day on which people visit one another to pay homage and ask for a blessing from elders or respected persons. Although Surang had been a classmate of Mo Boon, she had very high regard for him. Upon Mo Boon’s introduction, I asked for her permission to interview her in the near future. She did not know what to respond, but she did not refuse, and said only that ‘Mo Boon has now become a popular person.’ It was obvious that Surang had been a long time patient of Mo Boon, since before the time when he had become as popular as he currently is.

During our visit to Surang in 2008 we sat around a table in the middle of her house. Surang told us that her new husband had gone to a meeting in Bangkok, so it was convenient for her to talk with us. Mo Boon withdrew himself to make a phone call with one of his patients; hence we could talk freely about her story. Surang started to talk about her health, which had worsened in 2006. She had stopped taking Mo Boon’s medication around 2004 because her new husband had noticed that she was gaining weight as a consequence of the traditional drugs. Two years later, she came under great stress after she lost a serious amount of money. She lost weight and felt so weak that she had to seek care at the district hospital. Her CD4 count was 139, so the doctor managed to persuade her to take ARVs. At the moment we met, Surang suffered not only from the HIV infection, a peptic ulcer, and pain in her leg, but also from cervical cancer stage III, and she was in the process of being treated with chemotherapy and radiation therapy.

When I asked Surang how she had become infected with HIV, she responded that it was her husband who had passed the disease on to her. He was a secondhand motorcycle seller and a handsome and industrious man. He had been attracted to a girl in the transport
registration office and had a sexual relationship with her. It was from this woman that he had contracted HIV. He died in 1995 after spray painting the body of a motorcycle. It was believed that the aerosol fumes that he had inhaled from the spray paint had aggravated the fungal infection in his brain. After the death of her husband, Surang had a dream in which she went to a place where she met many people. But when she greeted them, nobody responded. She later met her grandfather in the dream, and asked him why nobody was talking to her. Her grandfather said that she had already been dead for three days. She went back to her house and saw herself lying down on the bed. She cried and then woke up. She told her dream to a respected nun. The nun said that her mind had left her already. The life given to her had run out. She should practice dharma because she could only stay alive due to her bun (merit). Soon, she decided to stay in the nun’s meditation practice center for seven days. She dressed herself in white and followed the eight Buddhist precepts.

Practicing dharma like this is a great form of merit making in Theravada Buddhism because it is aimed at mindfulness in every action that one conducts. Through this practice, one gains insight into all intended and unintended thoughts that are constructed by our greed, hatred, ignorance, and other negative, positive, or neutral characteristics of the mind. Bringing these unruly thoughts continuously to one’s consciousness will make one realize to a greater and greater degree the inconstancy, changeability, and uncontrollability of one’s mind. This insightful understanding (phaya) gradually develops during the practice of dharma and makes one realize that suffering does not belong to us, and that we can gradually detach from it.

Although seven days of dharma practice is a rather short period, it nevertheless helped Surang to accustom herself to conducting meditation in her everyday life. She said that she prayed and chanted every day before she went to sleep and then slept while meditating on bud-dho (Buddha), the same meditation that Mo Boon practiced. Since we could not evaluate the extent to which Surang’s insightful understanding had been developed through the dharma practice, the output that Surang had gained from this practice – at least her ability to transcend the suffering derived from the fear of death, which was hidden in her subconsciousness – might be seen as a proof of its effectiveness.

Surang went to see Mo Boon in 1999 after she found out that she was HIV positive. She had taken traditional drugs since then. Yet Surang, who knew Mo Boon since he was a young boy, did not conform to the healing in a passive and compliant way. She stopped taking the traditional drugs and developed herpes zoster. She was admitted to a hospital but did not have enough money to cure the disease. It was Mo Boon who had to cure her with his traditional drugs. A similar situation occurred again when her health became so bad that she could hardly walk – she could not even walk to the toilet – and she had to be admitted to hospital.

In 2000, Surang was persuaded by Mo Boon to join a ritual supported by a local researcher (Rangsan 2001).10 The purpose of this well known ritual, which is named phithi suat

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10 I collected this data by interviewing Mo Boon and Surang, and from the pictures of this event that were kept in Mo Boon’s healing center.
*bangsukun dip* (the rite for an assumed dead person), is to extend the fate of the participant. On the researcher’s request, it was held at the deserted temple. Videotapes of the ritual were recorded for educational use in a psychiatric hospital in Chiang Mai. Like a dead person, Surang lay down on the floor, put the palms of her hands together to make a salutation, and had her body covered with four pieces of white cloth. Four monks recited a particular set of Buddhist mantra in Pali. Later, four sets of readymade dresses (*pha bangsukun*) that Buddhists offer to monks were placed over the white cloths. Then the monks picked them up again while reciting a set of Pali words to consider the usefulness of the *pha bangsukun* dresses. The white cloths were later removed; the monks offered a verse for extending fate (*khatha suep chata*) and a blessing to the now sitting newborn, while reciting another Buddhist mantra. This ritual ended with the tying of a white thread around each of Surang’s wrists and a blessing was formulated in local words. This ritual performance is exactly the same as the ritual that is employed on the body of a deceased person.

Illustration 5. *Phithi suat bangsukun dip* – Surang at the healing center in 2000

Surang told me that while she was lying down, she had no idea of the meaning of the mantras that were being recited. She thought that she had already died. She meditated *bud-dho* (Buddha) while she worried about her daughters, since both of them were young. She had to
live or else they would have nobody to care for them. After the ritual she felt healthy and did not experience any illness for a long time.

**Ritual transformation: An analysis**

The ritual conducted on Surang differs from the case of an HIV patient mentioned in another study by Mathurot (2001: 114-115), also carried out in Chiang Mai. In Mathurot’s study, the family of the HIV patient conducted another religious ritual that was interpreted by the researcher as one to relieve the uneasiness of the ill person’s senior relatives, rather than of the HIV patient himself, who was unconscious and in the last stage of AIDS. Both cases show, however, that religious practices for transcending suffering are historically recognized by villagers. The connection of life threatening diseases or terminal illness with making merit is still strong among villagers and leads them to seek spiritual resorts which are not offered by local healers. It may be said that patients decide for themselves about whether they want to seek help from the religious sources available in the region. This means that local healing in the perspective of the patients goes beyond the realm of local healers’ practices, which mostly involve instrumental procedures.

**Religious practices and support for others**

Engagement in religious practices may not only result in transcending one’s own suffering but also in supporting others who suffer from HIV and AIDS, which in its turn contributes to the collective transcending of suffering. Religious practices may be intentionally chosen by the patients themselves, as shown in the story of Somsri, a woman with HIV who volunteers in a district self-help group. After the death of her husband from AIDS in 1995, Somsri and her three children struggled alone with poverty and illness. While breastfeeding her daughter, the baby became like a malnourished infant. She brought her for an HIV blood test to a university hospital and had herself tested as well. The doctor, however, only gave her some advice but did not reveal the results of the blood tests. This made her very worried. She asked for the result, insisting that she could accept it whether it was positive or negative. When the answer was ‘Yes, you are both infected,’ her thoughts went in all possible directions. ‘I thought ahead from zero to hundred,’ she said. One year later, she lost her two year-old daughter. She said:

Neither doctor nor relatives could help me. The doctor had no useful suggestion. My father-in-law and mother-in-law refused to help me. Nobody dared to visit me and talk with me. I was in a desperate situation. It was as if I had to find a needle in the ocean.

Like Yada and Surang, Somsri thought of her children; in her case, her twin sons who were only four years old. She had to survive to take care of them. Amidst darkness and impoverishment, she had to struggle with a kind of hopelessness that sometimes brought her to consider ending her own life. She said she was nearly mad, but that she had to keep her mind calm. She had grown up in a family that had trained the children to chant and meditate every night before going to bed and was therefore familiar with this habit since she was young. Practicing meditation helped her to reduce her anxiety.
Later, Somsri participated in the establishment of an HIV self-help group. She gathered more information about HIV and AIDS and learned about others’ experiences. She increased her understanding of the disease and could relieve her suffering little by little. She was persuaded to become a home visit volunteer and accepted the work despite the low wage. She did it with the intention of helping other persons with HIV who suffered and needed support. She found that helping others was a way of transcending her own suffering.

Somsri told me about her experience in helping Nok, an HIV positive woman whose parents had failed to bring her regularly to the hospital, even when her health and well being were in serious danger due to opportunistic infections. In particular, Nok suffered from retinitis – an inflammation of the retina in the eye that can lead to blindness – as a consequence of Cytomegalovirus (CMV), one of the herpes viruses. No volunteers were allowed to visit Nok at home, but Somsri managed to visit and take care of her since her father-in-law was a friend of Nok’s father. When Somsri first saw Nok in 2003, she had already lost the sight in one of her eyes as a consequence of the retinitis. Yet she had to care for herself and her parents did not allow her to go outside. When they traveled, they locked the house and left Nok alone. Later, Nok became completely blind. ‘Nok cried, hugged me and said that she was already blind. I appeased her,’ Somsri narrated. Sometimes Nok was left alone and had no food. During such times, Somsri gave her half a hand of bananas, even though she was also poor. When Somsri saw that Nok’s hair was growing too long, she cut it for her. When she noticed that Nok had hurt her foot after she had cut her nails, she put medicine on it. Somsri helped Nok until she became familiar with her blindness. Nowadays, Nok can take care of herself and is able to do all daily matters in her house.

In late summer 2008, through the help of the home visit volunteers, and together with Mo Boon and an NGO worker, I made a visit to Nok at her house. Nok’s house looked like that of other middle class people and was neatly cleaned. She had been infected with HIV by her husband and had divorced afterwards. In 2000, she was under so much stress that she had to be admitted to a hospital where she started to take ARVs. As her parents could not accept her stigmatized illness, they often left her alone and were not concerned about helping her. Later, Nok developed drug resistance towards the medications for CMV and in 2005 she was referred to the university hospital. In 2008 she had been blind for three years and was taking the third generation of ARVs. Aside from the change in her physical appearance, which was totally different from the pretty girl she was in the pictures that were taken when she was healthy, she had to tolerate various adverse drug effects at the beginning of the drug regimen, e.g. numbness of the tongue and jaw, difficulties in swallowing, loss of the gustatory sense, ringing in the ears, thickness of the feet, convulsions, insomnia, and occasional bad dreams. She also experienced drug induced high triglyceride and hyperglycemia. She said, ‘Oh dear, this is more than I can tolerate.’ Although her CD4 count was within safe levels, it was difficult to imagine how she would still be alive without the strong support from Somsri and her friends who visited her every week.

The case of Somsri, like the case of Surang presented in the previous section, shows that religious practices, including meditation, can enable persons with HIV to remain calm.
and relaxed and to worry less about the end of life. However, in the case of Somsri, her religious practice led to another practice that strengthened the effects of her pure religious involvement. She learned to accept life as it was, even when it was very difficult. When in the right circumstances, for instance within the support group, she could express compassion and was urged to go beyond her own sufferings. For Somsri, this meant participation in volunteer activities with the aim of helping other persons with HIV who were in an even worse situation than she. This practice reveals the possibility among HIV positive persons, whose minds are well trained in religious practices, to extend and share the ability to transcend suffering.

According to Reed (1991), significant life events, such as encounters with the end of life, have a great potential to facilitate a form of self-transcendent development. Attributes that contribute to individual development are introspection, concern for others, and integration of the past and future into the present. For Somsri, meditation is a method for introspection with calmness and for experiencing emotional well being. Furthermore, as a mother, the future of her children is of great concern. Participation in volunteer activities had the potential to expand the personal boundary of her self that Somsri exposed to others. This provided her with reasons to live, a source of strength to face the realities of daily life, and a sense of wholeness resulting from the integration of the adverse experience of living with HIV and AIDS into her self (Reed 1991; Dane 2000; Mellors et al. 2001).

The self of a person who has transcended suffering in this cultural context differs from the sacred self in Csordas’s work, which is the self that has been brought into harmony with God in Charismatic ritual healing (Csordas 1997). This difference is due to the atheistic character of Buddhism, which focuses on the detachment of the self from negative dispositions by practicing mindfulness meditation. That is to say that when insightful understanding grows on the one hand, self-involvement will decrease on the other. This also opens up a good opportunity for the development of the aspiration to help others who are suffering as well. In this sense, transcending suffering can entice previously suffering people to devote themselves to others. The fact that they can help others in turn contributes to a further decrease of their own suffering.

**The effectiveness of healing as a result of the intersection of various meaning making processes**

The meaning making aspects of the healing process as described above entail experiential or intrapsychic processes as well a range of processes at community level. All of these processes occur during a difficult situation – a threat that the community is not familiar with – to which the daily life practices that people are accustomed to cannot respond effectively. Intrapsychic meaning making processes involve the emergence of insight and religious experience (Csordas and Kleinman 1996: 10). These intrapsychic processes are embedded in meaning making processes on a collective level, in which the whole community is involved. The effectiveness of healing should therefore be considered the result of both processes.

The new meanings attributed to the various components of the healing process are intersected with changes in the meaning of life in general. The latter kind of changes
strengthens the capacity of patients to transcend their suffering with mindfulness and insight, and to voluntarily help others. Changes in the meaning of life may occur inside or outside the sphere of the healing setting. However, they all happen in the local world where the meanings of a good healer, an appropriate healing setting, the disease of AIDS, and human life in general are shared, reproduced, and challenged simultaneously. So the practices of dealing with the threat of HIV and AIDS have to adapt themselves to the meaning that the villagers render to these major components of the healing process.

In the context of Mo Boon from Ban Denchai, the transformation of an ordinary villager into a merit healer and the transformation of an abandoned temple into a healing setting changed the meaning that villagers attributed to HIV and AIDS as well as the meaning that HIV positive patients gave to their own lives. Without the good outcome of the healing, the meaning that people in the community attributed to HIV and AIDS would not have changed so easily. All of these transformations in meaning at all points of the healing process are therefore interrelated and contribute together to the effectiveness of the healing process that patients go through.

**Conclusion**

The idea of a meritorious person provides space for villagers to recognize this person as someone who can emancipate them from certain forms of suffering. This becomes real when such a person associates himself with the merit of local sacred beings. When a person transforms himself into a person of merit, and acquires local medical knowledge and practices, he achieves a higher prestige than an ordinary healer. A healer who possesses this qualification of merit is, of course, especially necessary when the community is attacked by a deadly disease such as AIDS. He can have a major influence on the community and on people suffering from HIV/AIDS, both through community events and the healing process.

During the HIV/AIDS epidemic, the healing setting had to be transformed as well. As shown in the story of Mo Boon, the community succeeded in transforming the abandoned temple into a place of merit making, associating it with local sacred beings and turning it into a meaning-endowed healing setting for people with HIV and AIDS.

In addition, the HIV/AIDS epidemic has inspired HIV positive persons to confront themselves directly with their own suffering. The epidemic provided a chance for in depth existential learning about the uncertainty of life and the search for the meaning of life. My study shows that the healer Mo Boon revived deliberate thinking through mindfulness and included it in the healing process to help patients transcend their suffering. Patients themselves turned to religious practices for the same purpose of transcending their suffering. Another approach in dealing with HIV/AIDS-related emotional distress was developed among the patients who joined the self-help group, namely to learn from one another’s suffering and devote themselves to others. This is a way of distancing oneself from self-involvement through concern for the suffering of others. Dealing appropriately with suffering resulted in a change in the meaning of life and helped many patients to survive AIDS.
Changes in the meaning that patients attribute to a healer, the healing setting, the disease, and suffering from the disease, in such a way that can promote a good outcome, should therefore be viewed as a criterion for assessing the effectiveness of local healing, parallel to other qualitative and quantitative parameters.
Chapter V

Meaning attributions to medicines and their effects
In many healing traditions, both patients and healers view medicines as a key aspect of health care. The same applies to the Thai traditions. In Thai culture, medicines are even considered to be one of the four necessities that human beings rely on in order to maintain life; the other three being food, clothing, and shelter. During the height of the HIV/AIDS epidemic, the importance attributed to medicines influenced the way in which people tried to overcome the disease. The fact that the formal health care system could not provide medicines for the treatment of AIDS led people to focus their hopes on traditional medicines from all over Thailand and the world.

The availability in Thailand of a range of traditional drugs from around the world, particularly those drugs that, according to people’s stories, provided a good outcome, provoked an interest among medical scientists in trying to develop new – biomedically efficacious – medicines to treat people with HIV and AIDS. Regarding traditional medicines administered by Northern local healers on the basis of local knowledge, currently there only exists Rangsan’s (2004) study. However, neither the study of Rangsan nor any other study that I know of – whether conducted in Thailand or elsewhere in the world – has paid close attention to the effects of traditional medicines and how these effects are attained from the perspectives of both healers and patients. This chapter aims to fill this gap in knowledge.

The chapter starts with a case study, in which various aspects of the meanings attributed by healers and patients to medicines and their effects are introduced. These different aspects – the sacralization of medicines, the naming of medicines, and associations between bodily sensations and the working of medicines – are presented in more detail in the following three sections. In the fifth section, I discuss the findings that my study has generated on the workings and effects of medicines as perceived by patients and healers, in particular in terms of the symbolic power of medicines. Throughout this chapter, the concepts of medicines and drugs are used interchangeably.

**Sathit: A case study**

I got to know Sathit as a patient of Mo Boon when I visited him at his home together with the traditional healer. It was late afternoon on a day in the beginning of the rainy season of 2008, when Mo Boon and I stopped in front of a house that he thought was the place we were searching for. He shouted: ‘Sathit! Is this Sathit’s house?’ A man with a look of amazement on his face approached us as he put on his shirt. ‘Mo Boon! Is that you? Come in please, we have not met for a long time.’

After some greetings, I was invited to sit on a plastic chair at the back of his house, where Sathit had cleaned a piece of ground that was surrounded by four longan trees. Mo Boon remained on his feet so that Sathit could sit on the other chair that was in the room. Sathit’s house was a small hut made from cheap wood, bamboo wood, and old metal plates. An aged motorcycle stood idly under the extended back roof. There was a plot with vegetables near his house that Sathit had just sprinkled with water.

It was our good fortune that Sathit was at home and had not gone out to work as usual. When I asked about his occupation, he said that he was engaged in general labor. Later, I
learnt that this involved cutting weeds, spraying herbicides, layering longan plants, collecting longan fruits, and harvesting rice. Sathit’s current wife worked as a housekeeper at an apartment in the city two days a week. Even though both husband and wife had a job, the family had little income and was confronted with constant scarcity. Nonetheless, most of the time I saw a smile on Sathit’s face, light in his eyes, and his gestures were humble and honest. From his appearance, it was hard to imagine that he had once been called ‘the father of AIDS’ by local people.

Sathit is the son of a local police officer in Pa Sang district of Lamphun. His father had been a noi (a person ordained as a novice) who had learned magical powers from a fellow monk. In the words of Sathit, his father was a good person and was a resort to other people since he could make worship candles (bucha thian) and sacred cloths (pha yan). At that time he was a famous person in the region because it had been proven that his sacred cloths could disable guns, meaning that the wearer would be protected against being shot. Sathit’s father could also lie down on the leaves of a banana tree without any other support. Only a special person is able to do that. But Sathit did not learn these magic practices from his father because they were seen as ‘hot.’ He learned only magic spells (khatha – a set of words that offer mystic power) to protect himself against dog bites and poisonous snakes.

Sathit’s father passed away when Sathit was thirty years old. About one thousand people participated in the funeral and, following Thai custom, Sathit was ordained for seven days. After his father’s death, all of his father’s scriptures on magic were offered to the abbot of a nearby temple because they were seen as too hot to be in the possession of a common person. Sathit, however, received his father’s amulets. He sold his father’s house, motorcycle, and other assets and wasted all the money on gambling. He then fell into the bad habit of stealing. At the age of thirty, Sathit was a handsome and mischievous man. He was involved in the local prostitution business and engaged in many promiscuous sexual contacts. He did not care about whose wife it was he was sleeping with or whether she was free from sexually transmitted diseases. He had frequent sexual intercourse with at least three prostitutes who

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1 *Bucha thian* is a ritual conducted by the lighting of three candles in front of a Buddha image. The purpose of the first candle is to send away bad things or bad luck (*song khro*), the second one is to extend one’s fate (*to chata*), and the third candle is to receive luck (*rap chok*). Inside each candle is inserted a unique sacred cloth.

2 *Pha yan* is a cloth that is inscribed with various symbols and ancient alphabets arranged in different patterns. Its usual purpose is to make other persons fall in love with the wearer or for the wearer to become popular among others (*metta maha niyom*), for the wearer to escape danger (*khlaew khlat*), or for the wearer to gain an impenetrable skin or become invulnerable (*khong kraphan chatri*).

3 ‘Hot’ knowledge or ‘hot’ practices have a strong magical power that only can be controlled by a person who possesses extraordinary emotional stability. Such a person has to follow strictly the code of conduct passed down from his teacher or he will face trouble.

4 When we became more familiar, Sathit showed me his father’s amulets and said frankly that he would like to sell some of them to me because he needed the money. I did not accept his proposal, but gave him 2,500 baht (about 62 euro) to buy a used motorcycle, since this would enable him to work further away from home.
were very popular. All of them were HIV positive at the time and later died of AIDS. Sathit described:

  I was involved with a loose woman two to three times a week. Altogether I had around 50 to 60 times sex with her without a condom. Everybody who has had sexual contact with her died later, including her husband. Everyone knew this and assumed that I would have to die in three months.

  In 1993, Sathit became ill and developed many symptoms, such as chronic diarrhea, severe headache, blurred vision, hair loss, weight loss, weakness, and papules. He did not only have to endure these physical ailments but also his neighbors’ mockery:

  A neighbor laughed at me. He said, ‘Look, look at Sathit. He is washing his clothes but he cannot even lift them. AIDS has already eaten him.’

  Another neighbor, who thought that I was almost dying, brought me the papers to apply for membership of the village funeral fund.

  Sathit felt hopeless and wanted to die. He carried a gun and a knife with him and was ready to kill anyone who annoyed him. He luckily avoided such an action when he found a way to possibly cure his illness. He had observed Mo Boon at the abandoned temple when he himself was a honey seller and Mo Boon was one of his customers. After some time he decided to seek help from the healer. To hide his illness from the other people in the healing center, he followed Mo Boon into the toilet and there asked him for help. Mo Boon told him that he should first have a blood test before taking any drugs. A few weeks later Sathit returned with the information that his blood test was HIV positive. To get more precise information, I asked Sathit many times about the blood test. He told me that he had taken the test at the district hospital and had shown the result to Mo Boon.

  Illustration 6. An amulet of Khruba Siwichai. Mo Boon and Sathit reminding each other of the old days when Sathit had paid Mo Boon for half a bag of traditional drugs with a Khruba Siwichai amulet.

  Sathit was poor, so he bartered with Mo Boon over half a fertilizer bag of traditional drugs in exchange for a Khruba Siwichai amulet, which he had received from his father. The amulet was made in 1939, one year after the death of the revered monk. It was a valuable thing...
because of its rareness and magic power. Mo Boon told me that he had wanted to have an amulet of Khruba Siwichai on his necklace. By chance, Sathit came and gave him his amulet, saying that if it belonged to Mo Boon, it would help more people. Aside from the half bag of traditional drugs, Mo Boon gave Sathit 700 baht (approximately 17 euro).

During the first couple of months of the healing, Sathit took traditional drugs in large doses. These consisted of the drug to kill germs (ya kha cheua), the drug to normalize blood and wind (ya dam), and the drug to cleanse blood (ya fok lueat). A few times he took them with liquor. He reasoned that if it could not cure him, it would kill him instead. When he took the drugs he felt very hot inside his body. He became so hot that he had to cool off using two electric fans, one behind him and one in front. When he took the drugs with liquor he got a strong headache, which forced him to pull out his hair and throw it in the river. Throwing bad things in the river and letting them float away is an action that has symbolic meaning within the local culture.

After three months the hot feeling disappeared and Sathit became healthy and energetic. He could drink liquor and eat meat without getting a strong headache, as had happened when he was ill. He even returned to have sexual intercourse with prostitutes because he wanted to check whether he had already recovered from his illness. As mentioned in Chapter 3 about the local perspective on venereal diseases, people believe that one cannot be re-infected when one has been cured by the use of traditional drugs. This belief led Sathit back to his previous risky sexual behavior. Once, while he was having sexual intercourse with his friend’s wife at her house, his friend returned home by chance and, enraged, cut Sathit’s forehead with an axe. Sathit went to the hospital to have the injury treated and asked the doctor to test his blood for HIV. The result was a great surprise, for it was negative. Sathit explained that he was so glad that it was as if his head could float up to the sky. As a result of his supreme gladness, Sathit acknowledged the mistake he had made by having sexual intercourse with his friend’s wife. In the meantime, out of fear of the repercussions for what he had done to Sathit, the friend ran away to another district leaving his little son behind.

To ensure that the illness would not return, Sathit continued to take the traditional medicines for a period of about three years. At this point in his story, Sathit said, ‘I knew I would recover from AIDS with these traditional drugs, Mo Boon knows something that protects me.’ I asked Sathit to explain further, and his response was that he attributed his recovery to the monk Khruba Siwichai, about whom he had dreamt twice. Just as in Mo Boon’s dream, Khruba Siwichai had taken Sathit to the Phrathat Doi Suthep temple. Both Mo Boon and Sathit had dreamt the same dream, although they had never told one another about it beforehand. I then came to understand why Sathit had decided to barter the amulet of Khruba Siwichai for the medicines. When I asked Sathit how he treated the medicines he had received from Mo Boon, he told me what he did when he brought them to his house:

I placed the drugs on the Buddha image shelf. Each time, before taking the drugs, I prayed for the khun of Buddha, Dharma, Sangha, Khruba Siwichai, Khruba Khaopi, Luang Pho Phromma, and Queen Chamathewi to protect me and fill these drugs with khun to let them be celestial medicine.

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5 This amulet, if sold today, would cost about 100,000 baht (around 2,500 euro) on the market.
Buddha, Dharma, and Sangha are the ultimate respected things in Buddhism. Khruba Siwichai, Khruba Khaopi, and Luang Pho Phromma are all famous local Buddhist monks. Queen Chamathewi (700 A.D.) was a queen of the kingdom of Haripunchai, the center of which was located in present day Lamphun province.

Sathit said that when he felt assured that he had recovered completely from HIV/AIDS, he managed to forget his feelings of anger and revenge. He became a new person. He no longer visited prostitutes and was no longer involved with other people’s wives. Another change for the better was that Sathit, out of pity for the fatherless child, went to visit his friend to apologize. The friend forgave Sathit and returned home. This story, as told by Sathit, seems to imply that Sathit believes that he has been cured by the medicines, particularly by the virtue inside the medicines that creates symbolic power (khun ya).

**Sacralization of medicines**

Khun is a primary virtue attributed to medicines. Khun in general refers to the virtue or good quality of persons, deities, abstract entities, or things which deserve respect. Buddhist daily chants always begin with the words for the recollection of the Buddha khun, the Dharma khun, and the Sangha khun. This chanting in Pali words is familiar to all Buddhists. The khun of Buddha, Dharma, and Sangha are sometimes called the virtue of the triple gems (khun phra si ratanatrai, or in short, khun phra). Thai Buddhists often turn to khun phra when they feel insecure, hopeless, or need help.

In popular Buddhism, people believe in the virtue of Buddha (Buddha khun) in both mystic and mundane ways. It is like a power that can be acquired by reciting certain spells or Buddha khatha and Buddha mantra (a set of words that aim to worship and praise Buddha khun, Dharma khun, and Sangha khun) with a concentrated mind. Many experts in mystical power, both monks and non-monks, can make amulets imbued with Buddha khun. These amulets mainly include small images of the Buddha or a Buddhist monk made from metal or other materials (phra khrueang), pieces of sacred cloth inscribed with ancient alphabets, drawings or mystic symbols (pha yan), or metal sheets rolled in a tubular shape (takrut). Each consecrated amulet has a certain power, such as making someone popular (metta maha niyom), helping a person escape from danger (khlaew khlat), making a person invulnerable.

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6 The Buddha khun has three main qualities: wisdom, purity, and compassion. It is also further elaborated in nine qualities: holy, fully self-enlightened, perfect in knowledge and conduct, accomplished (a person who has attained the supreme status of spiritual growth), knower of the worlds, the incomparable leader of men to be tamed, the teacher of gods and men, awakened, and blessed (Payutto 2002: 222-223).

7 The Dharma khun has six qualities: well proclaimed by the Blessed One, to be seen for oneself, timeless, inviting inspection, worthy of inducing in and by one’s own mind, and experienced directly by the wise (Payutto 2002: 223-224).

8 The Sangha khun has nine qualities: good conduct in the community of noble disciples of the Blessed One, upright conduct, right conduct, proper conduct, worthy of gifts, worthy of hospitality, worthy of offerings, worthy of reverential salutation, and the incomparable field of merit or virtue for the world (Payutto 2002: 224-225).
Chapter V

(khong kraphan chatri), bringing good luck (rap chok lap), bringing great power (maha amnat barami), curing diseases (raksa rok), and so on. The specific forms of power desired for the amulet account for the particular spells (khattha) and symbols (yan) used in the sacralization process.

Traditional Thai scriptures mention that some medicines can also be subject to the process of sacralization. It is suggested that in order to make a medicine sacred, the healer should conduct the five or eight precepts (see Chapter 4); he should worship the Buddha in the sanctuary of a temple with joss sticks, candles, flowers, and a food offering decorated with banana leaves and flowers, topped with a boiled egg (baisi); and he should grind the materia medica into a powder and recite the recommended spells (khattha). When the healer shapes the powder into sticks before making pills, he should recite another spell one hundred and eight times (Sophitbannarak 1962: 96).

Each healer may apply different methods to charge his medicines with sacredness. In the case of Mo Boon, after he had made the medicines for his first seven HIV patients, he put them (as I mentioned in Chapter 4) in cardboard boxes and placed them for three months at the glass altar of the Buddha statue in Nong Chang temple. This is believed to be a way of making the medicines sacred, for the monks perform chanting in the temple every Buddhist holy day. Initially nobody knew that Mo Boon had done this, and Mo Boon only told it to his patients later on, when he started his healing.

I observed Mo Boon as he made his medicines sacred. He sat in front of the altar where the image of the Buddha, Khruba Siwichai, other local monks, the ancient ascetics, and the picture of his father were placed according to their cosmological position. He lit the candles and joss sticks, closed his eyes, chanted the preliminary homage, recited the spell named ‘the heart of Buddha’ and ‘the heart of the triple gems,’ lifted the medicines in his palms above his head, and said for himself:

Let the bun barami of Buddha, Dharma, Sangha, all ancient teachers including Chiwaka Komaraphat [the personal doctor of the Buddha], Khruba Siwichai, Ui Takham [Mo Boon’s grandfather], Pho Mo [Mo Boon’s father], as well as the other present teachers, make these medicines effective.

Mo Somsak, a healer whose life history I describe in Chapter 7, was from the beginning extremely concerned with the power of his medicines, since he had to gather the medicinal plants himself in the forest. He recited specific spells and blew wind from his mouth to activate his knife and spade before he cut the part of the plant that he intended to use. While grinding the crude drugs, he recited specific spells to cure disease and ward off danger and blew this into the powder. When he decocted the drugs, he recited spells before putting the crude drugs into the boiling pot. When he had prepared the medicines he would recite spells over them again. Finally, like Mo Boon, he placed the medicine in front of his local altar and recited the words: ‘Let all teachers endow these medicines with sacredness. Let those who take these medicines have good lives, be happy, and recover from illness.’

When Mo Pinkaew was in his drug factory, he always recited spells and blew them into the air while his machines were working. Taking a different approach, Mo Thanachai put his
Meaning attributions to medicines and their effects

medicines on the Buddha image shelf and paid homage to the Buddha and the ancient teachers.

The practices of the local healers that I have described above show the significance of *bun*, which means merit, and *barami*, which means the stages of spiritual perfection achieved by a *bodhisattva* on his path to Buddhahood (Payutto 2002: 334). *Barami* in lay understanding refers to the merit that someone has accumulated from his or her previous lives to the present life, with the intention of attaining enlightenment. A person who has *barami* expresses it through the good quality of his or her mind and is believed to be able to access supranormal power. The *barami* of the supreme things of Buddhism, and of the ancient teachers and the present teachers of local healers, is also the source of the symbolic power of medicines, which can be acquired through the process of sacralization.

Tambiah (1984) provides a description of the cult of amulets in Thailand. Although he focused his analysis on the practices of forest monks from the Northeast, his description is also valid for the North. In his description of the process of the sacralization of amulets, common underlying mechanisms can be observed, namely the chanting of sacred words (*sek khatha*) and sitting in meditation (*nang prok*). The purpose of the former is to confer protection and prosperity, the latter transfers psychic energy (ibid.: 260). Tambiah proposed the notion of ‘objectification of charisma in objects and fetishes’ (ibid.: 339), which clarifies how the charisma of Buddhist saints becomes concretized and embedded in objects. It works because ‘these saints are seen as capable of transmitting their charisma through amulets they have charged and activated’ (ibid.: 335). This capacity is acquired through observing ascetic practices and strenuous meditative exercises, and by detaching oneself from the lure of desires and attachments. The expected result of this heroic act of ‘renunciation’ is the achievement of liberation (ibid.: 126). Simultaneously, it produces a by-product – the access to supranormal powers (ibid.: 333) – which is essential to the sacralization of amulets. Tambiah makes no mention, however, of the power of virtue (*khun*) in his work.

I propose that even though traditional drugs have pharmacological effects, they can nevertheless be treated as objects of sacralization for the purpose of curing disease. In contrast to Tambiah’s interpretation, the healers with whom I spoke have to ask for *bun barami* of the Buddha, local sacred persons, and their healer teachers in order to make their medicines sacred. They use the same mechanism as for sacralizing amulets described by Tambiah, but in a more concise form. To be successful, the healers have to commit themselves fully to exemplary moral conduct so that their accumulated merit is sufficient to initiate the transmission of virtue from the charismatic persons to the medicines they intend to use.

These practices show how the virtue of the supreme things of Buddhism, and of the ancient and present teachers of the local healers, are involved in the healing process, especially in the process of making medicines sacred. The local healer who can deal with these kinds of practices has to conduct his life and healing practice in a moral way so that his accumulated merit has sufficient power to mediate with the virtue of the greater or higher things in the cosmological hierarchical order. I will elaborate on this issue further in Chapter 7.

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*Bodhisattva* is one who has strong intentions to attain enlightenment in order to help his fellow beings or to be a candidate for Buddhahood.
Medicines in Northern Thai culture are not merely something material that anyone can produce. Rather, they belong to the healer teachers. Local healers are simply the persons to whom this knowledge has been transmitted. If a healer or patient does not behave himself in a proper way according to the teachings of the ancient teachers, the virtue of the teachers will no longer support the healer or patient or the medicines. For this reason, according to the perspective of local people, the virtue inside the medicines that creates symbolic power (khun ya) is not present in modern medicines.

The difference between traditional and modern drugs is clearly illustrated by the experiences of Sathit (described above) and Yada (the patient of Mo Boon who I introduced in Chapter 4). The fact that Sathit recovered completely from his illness and became a new person has to be understood on the basis of a common Thai value, namely ru khun. When someone has received a benefit from somebody else, however small it may be, he or she should recognize the virtue (ru khun) of the giver and attempt to reward that virtue (top thaen bun khun), or else he or she will not have a good life. For Buddhists, the best way to reward the virtue of Buddha, Dharma, Sangha, and the local sacred persons is not simply to pray but to do good practices according to the Buddha’s teachings.

When I asked Yada what she did before taking her traditional drugs, she said that she lifted them up and prayed for their effectiveness. With modern drugs she never did this. In another case, an elderly man from Lamphun province came to Mo Boon to cure the febrile convulsions of his grandchild with medicine that is made by rubbing woods with stone and water (ya fon). This man said that this medicine belonged to the ancient teachers, so he had to ask the ancient teachers to let it be effective before his grandson could use it. He said that he would come to pay his respects to the ancient teachers when Mo Boon conducted the annual ritual of paying respects. This man also did not act in this way when he dealt with modern drugs and medical doctors.

According to modern biomedical opinion, the placebo effect of medicines may be perceived as accounting for Sathit’s recovery. Some existing anthropological studies may attribute the success to symbolic effect; the result of possible linkages between transactional symbols (Dow 1986), emotions, cognitions, perceptions, aesthetics, and bodily responses (Lévi-Strauss 1963; Dow 1986; Kirmayer 1993). This latter interpretation is true to a certain degree when we consider that meaning, which is carried by symbols attached to the healing, can affect a patient’s perceptions and emotions and so on, and can therefore influence the immune system (Moerman 2002: 143-144). However, this consideration ignores the virtue inside the medicine that gives it symbolic power, which involves the power of intention, concentration of the mind, and the accumulated merit that the healer and the patient commonly hold. It is of course obvious to say that the synergistic interaction between the pharmacological effects and symbolic power of medicines lies beyond the realm of measurable perception within current scientific knowledge production.
Naming of medicines

In traditional Thai and Northern medical scriptures we find many medicines that have potentially meaningful names, and as such contribute to the healing effect of these medicines. One can distinguish three categories of names.

First, there are medicine names that refer in a metaphorical way to their curing effects. Examples are: *ya kamlang ratchasi* (the fabulous lion power drug), which cures weakness or dizziness and nourishes the blood; *ya lueang wayo phinat* (the yellow drug that destroys wind), which cures diarrhea and flatulence; and *ya prap chomphuthawip* (the drug that subjugates everything in the Indian subcontinent), which cures allergies, asthma, paralysis, and many other diseases.

Second, there are medicine names that refer to Buddhist or Brahmin deities or to a being that has supernatural power. Examples are: *ya phutthachaiya* (the winning Buddha drug), which cures many wind diseases; *ya khiao maha prom yai* (the great Brahma green drug), which cures blood disorders; *ya narai prasit* (the drug that gets its power from Narai, a Brahmin god), which cures *khai phit* (poisonous fevers) and *khai kan* (black fevers); *ya thip rot* (the divine tasting drug), which cures convulsions and blurred consciousness; and *ya hanuman chong thanon pit samut* (the drug of Hanuman taking the road and closing the
ocean), which cures dysentery and mucous secretion or blood in the stool.

Third, there are medicine names that refer to Buddhist cosmology. Examples are: \textit{ya chakkrawan fa khrop} (the drug of the heaven of the universe), which cures the poison of \textit{khai kan} (black fever); and \textit{ya anantakrailat} (the drug of the eternity of Krailat mountain), which cures convulsions and stiffness of the tongue and jaw.

In Thai culture, as in other cultures, giving names to things that are meaningful involves the value system of the society. Medicines, which are seen as good, since they can help reduce human suffering, are valuable things that deserve a carefully chosen name. The deities and all beings that have supernormal power in Buddhism and Brahmanism, plus their place within the local cosmology as well as their qualities, represent all the goodness after which only good things deserve to be named. Within this value system, giving names to medicines is not motivated by material rewards, but by their inner value.

The names of the medicines used by the local healers in Chiang Mai to treat HIV/AIDS, and as described in Chapter 3, are typically created according to their pharmacological actions or healing effects. None of these medicine names fall into one of the three categories I distinguish above. A major reason given for this disregard of the traditional naming scheme for medicines is the existing drug regulations in Thailand. According to the Drug Act 1967, it is prohibited to invent a name for a drug, whether a modern or traditional one, which advertises the therapeutic properties of the drug in a boastful way. When considering the above three categories of medicine names from the point of view of this law, all of them would be forbidden. This consumer protection inspired perspective on the value-free naming of drugs has resulted in healers no longer using the value-laden medicine names that were created by healers in the past.

Mo Boon described an experience that explains why it was difficult for him to use the medicine names passed down from his ancestors:

A drug administration officer in Chiang Mai came to see the medicines that I had displayed at an exhibition held in the city and said that my medicine names were illegal. \textit{Ya lom 80} [drug for eighty wind diseases] was problematic because of the suggestion that it could cure eighty wind diseases. \textit{Ya phra in-suan} [drug offered by I-suan] referred to I-suan who is respected as a god of Brahmanism. These medicine names tended to attract publicity.

After Mo Boon was alerted by the officer about the illegality of his drug names, he changed \textit{ya lom 80} to \textit{ya fok lueat} (drug to purify blood) and \textit{ya phra in-suan} to \textit{ya thai} (purgative drug). These new names are based on their general healing effects, and as such do not go against the law.

Although the medicine names used in healing HIV/AIDS are based on their therapeutic effects, patients still perceive these medicines not merely as a material drug but also as a symbol of particular healing effects. The name \textit{ya fok lueat} (drug to purify blood) was invented by Wipha (a patient of Mo Boon whose story I narrate in Chapter 8), since it cleansed the dirt in her blood caused by HIV. After she had taken this medicine for two months, she regained the fair complexion that is the result of good blood. This also occurred with Ampha (another of Mo Boon’s patients who I describe in Chapter 8), who said that \textit{ya fok lueat} changed her
dark skin to a more translucent tone. For Ampha, as a housekeeper at a resort, washing dirty clothes is routine work. The change in her complexion, as a reflection of the cleansing of bad blood caused by HIV, symbolically referred to something she was familiar with. Moreover, she thought that menstruation causes bad blood, which was also treated by *ya fok lueat*. Once she reached menopause, she therefore no longer thought it necessary to take the drug.

The perceptions of Wipha and Ampha draw our attention to the fact that lay people, whether in Thailand or elsewhere in the world, can perceive a medicine’s name in an idiosyncratic way and may attribute either positive or negative healing outcomes to it. Chom, another patient of Mo Boon, identified *ya fok lueat* with the folic acid tablets she received from the hospital after she started to take ARVs, since she was told that they were medicines to nourish the blood. Ampha also imagined that the *ya kha chuea* (drug to kill germs) had gradually day by day killed the germs inside her body. Although she thought that HIV was a kind of fungus and related to cancer, she could perceive the hot sensation caused by the drug as well as the alterations inside her body. This was enough to convince her that what she had previously imagined regarding the content of the medicine indeed made sense considering the positive effect it produced.

When I heard about *ya kha chuea* for the first time, I wondered why Mo Boon used this name, because it sounds like an anti-HIV drug. In fact, I knew that in the traditional concept of healing there are no germs, whether bacteria or viruses, as described in modern medicine. I was therefore not sure of whether Mo Boon had created the name for this medicine or whether he had modified an old one. Mo Boon told me that he has two formulas for *ya kha chuea*. The first recipe is derived from *ya kae lueat phikan* (drug for treating blood dysfunctions), and was obtained by his father from his ancestors’ medical scriptures; Mo Boon received the advice from his father to use it for HIV/AIDS patients. The second recipe was developed by Mo Boon himself from Khruba Khaopi’s dharma palm leaf scripture. The scripture states that there will come an incurable disease in the future and that this disease can be treated by the drug that is described.

Mo Boon named the two recipes respectively *ya kha chuea neung* (anti germ drug number one) and *ya kha chuea song* (anti germ drug number two). The reason for this naming is due to the fact that when he started his healing activity in 1993, HIV positive patients felt hopeless after the Ministry of Public Health announced that there was no drug that could treat HIV/AIDS. Naming traditional drugs *ya kha chuea* helped to reduce their hopelessness and encouraged them to cope with their illness properly. However, from the perspective of Mo Boon, the power that patients in their ‘imagination’ ascribe to these medicine names cannot achieve a good outcome alone; the medicine must also be compounded according to the correct formula and method. In addition, patients should comply with the traditional drugs – both *ya kha chuea* and the other medicines prescribed – in order to normalize the blood and wind in the body.

As explained above, the gradual acceptance of biomedicine as a powerful kind of medicine has been accompanied by a shift in the kind of names given to medicines and the perception of these names. This particular shift is embedded in the more general shift from a
belief in the supernatural world to a belief in the current modern world, from an imaginative
and subjectivist perspective on life to a realistic and objectivist one, and from a spiritual
to a material worldview. Yet, from a lay perspective, what works under real circumstances
and with limited resources is still the best practical choice. Traditional drugs, which have
been disregarded by modern medicine as products of an ancient world, have been picked
up by lay people to solve their problems on the basis of local beliefs. From their perception
of the world, medicine names from ancient scriptures are not only instruments with which
to communicate, but the names themselves are meaningful. This becomes evident when we
relate them to lay people’s social world, natural environment, and supernatural world. Lay
people also situate themselves in the modern world, in which information from other sectors
overwhelmingly and continuously affects their perception. We can therefore see a merging of
the new and the old in the practice of everyday life. The anti germ drugs (ya kha chuea), as
they are called by the healers, are an example of this merger.

The following section will show how patients imaginatively associate particular bodily
sensations with the effects of traditional drugs.

Bodily sensations as effects of medicines

It was not only the ethno-pharmacological effect that Mo Boon and his father found in ya
kha chuea that helped HIV patients, but also its perceived ‘hot’ quality. Mo Boon observed
that the extremities of most HIV positive patients are cold due to the blood disorder. To
cure this blood disorder, the patients would need a hot medicine. This is the reason why Mo
Boon and his father searched the old scriptures for drugs to cure blood disorders that contain
hot quality ingredients, and subsequently chose the hottest one among them. The name of
the drug they selected from the scripture is ya kae lueat phikan (drug for treating blood
dysfunctions), which later became known as ya kha chuea neung (anti germ drug number
one). When this drug was prescribed to HIV positive patients, its hot quality appealed to
many of them because it could contribute to the healing of bodily ills. As Wipha explained:
The hot medicine made the blood hot. So the germs could no longer live in the blood. To
survive, they have to run away from the blood and find a new place. That is the skin. I can
feel the itching below it.

In the case of Ampha, she also discovered that her strongly itching papules, which made
her feel bad, could be relieved when she pressed a hot bottle on them:

These germs don’t like heat. When I feel itching under the papules, I boil water and pour
it in a tonic bottle. I lay down the bottle near the papules. The itching sense will disappear.
My mind will feel better. This shows that the germs fear heat. If I do it repeatedly for many
days, the red papules will fade out.

Such sensations helped Ampha to imagine that later, when she was prescribed medicine
by Mo Boon, the germs were being killed by the heat provoked by the medicine. She
experienced notable tactile, gustatory, and visceral sensations, and felt hot inside her body
for the first three months of taking these medicines. ‘When I first took medicines, I always
imagined that the germs were killed, even though it was a small amount of germs, but it was
better than letting them proliferate.’

The hot taste and hot feeling inside her body as a result of taking the medicines – a gustatory and visceral sensation – and the reduction of the itching by using a hot water compress – a change in the tactile sensation – formed for Ampha the prominent experiential evidence of the medicine’s effect, aside from the change in her symptoms, e.g. a more healthy complexion. This experiential evidence, which Ampha evaluated as the positive result of the healing, persuaded her to comply with taking the traditional drugs without seeking alternatives. She also took them long enough to assess their effectiveness. Ampha’s testimony to the effectiveness of local healing is that for the last couple of years she has no longer had the itching sensation that bothered her before, even though she has eaten prohibited foods such as chicken and coconut juice.10

I would like to underline here that the lay experience with drugs and the lay perspective on how drugs work, as described above, do not simply float in the air. They can be explained by local disease theory, as I will elaborate on below.

*Phra Khamphi Takkasila*, a scripture of traditional Thai medicine that gives details on various types of feverish diseases – e.g. *khai nuea* (the Northern fevers), *khai phit* (poisonous fevers), and *khai kan* (black fevers) – explains that these epidemic diseases have common symptoms. They produce red, black, or dark green papules all over the skin (or at specific locations on the skin) for one to three days, after which the person will develop fever and aggravated papules in the form of round spots or grains of sand. The healer has to use cold drugs (*ya yen*) to push out the fever (*kratung khai*) completely, in order to prevent it from turning inside and producing febrile toxins that could destroy the internal organs such as the liver and lungs. If the internal organs become affected, hematuria (blood in the urine), hematochezia (blood in the stool), hematemesis (vomiting of blood), stiffness of tongue and jaw, convulsions, and unconsciousness can occur.

Mo Boon, as advised by his father, did not consider HIV/AIDS a type of poisonous fever with a toxin that originates from the outside (the skin). He thought that HIV/AIDS already produced toxin inside the body and was the cause of bad blood, so it needed hot drugs (*ya ron*) to push the toxin out (*khap phit*). Papules and the itching sensation under the skin are the signs that the HIV and its toxin are being pushed out to the skin. With the help of *ya dam* (literally, black drug prescribed to normalize blood and wind), these papules and itching sensations would gradually disappear.

As mentioned in Chapter 3, Mo Somsak had initially considered HIV/AIDS to be a poisonous fever that had to be treated with *ya kaew ha duang*, which the *Phra Khamphi Takkasila* refers to as the major drug to push out fever. But this drug did not work. So he rethought his approach and concluded that HIV/AIDS cannot be considered a type of poisonous fever. He later experienced that persons with HIV who use his *ya khap phit* (drug to purge toxin) had strongly stinking feces with mucous and sticky fat, as well as strongly

10 Ampha said that after she became infected with HIV, she could not eat certain kinds of food like meat, chicken, duck, egg, or coconut juice, because they would cause itching papules. But now she can eat these foods without problem.
smelling urine in the morning. After one week, when their urination and defecation returned to normal, they felt healthy again and had no or only small problems when ingesting prohibited foods. This effect also occurred in the blood of menstruating women, which changed from dark and strongly smelling to normal. These experiences caused Mo Somsak to believe that these changes were important signs showing that the toxin was being pushed out of the body of persons with HIV.

Mo Pinkaew uses *ya thai khang* (drug to purge *khang*) with HIV patients who have papules and pustules caused by bad lymph. His patients experience stinking feces, often smelling of rotten or fresh fish, while some have stinking urine.

From the experiences of these local healers, one might conclude that the traditional drugs they use for healing HIV/AIDS have the specific effect of pushing the germs, their toxin, and/or the decomposed products formed during the healing procedure out of the body through the skin, urine, feces, and menstrual blood. These effects will only be produced in HIV positive patients, and will be perceived by them and their healers through the senses. A person without any illness will not be affected after taking these drugs.

The healers were not in agreement, however, about the route of excretion of the drugs. Only Mo Boon used certain hot drugs to excrete the toxin through the skin, while Mo Somsak and Mo Pinkaew used drugs to push out the germs or their toxin through the feces and urine, regardless of their hot/cold quality.

Another issue I would like to draw attention to is the seeming contrast between the explanation regarding the use of certain hot drugs by Mo Boon and regarding the prohibition of hot foods by Mo Pinkaew. According to Mo Pinkaew, foods that aggravate *khang* diseases can be characterized by their taste and odor, i.e. they a strong sweet and fatty taste (*rot man*), as well as a stinky and fishy odor (*klin chun* and *klin khao*). When these sweet, fatty, and stinky foods are digested and absorbed into the blood stream, they produce heat inside the body, which is suitable for the proliferation of germs and worsens the illness. In contrast, Mo Boon explained that the hot drugs that he prescribes push the toxin out, and his patients explain complementarily that the hot compress on their skin kills the germs.

Since the above presented explanations of the working of the drugs are based on sensual experiences, disease observations, and the progress of healing, there is no need to find out which explanation is more valid than the other. I will try to present an overarching explanation that covers all aspects addressed in the various explanations. Strongly sweet and fatty foods, as well as stinky and fishy foods, can promote a suitable environment in the human body (such as the proper temperature and nutrition in the bloodstream) for the proliferation of germs. Eating such foods is therefore prohibited for the sick. Taking certain hot drugs, on the other hand, can promote blood circulation and cause flushing and itching sensations on the skin. Such drugs can increase the body temperature and create drug induced fever, which is a self-healing mechanism of the body in the case of infection.

A final point that I would like to highlight is that the sensations brought about by taking traditional drugs – whether they are hot sensations inside the body, itching on the skin, or the strong stinking, rotten smell of urine and feces – are perceived as the effects of drugs since
they occur only in sick persons who take these drugs. This perception gains strength when they disappear as soon as recovery from the illness is experienced. The kind of sensations described can be clearly perceived in sick persons when their bodies are activated by a suitable drug. We may generalize that the traditional drugs change the hidden imbalance of the body into an apparent one. Then they activate the person to regain a new homeostasis so that the person’s body can proceed to function under the new situation created by the invasion of HIV.

I do not assume that the HIV positive people I have quoted in this chapter have recovered entirely from HIV/AIDS, as defined by medical science, since a lot of effort would be required to prove the results of traditional medicine scientifically. Furthermore, I do not intend to create a new hypothesis about drug mechanisms that transcends the current pharmacological theory. Rather, I propose that learning from the effects of drugs, in terms of the sensations of people’s bodies and minds, as well as people’s reactions to these effects, might contribute to the development of knowledge that can be successfully applied for the healing of humanity. Secondly, I would like to stress that recovery from HIV/AIDS may still be experienced by people who, according to biomedicine, still have the virus in their blood.

A reflection on the symbolic power of medicines

With regards to my thoughts on the power of medicines, as perceived by patients and healers, I would like to review an anthropological study of pharmaceuticals that is relevant to the findings I have described above. Whyte and van der Geest (1988; 1989) claim that medicines can have a liberating power since in therapy they can, as physical substances, be separated from the skill and knowledge of the physician. This idea sets medicines apart from other kinds of treatment since they are believed to be imbued with healing power. Medicines do not require a therapeutic relationship to a practitioner, though they can carry metonymic associations with knowledgeable physicians and technologically sophisticated production. Anyone who can access medicines can profit from this imbued power. Medicines thus permit patient autonomy through this release from the professional territory of doctors and pharmacists. One can acquire and use them independently, and thus assume responsibility for one’s own health. Medicines carry meanings in both a metaphoric and metonymic sense, which makes it easier to think about them. They also expand the perception of illness as something tangible that may be manipulated (Van der Geest et al. 1996).

Among the patients and healers who participated in my study, traditional drugs are believed to be imbued with healing power in a manner that differs from the pharmaceuticals as described by Whyte and Van der Geest. Traditional drugs in this case still require an association with the merit of the healer. At the same time, they also require a connection with the bun barami of the Buddha, local sacred persons, and healer teachers. It is precisely these ties between the sacred entities, the local healer, and the patient that imbue traditional drugs with the healing power that they are perceived to have. Traditional drugs work since they carry meanings that are situated in the local world of villagers, a world in which these sacred entities and the healer also belong. The next chapter will elaborate on these sacred entities in the local world.
This shared cultural meaning in the local world has a major influence on all patients referred to in this chapter, especially those who belong to the same generation as the healers. The healers and patients all grew up amidst a local Buddhist and animist culture with little interference from modern society. All believe in sacred beings and have experienced local healing since they were young. This developmental learning context offers them a shared cultural base that is necessary in order for symbolic healing – as induced by the merit of local sacred persons and the names of traditional drugs – to have an effect.

The symbolic power of medicines induced by shared cultural meanings on an abstract level needs to be strengthened by some apparent psycho-physiological changes in order to result in concrete effects. As we have seen, traditional drugs that are claimed to have certain effects that are meaningful in the context of local disease theory – such as purifying blood, killing germs, or purging toxins – can fuel the imagination, such as imagining that germs are being killed by a hot drug, or that germs and toxins are being purged. This imagination becomes real for a patient when he or she feels some changes in his or her body, such as feeling hot inside the body, or producing urine or feces with a stinky odor. This patient can then experience some apparent effects of the medicines, such as refreshment of the mind, a fair complexion, or a well nourished body.

It can be concluded that the symbolic power of a traditional drug is evident when (1) a patient perceives the effect of the drug as meaningful within local disease theory and it can open a possibility for positive imagination; (2) the sensory responses of a patient to traditional drugs correspond with what the patient expected from his or her positive imagination; and (3) some apparent psycho-physiological effects, which are the signs of a good healing outcome, take place as a result of the healing.

As noted by Kirmayer (2006: 593), meaning attributions depend, however, on the developmental learning history of the individual, of which some will be shared with others and some will be idiosyncratic to the individual. Therefore, the pattern of psycho-physiological responses as related to the meanings attributed to medicines may be different between individuals. This clearly makes difficult the study of the effects of meaning attribution to medicines, and in turn the effects of these meanings on psycho-physiological processes, among a large number of patients from different cultures. It is further complicated when we consider these responses in pluralistic societies where the ‘culture’ may exist in a variety of forms. In Thai culture, the ideas and imagination about drugs and their effects can be said to be – and to have been – in a state of constant flux, transformation, and hybridization (Kirmayer 2004: 45). This study, like others, cannot adequately address this complexity.

Conclusion

Medicines as artifacts used in traditional healing have been passed down from generation to generation in Northern Thailand, as is the case elsewhere in the world. In my area of study, the scriptures – where healing knowledge and medical formulas have been recorded – are respected as a form of wisdom inherited from the healer teachers, who are seen as divine-like persons. This perspective on knowledge leads to a specific relationship between a healer and
Meaning attributions to medicines and their effects

the healer teachers, as well as between a healer and his patients for whom the knowledge is used. These relationships are situated in a local world, and based on a set of cosmological foundations. They create a local world in which healers, patients, and the community have reciprocal relationships. Within this set of relationships, something that goes beyond the material develops. A prominent example of this is the symbolic power of medicines associated with their virtue (khun ya). This power is generated by relating medicines to the supernatural supremacy of sacred things and to the healer teachers in local cosmology. The limitations of the current methodologies available to study the effectiveness of the symbolic power of medicines in traditional drugs hinder us from proving this effectiveness, since many complex conditions are involved, whether this is to do with the healers, patients, or the medicines. All that we are currently able to do in the world of medical science is to throw the effects of the symbolic power of medicines into the basket of placebo effects.

The sensations that patients attribute to traditional drugs and the imaginations that patients have about these sensations, as well as the patients’ reactions to both, reflect the fact that patients are not passive or docile. Once, in an ancient world, these sensual perceptions and imageries formed the grounds for the sophisticated medical knowledge and practices available at the time. Although they have been officially abandoned since the arrival of the cognitive mode of modern medical knowledge, they still exist in a lively way in the experience of local healers and lay people and deserve to be respected as a legitimate mode of human knowledge.

The effects of the symbolic powers of medicines presented in this study are specific to the shared cultural base of the local world of Northern Thai villagers. The effects caused by these powers imply a history of learning for the individual about local healing. A major prerequisite for effective healing is thus the presence of ties between the healer, the patient, and the healer teachers.
Chapter VI

The significance of the local moral world for the healing process
This chapter presents the local world that enables local healers in Northern Thailand to practice in a moral way, as promoted by the local healing tradition. This local world contains a culturally constructed reality in which spiritual entities and virtues are given a prominent place by healers, patients, and the community. The chapter describes the significance of these entities and virtues in the lives of villagers and healers, and the ways in which they succeed in overcoming the threats of encroachment of outside social forces into this moral world. This chapter describes how a particular local healer – who plays a key role in the struggle to sustain a life world in which traditional norms and values prevail – manages to keep the risk of losing social recognition and prestige at bay. The chapter demonstrates that without this recognition and prestige, and without adherence to the traditionally valued local morality, this healer would not be able to continue his healing practice effectively.

The main spiritual entities in Ban Denchai

This section presents the main spiritual entities in Ban Denchai. I focus on this village because it is where Mo Boon resides. It can also be considered representative of other villages in Chiang Mai since the beliefs and customs of villagers here reflect those belonging to Tai Yuan villagers elsewhere. Ban Denchai is a place where a particular healer, Mo Boon, has succeeded in holding on to the moral values of a good healer. The main spiritual entities that matter in the lives of the villagers and healers in the village therefore deserve to be explored in further detail.

One can distinguish two groups of entities. The first group consists of phi, the ancestral spirits that are the guardians of human beings, and the second of khru, the spirits of healer teachers who inhabit and guide current local healers.

Phi

Early in the morning, at the shrine in front of Mo Boon’s healing center, a ‘rite master’ dressed in white pays his respects to the spirit that protects the place (chao thi), while Mo Boon squats behind him. After a while, the master pauses, turns his face to the shrine, and resumes his recitation. With my gaze following his movements, I catch a glimpse of a set of bowls filled with food offerings placed inside the shrine, as well as a brightly colored plastic garland hanging in front of the shrine.

The rite did not take long since it was performed at an individual household as part of a larger communal village event which celebrated the inauguration of a new shrine hall at the Denchai Buddhist temple. Neighboring villages also participated in the celebration and were represented by processions of members carrying their donations in the form of ‘money trees’ to the temple. The entire village put in a lot of effort to organize the three day celebration, both at the temple and at individual houses, and much community resources – time, effort, and money – were spent on the special occasion. A number of prominent guests were in attendance, including celebrities from a free TV channel in Bangkok.
Villagers in Ban Denchai, like villagers elsewhere in rural Northern Thailand, are Buddhists who also hold local beliefs and customs regarding natural, ancestral, and household spirits. For instance, they worship the spirits or *phi*, which are believed to be the guardians of places and communities, such as the protectors of a specific locality (*chao thi*) and protectors of a village (*phi suea ban*). The villagers also worship the ancestral spirits that protect and govern the descendants of the maternal lineage (*phi pu ya*). Mo Boon’s ancestral spirits inhabit the two shrines at his uncle’s house in a neighboring village. Every year, at the start of the local new year (*Phaya Wan* Day), which falls on April 15th, a rite is performed where all the members of Mo Boon’s maternal lineage gather together to pay their respects to the ancestral spirits.
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Illustration 10. The shrines of the ancestral spirits

*Khuet* (the word for taboo among the people of Northern Thailand, which I discuss in Chapter 2) still influences the lives of villagers in Ban Denchai. Any possible violations of *khuet* are a major concern. For instance, when Mo Boon presented his plan to use the disused Nong Chang temple as the location for his HIV/AIDS healing center, the temple committee raised concern over prohibitions that forbid the felling of trees for building houses in the vicinity of deserted temples. The project was only approved on the strict condition that Mo Boon would not fell any trees around the temple to build shelters or buildings for the treatment of HIV/AIDS patients.

Since the area surrounding the temple was planted with a number of longan trees, Mo Boon had to figure out ways to build the facilities necessary for his healing activities while at the same time observing *khuet*. First, Mo Boon built two wooden halls with palm leaf roofs among the longan trees. They provided shelter for the HIV/AIDS patients who had travelled from distant areas. Second, a chance incident helped him out when, a year later, he decided to have a concrete building constructed to serve as a shrine hall with a Buddha statue and as a room for treating patients every Buddhist holy day. When he measured the site, he realized that the space between the two rows of longan trees was too small for the size of the hall he intended to erect. A few days later, however, all six longan trees standing around the marked area inexplicably fell down simultaneously, opening up a space large enough for the construction. For some people, the incident was viewed as more than a mere coincidence. One of his neighbors even accused Mo Boon of hiring a backhoe machine to fell the trees. But Mo Boon and his friends believed that it was an act of angels (*thewada*) who wanted to help him succeed in making great merit.

*Phi ka* is probably the most well known spirit group that causes harm and evil to villagers in Ban Denchai.¹ They are ancestral spirits of the maternal lineage that turn malevolent

¹ The story of *phi ka* is elaborated upon in the book *A Physician at the Court of Siam* written by Malcolm Smith (1985), who served as a court doctor for Queen Saowapa Phonsi, one of the four royal consorts of King Rama V, between 1905 and 1910. This was in the early period of the Christian mission in Chiang Mai, when villagers who were accused of being possessed by *phi ka* converted and became part of the Christian community.
because they are not treated properly or because their descendants have violated khuet. It is said that a phi ka family lived in Ban Denchai, and that its members usually shunned contact with their neighbors. Once, Pho Mo, Mo Boon’s father, when he was eighty years old, became sick and a woman from his family came to visit him in a hurry. She quickly entered the room of the sick man, removed the ring from his finger and put it on her own finger for a while before putting it back on his finger. After she had left, the healer began to show strange faces behind the backs of others – a sign of possession by phi ka. Mo Boon said that the woman came to get revenge on his father because Pho Mo used to release people from the grip of the phi ka when it possessed them. This story shows clearly how the belief that phi ka can inflict great harm on people remains strong in Ban Denchai.

The customs I observed in everyday life in the village reflect how deeply the belief in phi is ingrained in the consciousness of the villagers and local healers. When I paid a visit to the healers from the North who had travelled to Bangkok and stayed in a rented room while attending the National Herbal Medicine Fair, I found that every morning before breakfast they offered food placed on a plastic sheet to the protectors of the specific locality where they stayed (chao thi), in the belief that it would protect them from harm and danger.

When suffering from afflictions caused by phi or the violation of khuet, villagers in Ban Denchai will conduct a ritual to ask for forgiveness. I witnessed such a ritual held in a patient’s house and noticed that many villagers joined the event, which lasted for several days and in which folk plays and dances were performed, along with feasting. The ritual ended with the dedication of offerings at the shrine of the ancestral spirits.

It is interesting to note that since health officials have successfully conveyed the message that HIV is a communicable disease, the villagers in Ban Denchai do not associate the disease with phi. Some healers refer to HIV/AIDS by local terms such as mutta khuet (bad urine). From this point of view, AIDS is associated with khuet, as its cause is considered to be misconduct in sexual behavior.

Khru

Khru is the spirit of healer teachers from the past. It is considered an abstract entity rather than the spirit of a single teacher. Medical knowledge is thought to belong to the khru, who pass it on to new healers through the generations. Every year each local healer has to carry out a ceremony to pay homage to the khru (phithi wai khru).

When Mo Boon conducted this homage ceremony on the local New Year’s Day of 2008, I was there to observe it. Presiding over the ceremony was a Buddha statue sitting on a wooden shelf. On the top of a three foot high cabinet, Mo Boon had placed a statue of the god Phra Phitsanu (Ganesh, see below in this section) and pictures of the monk Khruba Siwichai (see following section below). An assortment of offerings was arranged on a one foot high

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2 The preferred date for this ceremony is any Thursday in the period between March and June. In Brahmanism, Thursday (Phraruehatsabadi day) is designated as teachers’ day, for the angel named Phraruehatsabadi is said to be the teacher of all angels. However, some healers hold the ceremony on any day that is convenient.
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table, and this was placed in front of a rattan tray holding a photograph of Pho Mo. All of the medical scriptures in Mo Boon’s possession as well as his healing equipment – the healer’s knife (mit mo) and a herbal rubbing tray – were also present. Mo Boon’s healer teacher’s bowl (khan tang) was placed in front of the picture of Khruba Siwichai.

Illustration 11. Mo Boon’s ceremony to pay homage to the healer teachers

It is tradition that when a patient starts receiving healing from a local healer, the patient has to pay a symbolic fee to honor the healer teachers. In Mo Boon’s case, the fee is four baht (approximately 10 euro cents) for massage, twelve baht (approximately 30 euro cents) for medicine treatment (herbal medicines), and thirty-six baht (approximately 90 euro cents) for awman (a special type of massage that his teacher had learned from a Burmese healer). The fees are kept in the healer teacher’s bowl until the next year. On the morning of the day of the ceremony, the money is collected from the bowl. In the year that I was present to observe the ceremony, there was more than five hundred baht (around 12.50 euro) in total. The money was spent on offerings and herbs, and the rest was donated to the temple.

One of the people attending the ceremony was a man from Lamphun whose granddaughter had fallen ill from febrile convulsions but had recovered after taking herbal medicines that were rubbed off with a rubbing tool. This man said that he was present to show his gratitude to the khru, because the medicine that had cured his little granddaughter had been passed down from the khru to Mo Boon. Mo Boon is thus seen as simply a carrier of the khru’s healing power and knowledge. The ceremony to pay respects to the khru, in the way prescribed by tradition, is thus vital for letting Mo Boon maintain his healing powers. On this occasion, since only a few patients could come personally to participate in the ceremony and pay their respects to the khru, Mo Boon performed the duty on their behalf.
Phra Phitsanu, as the Hindu god Ganesh is called in Northern Thailand, is originally a Brahmin deity worshipped for his expertise in all branches of the ancient arts and sciences. In the Central Region of Thailand, he is not regarded as a teacher of healers, though in the North he is highly respected as such. Phra Phitsanu, who has a human body, an elephant head, and four hands, represents the ability to overcome obstacles and accomplish things. Thus the local healers of Chiang Mai often invoke his power when they are healing their patients. I once observed Mo Som, a local healer in San Kamphaeng district, offering a
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The statue of Phra Phitsanu to a patient who suffered from paralysis, and telling him to ask for the god’s blessing. Not long after this, the trembling that had kept the man awake throughout the night subsided and he was finally able to sleep. The power of the *khru* will be elaborated on in the next chapter (Chapter 7), where I will show how HIV/AIDS patients relate it to the effectiveness of the healing they receive.

**Khruba Siwichai (1878 -1938): The most respected monk in Northern Thailand**

Among the Buddhist monks in Northern Thailand, Khruba Siwichai is the most respected. He is acknowledged as a monk who possessed the virtues and supranormal powers of a bodhisattva (one who has strong intentions to attain enlightenment to help his fellow beings) (Tambiah 1984: 303). There are three reasons why this status has been accorded to him.

First, Khruba Siwichai was a Buddhist monk whose practice was grounded in the tradition of Northern Thai Buddhism. As political and cultural threats intruded upon the Northern people’s way of life as a result of the central government’s attempts to control the region, Khruba Siwichai’s support of the preservation of local traditions and customs was greatly appreciated by the people.

Second, Khruba Siwichai is a symbol of resistance against the power of the central government. Over a period of thirty years, he had to face three separate allegations from the Lamphun Sangha provincial chief on different charges. The first charge was related to the fact that, as a locally revered monk following local customs, Khruba Siwichai performed ordination. He was accused of performing illegal ordinations since he did not obtain the official permission to do so, as legislated in the 1902 Sangha Act (a law to control the monastic community of ordained Buddhist monks). His second charge came because he disobeyed the Sangha provincial chief’s order that every temple should be decorated with lights for the celebration of King Rama VI’s accession to the throne. Instead, Khruba Siwichai asked the locals to observe the precepts, pray, and meditate at the temple to celebrate the occasion. Finally, Khruba Siwichai was accused of performing illegal ordinations and cutting down trees in the forest to build a road to the Phrathat Doi Suthep temple on Suthep Mountain. Although he was arrested and taken to Bangkok twice to be questioned and educated on the new law, he was able to prove his innocence. He was acquitted and gained stronger support from many local people and monks.

The third reason for Khruba Siwichai’s high status is that he led local people in the North in raising funds and organizing the construction of new temples and the restoration of old and decayed ones. The story of how he led villagers and monks to build the road to Phrathat Doi Suthep temple using only voluntary manual labor and simple tools, and without any support from the state, has become legendary. Indeed, the number of people who wanted to participate in the project was so large that schedules had to be made to allow everyone to work.

As told in Chapter 4, Mo Boon himself takes pride in his ties to Khruba Siwichai through his grandfather, Ui Ta Kham, a local healer who lived in the same period as Khruba Siwichai. Ui Ta Kham was in his thirties when he left Mawlamyine, a Mon state in the Union of Burma.
When the borders between Siam and Burma were closed during World War II, he decided to settle in Ban Denchai in Chiang Mai and it was there that he started his career as a local healer. Because of Ban Denchai’s proximity to Lamphun province, where Khruba Siwichai resided, Ui Ta Kham became the personal doctor of the revered monk. Khruba Siwichai, according to Mo Boon, suffered at the end of his life from *mahok lueat* (an internal hemorrhoid) and took the traditional drugs given to him by Ui Ta Kham until he was eventually hospitalized and later died at the temple in Ban Pang, his birthplace. It was said that his illness worsened because he sat for too long receiving visitors who came to pay their respects or donate money for the construction or renovation of temples, and because he had eaten forbidden food while in the hospital.

In one way or another, Mo Boon tends to relate many of his healing activities to Khruba Siwichai, whether through the ceremony to pay respects to the healer teachers or his practices in daily life and at special events. This reference could possibly serve two purposes. First, by identifying himself with Khruba Siwichai, Mo Boon may make villagers more eager to donate money for his cause. In order to establish the healing center for HIV/AIDS patients, Mo Boon had to raise funds to build a concrete hall, wooden houses for the patients, and other facilities. The hall was named the Hall of Merit Making (*Sala Bamphen Bun*) and was dedicated to Khruba Siwichai.

Second, it is a way for Mo Boon to seek protection from the great merit of Khruba Siwichai and invoke his spiritual power to help him succeed in healing patients. Mo Boon pointed out to me that no HIV/AIDS patient had ever died at his healing center. Once there was a patient who suddenly fell very ill while staying there. His condition, which was caused by eating improper food, worsened before Mo Boon gave him the herbal medicines that cured his illness. In this case, Mo Boon attributed his success to the merit of his teachers and to Khruba Siwichai, who had saved the life of his patient and thus protected him from the accusation of being a quack.

**Illustration 14.** Sprinkling water on the Buddha’s relics. Left: A silver flash pulling up to the pagoda of Phra That Hariphunchai temple. Right: Mo Boon walking around the pagoda to worship the Buddha’s relics.
Phra that and Pho: Symbols of the Buddha

My first visit to Mo Boon in 2006 fell on Visakha Bucha Day, the commemoration of the birth, enlightenment, and death of the Buddha, which takes place during the full moon of the sixth lunar month. On this occasion, I accompanied Mo Boon to Phra That Hariphunchai temple – one of the oldest temples in Northern Thailand (dating from 1108 A.D.), located in Lamphun province – to worship the phra that (relics of the Buddha or Buddhist saints). With a bunch of flowers, we lit candles and incense sticks, walked clockwise three times around the pagoda in which the Buddha’s relics are housed, and then sprinkled water with the dried fruits of soap pod (Acacia concinna [Willd.] D.C.) and safflower onto the pagoda, the Buddha statues, and the other holy figures placed around the pagoda. We concluded by collecting the water flowing down from the pagoda for worship at our houses.

The phra that (relics) are regarded as representations of the Buddha and held in highest reverence by Buddhists, who believe that it is auspicious and of great merit to pay homage to these objects of worship. Among Northern Thais it is believed that the Buddha’s relics are kept at twelve places: eight in Northern Thailand, one in India, one in Burma, one in Laos, and one in the heaven that is called Dawadueng. These phra that are associated with the twelve year animal cycle (nak sat) in the local horoscope. At least once in a lifetime, a Buddhist should travel to pay his or her respects to the phra that that corresponds to his or her year of birth, and for this he or she will be rewarded with longevity, luck, and prosperity. Of all phra that in Northern Thailand, those at Phra That Hariphunchai temple and Phra That Doi Suthep temple are the two most significant ones to Mo Boon, since the former is associated with the year of his birth, and the latter with Khruba Siwichai, his local spiritual teacher.

Illustration 15. Procession of tree props. Left: Two four meter long poles carried by a pickup truck. Right: The moment the villagers cheerfully prop up the Pho tree’s branches.

Another Buddhist event that Mo Boon and the villagers of Ban Denchai value very highly is the procession of tree props (phithi hae mai kam), which is a religious event distinct to Northern Thailand. I was once able to participate in this event and closely observe it. The
event was held in the evening of the final day of a three day celebration for the local New Year in 2008. The centerpieces of the procession, in which the joyful villagers walked and danced, were the tree props placed on a pickup truck that the villagers used to support the pho tree (*Ficus religiosa* L.) on their way to the temple. This action symbolizes the efforts to uphold Buddhism. In doing so, longevity and safety in the coming year are promised to the participants.

From an academic Buddhist perspective, one can say that *phra that*, holy water, and the *pho* tree are symbols that Buddhists relate to the purity, compassion, and wisdom of the Buddha. The sanctity of these objects does not rely on the miracles or supernatural power usually associated with them. Rather, their true function is to serve as a reminder to people not to fall into carelessness. To be a good Buddhist, one needs to behave and lead one’s life in adherence to the Buddha’s teachings and not merely depend on sacred things. In other words, these things will protect only those who follow the right path and not those who deviate from it.

In Mo Boon’s healing center at the deserted temple, a Buddha statue was acknowledged as the president of the shrine hall, to whom HIV/AIDS patients always paid their respects before any affairs were performed there. Everything that was intentionally conducted in the shrine hall could then be related to the sanctity of the Buddha. This was why Mo Boon always conducted his healing practices in front of this Buddha statue. He also empowered his first set of traditional drugs for the treatment of HIV positive patients with the power of the virtue of Buddha in the shrine hall of Nong Chang temple (see Chapter 5).

In short, traditional animistic beliefs have played a significant role in the mundane activities and kinship relationships of Northern Thais, who seek the protection of natural and ancestral spirits for themselves and their families against dangers and bad luck. This function has naturally been incorporated into Buddhism, and the respect accorded to the local spirits has been extended to religious objects such as Buddha statues, *phra that*, the *pho* tree, amulets, and so on. For Northern Thais, these symbols command even more respect than the local spirits, since their sanctity and potency in protecting them against evil spirits, dangers, and misfortune, as well as their power to reward them with success, are deemed greater.

**Hierarchical order of entities and human beings**

The entities in the local world are placed in hierarchical order according to their respective purity and kindness. Apart from the Buddha, who is the ultimate and most respected of all sacred beings, other beings inhabit different levels of heaven, which is higher than both the human world and hell.

Mo Boon described for me the three worlds where different beings reside. In the middle level, the human world to which we belong is located. The upper world is heaven, which is the residence of all sacred beings. The underworld is the place where human beings who have conducted bad deeds are consigned in their afterlife to face suffering and punishment.

Mo Boon told me that he had once witnessed the world of the dead in a dream during his three month retreat at Nong Chang temple. In his dream he saw many dead people gathered
in front of the god of the underworld. Newly arriving people received food from one of his neighbors, who was a good merchant in the village. They were then brought to one of the nine levels. He saw that a neighbor who had just taken his own life by drinking pesticides was taken to the third level. Another neighbor was awaiting judgment over his misdeeds – grabbing women’s rears – but before the decision was handed down, a fat woman came to his defense saying that he had made merit by providing tents for the events held by the community, and for that reason he should not be punished in hell. This objection saved the man from his punishment. Another man, an earth digger, was in hell because he always dug the soil without asking permission from Mother Earth (Mae Phra Thorani).

Mo Boon said that in his dream he was only allowed to see the third and fourth of the nine levels of the afterlife. The third level was a gloomy, horrible place with houses like those in slums. When he saw several ghost-like beings walking toward him, he slipped into a house to hide. Inside he found worms crawling all over the bamboo walls. He also found a ghost lying in a pool of foul water. While walking to another level, he saw a boy and an old man wearing wet clothes, crying and asking for food. Mo Boon asked his elder brother to offer them celestial rice. The fourth level was a place that looked like the human world but was more beautiful and peaceful. He walked along a road lined with houses on both sides. The smaller houses belonged to those who made little merit, the larger ones to those with great merit. He knew intuitively that his mother could be found at one of the houses in the fifth group at this level. He stopped at a junction and started to search for her place, but he woke up before finding it.

I asked Mo Boon why he thought he had not been allowed to see the other places beyond the third and fourth levels. He replied that the sight of the third level was enough to imagine how many more horrible things there would be in the second and first levels. Likewise, visiting the fourth level, in which general conditions were a far cry from the third, was sufficient to picture how much better the higher levels would be.

Mo Boon told his neighbors about the dream. He also advised the person who was an earth digger to donate a truckload of soil to a temple as penance for his past misdeeds, and from then on to ask for permission from Mother Earth every time before digging the soil. According to Mo Boon, the actions of each man will decide to which level of this unseen world he will go after death. Those who regularly commit sins are destined to suffer in the lower levels, while those who always do good deeds will enjoy pleasant things and happiness at the higher levels. Having proper relationships with all beings and things is thus considered a moral issue. Even the soil is regarded as a divine being. Improper behavior with regards to the soil, with or without others’ knowledge, is therefore immoral and can lead to punishment in the afterlife. Merit can, however, compensate for such transgressions and save from hell those who accumulate it sufficiently.

When focusing on the virtues of human beings, Mo Boon distinguished people according to their efforts to help others. At the bottom are khon, those people who just work to earn money and take care of their own families. Greater potential have manut, who not only support their own families but also others in the community. The further a person’s efforts to
help others extend beyond themselves, the higher they will rise, to eventually reach the status of *thewada* (angels), *phaya in* (the chief of *thewada*), and *phrom* (noble beings in the high heaven), given here in ascending order.

Mo Boon’s thinking is evidently influenced by the value and application of local cosmology in everyday life. For instance, in traditional cosmology, *thewada*, *phaya in*, and *phrom* exist only in heaven. Humans who have amassed much merit from their past and present lives will change into one of these entities after their death. Mo Boon includes them in his classification for living beings, however, making the status achievable to persons also in the present life, instead of one having to wait for the next life in an invisible world.

**Merit (*bun*)**

Popular Buddhism has created its own sacred things, not only to answer people’s need for security and desire for luck but to fertilize their mind with the Buddha’s teachings, which emphasize the appropriate ways to elevate human spiritual well being. One of the teachings well known among Thai Buddhists is that of the three bases of meritorious action (*punnakiriya-vatthu*), which consist of giving or generosity (*danna*), observing the precepts or codes of moral conduct (*sila*), and mental development (*bhavana*) (Payutto 2002).

The concept of merit (*bun*) involves almost every aspect of the Northern Thai traditional way of life, because it assures Northerners of a good life in the present and promises a better next life. A good life is traditionally measured by a person’s ability to support himself, his family, and community in performing the three bases of meritorious action. Therefore, until the advent of modern day life, the norms for moral conduct in village society in the North were not very complicated or difficult to conform with.

In Ban Denchai, like elsewhere, the temple has remained the center of merit making for villagers. Every Buddhist holy day they go to the temple to pray, pay their respects to the statues of Buddha, give alms to monks, and donate money. These activities are commonly known as *tham bun* (merit making). Even though the Buddha’s teachings make it clear that meritorious actions encompass several actions (from moral conduct and mental development through meditation to giving), merit making has taken on a much narrower meaning that focuses on giving or donating money or things to monks and temples. Observing the precepts and practicing meditation are seen as activities only for elderly people, who dress in white and stay at the temple on Buddhist holy days.

In Mo Boon’s case, his father taught him that the ultimate goal of a healer is to amass merit, since merit is an essential attribute of persons who desire to help a large number of people. A healer who acquires great merit will attain a greater capacity to help patients. In the context of the Buddha’s teachings, this idea equates healing with a sort of giving – that is, to help others without expecting any reward in return. Since Mo Boon became a healer, this religious ideal has had a great influence on him. To some extent, Mo Boon attributes his success in healing to his own merit (*bun*) and to the *barami* of his healer teachers and Khruba Siwichai. The word *barami* refers to an aggregation of merit that one has cultivated in one’s past and present lives. It signifies a high quality of mind and moral authority, which
is needed to accomplish feats that ordinary people would fail to undertake. A culmination of *barami* is a prerequisite for achieving enlightenment. In this respect, the ideal of being a local healer implies more than a social or physical accomplishment; the act of healing is directly connected to the accumulation of *bun* with the ultimate aim of enlightenment.

It is not only healers who believe in the role of merit and its effect on healing; patients themselves also accept the importance of this role. I posed a hypothetical question to Sathit, a former HIV patient of Mo Boon, whom I introduced in Chapter 5. I asked him what he thought would happen when Mo Boon passed away. Would one of his sons succeed him and dispense the same medicines as his father? And would he be able to achieve the same results? Sathit thought that they would be different. This answer reflects the acceptance of some idiosyncrasy of the healer in the healing process, in which a healer’s virtues are significant. Apart from knowledge and experience, the accumulated merit of each individual healer, as perceived by others, also counts in their practice.

Wiyada, another of Mo Boon’s HIV patients, told me that when Mo Boon and she became more familiar, he told her the story of his lapse into unconsciousness for five days, during which his spirit sojourned in heaven and witnessed things that happen there. Before he was sent back, he had been told that he would be called to heal the sick. This implies that Mo Boon expects his patients to perceive him as a meritorious healer. When asked to choose between a healer who has a deep concern with merit and another one who does not, Toei, another HIV patient of Mo Boon, said that she would prefer the former. She reasoned that a healer unconcerned with merit would not care to use the money he receives from his patients to make merit. ‘Does this imply that a healer’s merit affects his practice?’ I asked. ‘Yes,’ she replied. Mo Boon also showed both Wiyada and Toei things that his father had given him – a lightening-struck stone, a healer knife, two ivories from water elephants, and an ancient broken metal utensil shaped like a serpent’s head. Traditionally, these items would have been used to ward off evil spirits, but they are believed to have magical powers and should naturally be in the possession of worthy owners like monks or healers with great merit.

Conventionally, local healers who adhere to merit will earn unwavering support – both material and social – from the entire community. This enables them to continue their practice and pass on the ideal of good healers from generation to generation. The story of Pho Mo, Mo Boon’s father, illustrates the zeal with which a healer, who faithfully regarded his practice as merit making, did his utmost to realize this ideal. Even when his own family barely had enough to eat, he still gave the little rice left in their kitchen to some of his poor patients. When he was young, Mo Boon had serious doubts about his father’s conduct:

Looking at my father, I often asked myself why he had to live such a hard life. Why had we no money? Things never improved for us, not for his

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1 In Buddhism, *barami* is defined as ten qualities of the mind, namely giving, good conduct, renunciation, insight understanding, endeavor, forbearance, truthfulness, self-determination, loving kindness, and indifference to praise and blame in the performance of duty.

2 The water elephant is a mythical animal said to live near streams in deep forests. It looks exactly like an elephant but is very tiny in size. A traditional belief is that its ivory can frighten away elephants.
children and not for himself. At night he was deprived of sleep because the villagers called on him when somebody was ill or a child was crying and sick. He would go off in a hurry. They would protest noisily if he did not come immediately. My father knew that he would not be paid, even the medicines he had to give them. There was no rest for him. His eyes were perpetually red and wet from lack of sleep and keeping watch at the patient’s bedside. After a lot of thought, I told my father: ‘There’s nothing to gain in doing this. Give it up father, please. You’re getting old.’ He replied: ‘No, son. It’s making merit, and I’ll keep doing it.’

In order to fulfill the role of a good healer, Pho Mo had to sacrifice the prospect of receiving any material gain and even his children’s opportunities for further education. The ultimate goal of making merit was firmly held by the old healer throughout his whole life, and in turn greatly influenced his son’s life as a healer. But in order to sustain this ideal in confrontation with social change, Mo Boon has had to adjust his ideas and his practice.

Remaking a moral life amidst social change

To analyze the disturbance in healers’ moral lives in the context of large scale socio-political and economic changes, I apply the framework presented by Kleinman in his book *What Really Matters* (2006b: 227-228). According to this framework, the transformation of a moral life results from the interaction between three different things: ‘cultural meanings, social experience, and subjectivity (inner emotions and sense of self)’ (ibid.: 227). This framework can be used to argue that moral practices in response to human problems change when local worlds and the people living in them change.

In the case of Northern Thailand, changes in society, economy, politics, and mainstream culture have continuously influenced the local world of the villagers since the emergence of the Thai nation state. However, during the last three decades, these changes have become so profound that the local world can be described as somewhat confused (see Chapter 2). These changes have influenced what local people believe in terms of material growth, and have shaped a collective experience in which people are socialized toward competitive action. As I observed in Ban Denchai, the belief in animism and Buddhism has become weaker among the local youth. Young people in the villages participate vigorously in community events, in so far as they serve their needs for entertainment – for example, they will dance along with the mobile discothèque processions of money trees – but they will also abuse alcohol, which often leads to quarrelling and fighting. Free sexual behavior has also become widespread, contributing to the spread of HIV. Searching for material wealth by whatever means is another new trend, which has motivated some Northern villagers to join the narcotics business, which is spreading from the Thai-Burma border. All of these changes transform the selves of some people in the local world – especially the young – into new ones, which are likely to alienate them from their own past moral values.

As society is transformed, the fabric of community life that traditionally supported the role and practice of local healers is becoming unraveled. According to the local healers in
Chiang Mai, it used to be tradition that on local New Year event and at the start of Buddhist Lent many well wishers – most of them their present or past patients – would come to their house to pay their respects and bless them. This expression of gratitude was highly valued and crucial for local healers, who regarded the practice of their art as a moral obligation and did not expect any material gain in return. Today things have changed; on such occasions, fewer patients visit healers to pay their respects.

Mo Boon reasons that the advent of modern medicine has introduced a relationship between doctors and patients that is based on fees for their services, and this has significantly contributed to changes in local values. Most people think that they only have to pay money in exchange for a medical or healing service. No longer are they concerned with the traditional relationships between healer and patient. Local healers and their families find themselves in disarray amidst this change, which has profoundly shaken their beliefs and practices. Consequently, some healers have failed to hold to the moral values of a good healer. Others have turned their practices into a business or have tried to compete with modern medicine by adopting the use of modern equipment. Under the threat of punishment through the laws governing traditional medicines, many have chosen not to continue their practices at all, and they do not pass on their knowledge to their children.

Amidst the changes in cultural meanings and social experience in the local world, it is for Mo Boon a great challenge to live a moral life in line with the moral values passed down from his ancestors. He desperately wants to maintain the things that he thinks really matter, but he also has to take his family life into account. On the one hand, he knows that his sons must have a better education than he himself received. This means that aside from supporting his family, he has to earn enough money to pay their many educational related expenses. On the other hand, he has to keep living up to the traditional ideal of a local healer, who observes moral values oriented towards merit making.

Mo Boon applies at least four strategies to reconcile his morally grounded healing practices with the material needs of his family. These strategies represent his subjectivity in dealing with the changing local world.

First, he casts around for donations from people and organizations beyond his community. This is not too difficult for him since HIV and AIDS and traditional medicine have become prominent issues in Thailand, and his activities have received local and national publicity through books, radio, and television programs.

Second, Mo Boon places an emphasis on transparency in the healing center’s financial management. To build trust among the villagers for this endeavor, the center’s finances are overseen by a committee of advisers. An account of the donations and expenses, including all the receipts, is kept and is always ready for inspection. Moreover, the donations are differentiated according to their sources, so that the money can be spent according to the purposes intended by the respective donors. For example, donations from villagers go to the building of structures such as the shrine hall, shelters for patients, toilets, or maintaining the water supply, whereas a grant he received from the Department of Disease Control was spent only on organizing activities to empower persons with HIV/AIDS, such as occupational
training.

Third, Mo Boon informs his patients that his medicines are prepared from plant materials purchased from stores in the city and that they therefore have to share the costs. Despite this, the prices of his medicines are both reasonable and lower than those of other healers; for example, a powdered herbal medicine of 40 grams to be taken for one week costs a patient only 20 baht (around 50 euro cents), and a full medicine set comprising five medicines against HIV/AIDS costs around 12 euro a month. With patients who can afford to pay the full price, Mo Boon says that their money helps to cover the costs of medicines that he dispenses to poorer patients at a lower price or free of charge. Some patients write him letters asking for medicines, and in some cases he sends them free of charge. Mo Boon considers this act of giving access to medicines a way of making merit. Furthermore, by channeling help from well off patients to poorer ones, he lets these patients share the merit with him.

Fourth, Mo Boon supports his livelihood not by what he earns from healing but through the income he receives from his other activities. For example, he has a longan orchard business, and he makes money through the sale of powdered herbal materials from a tuberous root, a kind of Pueraria candollei,5 to his former HIV positive patients, who use it as a growth hormone for chickens. He also sells traditional medicines to a Thai traditional practitioner in Bangkok, who in turn sells the products to his clients. Through these arrangements, Mo Boon does not have to live under financial pressure.

With these four strategies, Mo Boon has been able to continue practicing according to the local moral vision characteristic of the healing tradition, while living in the modern world. The strategies have worked well in maintaining his moral conduct and reputation in the village context. However, they were not effective when he got involved in a project embedded in a context transcending the local one, and on which he had no grip. I will describe this in the next section.

Maneuvering in a situation of moral breakdown

In what follows, I will explore the moral experience of Mo Boon during a difficult period, and through analysis of this situation I will try to interpret what really matters to him in his healing tradition.

Mo Boon and the minivan

At the beginning of my fieldwork, I was asked by the coordinator of the Northnet Foundation to help figure out the problem that had been troubling Mo Boon for over a year. It was related to a project funded by an international agency, which was supposed to provide him with funds for a minivan that he could use for multiple purposes: giving rides to potentially HIV positive people to visit a hospital for blood testing; transporting medicinal plant seedlings

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5 Pueraria candollei is a phyto-estrogen containing plant with great commercial potential, found mostly in the northern and north-eastern regions of Thailand. The name used in Thailand is kwao khruea khaw. Its scientific name is Pueraria candollei Graham & Benth. var. mirifica (Airy Shaw & Suvatabundhu) Niyomdham.
to be distributed for cultivation; conducting educational and nutritional programs; arranging
emergency hospital visits for community residents; and making house calls. The rest of the
funds would be used for training activities in four districts and for the provision of free
lunches and token pocket money for orphans.

At first glance one might wonder why a project that promised such good things turned out
to trouble Mo Boon so deeply. To find out what really happened, I spent a week talking with
Mo Boon at his healing center, going through all the relevant evidence, and finally checking
the project’s own bank account. Piecing together all the information, the following is what I
believe happened to the project.

The project started in 2004 when the 15th International AIDS Conference was held in
Bangkok. Mo Boon’s attendance was sponsored. At the conference, he was persuaded to
participate in the ‘Mo Boon Project,’ which was initiated and run by a team of foreigners.
When Mo Boon was first approached for his participation in the project, he was told of the
plan to raise funds to construct a three story building on a three rai (1.18 acre) plot to serve as
a community health center, which would provide care for people affected by HIV and AIDS.
However, in the aftermath of the tsunami disaster in December 2004, most of the funds, as
he was told, were diverted to provide relief for tsunami victims. Consequently, the funds
reserved for the project were sharply cut, and the amount made available was just enough for
the purchase of a minivan and the support of a few other activities.

To announce the funding of the project, a ceremony was arranged at a restaurant in Chiang
Mai. It was attended by witnesses from a local charity organization, as well as Mo Boon and
his wife, who were to play the key roles in the meeting. The declared purpose of the project
was to assist Mo Boon, his HIV positive patients, as well as orphans whose parents had died
from AIDS.

Illustration 16. The minivan at the healing center

The vehicle was properly registered under the Northnet Foundation, but it was agreed
that the minivan would be transferred to the project when the project was registered as
a foundation. The minivan was handed over to Mo Boon’s healing center in April 2006.
Subsequently, the activities covering four districts commenced. After a short time, conflicts
between Mo Boon and the project’s translator began to surface, arising from the former’s suspicion of the latter’s misconduct in handling the project’s funds. According to Mo Boon, the project had overpaid for the second hand minivan, which had been procured from Bangkok by the translator herself and her boyfriend. Any mistrust that Mo Boon and his patients already had of the translator was deepened when she kept hold of the money that the villagers had donated for the construction of the center. She wanted to expand the project’s activities to five other districts where none of Mo Boon’s patients resided. When she forced the idea upon him, Mo Boon felt that it was the last straw and he stopped working with her altogether.

The clash was soon followed by the withdrawal of the minivan. After only nine months in community service under Mo Boon’s direction, the vehicle was taken from the healing center on January 31st 2007 with no clear explanation except that it needed repairs. From this time until when I met Mo Boon in 2008, he had heard nothing about the minivan and had received no funding at all for his activities.

Northnet was also unaware of what had happened to the minivan, either its whereabouts or for what purpose it was now being used. To make an enquiry into this, on March 15th 2008, the president of Northnet, Mo Boon, and myself paid a visit to the local project coordinator’s house in Chiang Mai. To find a solution acceptable to both parties, the Northnet president tactfully suggested that the coordinator would only be able to take control of the minivan if he obtained a letter from the funding agency stating that they approved the changes in the terms and conditions of its use, as stated in the agreement.

Following another meeting at the office of the Northnet Foundation on April 18th 2008, the local project coordinator returned the vehicle to Mo Boon. In addition, Mo Boon was told that he would receive further funds for his activities, totaling 50,000 baht (approximately 1,250 euro), to be paid in installments.

Not long after Mo Boon got the minivan back, he was informed verbally and by email by the local project coordinator that the funding agency had agreed to transfer ownership of the minivan to another foundation in Chiang Mai (which I shall refer to hereafter as the Feast Foundation). Since the vehicle was returned to his care in May 2008, I noticed a calmness in Mo Boon; he looked as if he had broken with his worries about it. Even the possibility of losing the minivan once again did not seem to upset him. I asked what he would think if the minivan would have to be handed over to the Feast Foundation. He replied that if that was the donor’s wish, he would accept it. Eventually, Mo Boon did have to hand over the minivan to the Feast Foundation in early 2009.

**Sensitivity to social recognition**

Why was Mo Boon so troubled the first time the minivan was taken away from him? And why did he want to get the vehicle back to the center so badly? I tried many times to get an answer to these questions. Although Mo Boon admitted that he had lost face in the incident, to me this did not suffice to provide an in depth understanding of the case. Once I suggested to Mo Boon that it may not be worth the fight to get back the minivan, pointing out that even if he succeeded, it would become a burden for him after the completion of the project because
he would have to spend his own money to have it serviced and repaired. But he could not be swayed. By examining his life story, I came to understand the reasoning behind Mo Boon’s reaction to the lost minivan, and what the vehicle signified to his family.

First, for Mo Boon, his family, and neighbors, receiving the minivan represented the recognition he gained from society as a good healer. Receiving funding from an international agency, which was socially recognized, was an event that reconstituted the social recognition which for long had been denied his healing tradition. It was also a way to prove that his dedication for nearly two decades to healing people with the spirit and tradition of Northern local healers was recognized, not only at the provincial or national level but also at the international level. The sudden loss of the minivan without a clear explanation therefore troubled him, since the event might symbolize that his social recognition was in danger.

Second, for Mo Boon and his family, the struggle to get the minivan back metaphorically represented a fight with a devil, one which impeded his good deeds. The minivan incident was the second time in his life that he faced a crisis that would test his mettle. The first time had occurred seventeen years earlier, when his decision to help HIV/AIDS patients drew the wrath of an influential woman in his village, who attacked the idea. Their meeting at this woman’s house became confrontational, but Mo Boon did not return the abuse. With the support of his father, whose words of wisdom – ‘To make great merit, one has to confront mara (a devil)’ – gave him courage, Mo Boon ignored the woman’s taunts and went ahead with his plan. He was vindicated when he showed that his healing could help HIV/AIDS patients, and the project began to receive support and contributions from local communities, local and national health authorities, as well as NGOs. His healing center received visitors from HIV self-help groups, and domestic and international public health agencies, who came to learn from its experience.

The mara (devil) which Mo Boon was facing in his second crisis was more formidable, and he could not solve the problem on his own as he was used to. He had no channels through which to make his predicament known to the local or international project coordinator or the funding agency, since all were English speaking foreigners. When he approached the agency’s local partner based in Chiang Mai for advice, they told him that the conflict was based on personal infighting and that it would be a discredit to Thailand if he aired his complaints to the funding agency. What he eventually did was to explain to everyone – the villagers, his patients, his colleagues, elderly people at the temple, a district chief, and even a few merchants that he knew in the city – about what had happened to the Mo Boon Project and the minivan. He told them that he had been a victim of the manipulations of the project’s translator, and that he needed somebody to help him uphold his right to reclaim the minivan.6

6 The question may be raised as to why I am sure that the translator was a tricky person. Some proof to support this allegation is the copy of the project’s bank account that Mo Boon received from her upon his request. What she produced was in fact her personal account, which had nothing to do with the project. It would seem that the woman did not want Mo Boon to have a look at the project’s financial standing. Another piece of evidence was the notification that the bank gave when Mo Boon and I went to there to ask for the project’s bank statement. It appeared that all the money deposited in the account had been withdrawn without Mo Boon’s knowledge.
With my help and Northnet’s support, Mo Boon felt emboldened in his moral right, since my status as a researcher from elsewhere and Northnet’s reputation as a non-profit organization would be seen as independent and free of personal interest. Ultimately, the return of the minivan would be a vindication of his belief that in the struggle between good and mara, the former always comes out on top.

Third, Mo Boon always had the hope that he would pass on his healing knowledge to his two sons so that they could become healers themselves and continue the tradition of his family. He realized that the daily experience in a contemporary healing center alone was not enough to inspire his sons. This thought resulted from what he had learned from his own experience, since he only came to appreciate his father’s work when he succeeded in helping someone to survive in his struggle with AIDS. This feeling was difficult to explain to those who had never experienced it themselves. To become a good healer, it is therefore necessary for someone to have such an experience himself. The convenience of transport and financial support provided by the project afforded Mo Boon an opportunity to create this form of apprenticeship for his sons. It was part of the process for them to absorb experiences through witnessing the suffering of the patients and observing the treatment given by their father. By these means, he wished to cultivate the desire in his sons to help and care for those who suffer.

Fourth, the minivan made the extension of the new role of Mo Boon as a local healer possible. The minivan’s arrival came at a critical juncture. In 2004, the move to provide universal access to antiretroviral therapy (ART) in Thailand threatened to diminish the role of local healing in treating the disease, particularly since users of local healing had to pay for the traditional drugs, whereas ARVs were distributed for free by the hospitals. Consequently, Mo Boon and other local healers saw the number of their patients dwindle. What concerned Mo Boon was not only the loss of his patients but the weakening of the prestige of his calling in the eyes of his sons. Therefore, under the Mo Boon Project, he wished to expand his role by making house calls, giving training to people with HIV, and so on. This was his way to cope with the new challenge, and for this the minivan was essential.

To summarize, the Mo Boon Project started with the creation of the expectation among Mo Boon and his family that Mo Boon’s healing activities could be more actively expanded, with the funding support and acknowledgment of an international organization. But it turned out to be a total disappointment. All that had been promised by the project vanished: the minivan – the evidence of material support – was taken away and the financial support was withdrawn. Instead of strengthening his capabilities and performance, it merely discouraged and troubled him.

It may be concluded that this sensitivity to social recognition, which has gradually developed among local healers and their families during the past half century, is their response towards the changing local world, which tends to threaten the local healing tradition. For Mo Boon and his family, the situation worsened when people from outside led them to expect that their healing tradition would be widely recognized due to its effectiveness, but instead they were cheated and exploited by persons whom they were unable to fight using their own
means. It was a time in which Mo Boon felt a lack of power to control the situation, and in which he risked losing career prestige and facing defeat by devils. This circumstance can be further clarified using the notion of moral breakdown.

**Analysis of Mo boon's coping with moral breakdown**

When Mo Boon decided to engage in the Mo Boon Project, he did not prepare himself for the adversity it would generate, even though Mo Somsak, his friend and fellow healer, warned him that getting something so easily may entail big trouble. Mo Boon, who had always succeeded in his healing career, was rather confident that everything would go well due to his good intentions and the protection of his accumulated merit.

Mo Boon came to experience that his optimistic view had brought him into a difficult situation. When he was engaged in the project, he found himself in an unfamiliar world in which he was unable to control its course, since it was administered by outsiders who did not share his values and those of the majority of villagers. He was abused, his words distorted, and his beliefs treated with total disregard. The translator, who allegedly abused the project’s funds and villagers’ donations for her own benefit, apparently looked down on the villagers and had no regard for the values of merit making that were central to Mo Boon and the villagers’ beliefs. Even though I explain above how many local beliefs are changing, particularly among youth, most villagers nevertheless hold on to their local values.

To respond to the situation of moral breakdown in which he found himself, Mo Boon dissociated himself from the Mo Boon Project – the unfamiliar world – and returned to his familiar local world to reflect on what was morally at stake for him. The stress caused by the breakdown made him retreat into his familiar local world and search for ways, based on his own moral beliefs, to legitimize his actions in dealing with the unfamiliar world.

The next step was the process of negotiation. With the support of Northnet and myself, Mo Boon was able to learn what had really happened. He was able to understand the values that he was encountering, and we could indicate the illegitimate actions of the project and find a strategy to negotiate with the project coordinator. It was clear that the conditions set for the use of the minivan in the agreement had not been broken by Mo Boon. Furthermore, Northnet was still its registered owner and Mo Boon needed it for his activities. These facts were sufficient for Mo Boon to negotiate and secure the return of the vehicle to his healing center, plus receive some funds to continue his house calls. Mo Boon thus felt vindicated and could continue with his everyday life, falling back on his previously held moral dispositions.

The risk of losing social recognition led Mo Boon to seek support from the members of his community, and to communicate openly with them about what had happened and the strategies he would follow to cope with the situation. In the end, Mo Boon survived his moral struggle unharmed in terms of his social recognition.

Mo Boon realized that he lacked the capacity to deal with the complexity of the modern world alone, and thus accepted assistance from others to deal with this complexity. He also learned a few lessons, for example that dealing with persons who have very different moral beliefs is sometimes not possible. When Mo Boon had to return the minivan at the end of
the project under the order of the funding agency, it went beyond his understanding why the values and meanings attached to ‘donation’ in the eyes of the funding agency were so different from those of his local community. Nevertheless, he complied with the agency’s decision without complaint.

One may ask why, this second time around, he did not find these differences in values as distressing as he did the first time he lost the minivan. A possible explanation is that the value attached to a donation – the value of the intention to help others – is a value that he and the local community shared with the funding agency. This common value meant that in the first episode of the minivan story, Mo Boon, his family, and the villagers had no reason to doubt the appropriateness of accepting the minivan from an unknown agency. This shared value also supported Mo Boon in his full acceptance of the eventual change in ownership of the minivan and its utilization to the advantage of other villagers. For that reason, he could without hesitation convincingly explain to the villagers that he would continue to practice without the minivan.  

Conclusion

I have described the local world of one particular healer, his family, patients, and neighbors as a social world that is filled with a culturally constructed reality in which they all engage together in their everyday lives and in the context of healing processes. This reality consists in part of a cosmology in which beliefs in spirits, Brahmansmith, and Buddhism are fused. The various cosmological entities guide healers such as Mo Boon and villagers in terms of how to properly relate to them and how to relate to one another in a morally justified way.

As I have frequently stressed, a moral code that is oriented towards merit making provides social space for a healer to practice healing for the benefit of patients rather than for material gain. This space can be seen as one where the local moral discourse of amassing merit and the macro forces that promote the quest for material wealth accumulation are in contestation. In this context, a healer has to organize his moral life carefully, engaging in strategies that are compatible with the material needs of his family, while still maintaining a healing practice based on the morality of the healing tradition on which his practice is founded.

7 After April 2009, the minivan was transferred to the Feast Foundation, and the license of ownership of the van was supposed to be transferred from the president of the Northnet Foundation to the Feast Foundation. For a long time I heard nothing more about it. However, in February 2011, the coordinator of Northnet told me that he had received a letter from the Highway Police Division informing him that the foundation had to pay a 400 baht (around 10 euro) fine, since someone driving the minivan had violated traffic laws by speeding. This event alerted us to the fact that the Feast Foundation had not transferred the ownership of the van as promised. Northnet then urged them to arrange it as soon as possible to prevent the same or bigger problems in the future. However, the Feast Foundation ignored the request. Finally, Northnet decided to notify the incident to the local police, officially blocked use of the vehicle, and informed the Feast Foundation to return the minivan. Now the minivan is under the care of Northnet and is being utilized for the activities of the Institute of Lanna Wisdom for Health, an organization set up by a group of social workers and local healers in Northern Thailand, of which Mo Boon is an active committee member.
The social engagement of the healer with the local world is not confined to contesting and negotiating all sorts of actions, however; it also includes encountered threats. My findings show that moral dilemmas easily emerge in difficult times. I have illustrated this by presenting the story of Mo Boon’s troubles with the minivan. Mo Boon encountered trouble when he became engaged in an unfamiliar world in which the dominant values were incompatible with his own. To emerge from this moral breakdown, he had to dissociate himself from that world and return to his familiar local world. To avoid the loss of social recognition and prestige as a healer and to legitimize his actions, negotiations were necessary to help him deal appropriately with the ethical dilemma he was confronted with. His final responses were aimed at maintaining the local morality inherent in the healing tradition that grounded his work as a healer. The manifestation of this local morality in its facilitation of the effectiveness of healing will be described in the following chapter.
Chapter VII

The role of morality in the practice of healing
The previous chapter showed how morality plays a prominent role in the local world and healing tradition in Northern Thailand, through focusing on one particular healer, the local world he lives and practices in, and his healing tradition. This chapter complements the previous one by paying attention to the role of morality in the healing process as it unfolds in practice. It examines in particular the causal connections that healers and patients personally make between morality in the healing process and the outcome of this process. The chapter begins with the story of a healer who began performing ‘meritorious healing’ to help his relative and neighbor during the peak of the HIV/AIDS epidemic. It then analyses the moral elements involved in this meritorious healing from the points of view of both healer and patients, which, according to both, contribute to the effect of healing.

While Chapter 4 started with the life history of the healer Mo Boon from Ban Denchai, this chapter starts with the life history of Mo Somsak from Ban On Klang. It introduces the various moral dispositions that play a significant role in his healing practice, which is – like Mo Boon’s – directed at merit making, but in a different way. Mo Somsak is a healer whose mission does not involve local sacred things. His healing practice was initiated through his own efforts in the midst of a difficult situation, and he receives less support from senior healers and the community than Mo Boon. His care mission therefore also reflects the attempts of a healer to do his utmost to help his neighbors and patients, but in quite a different manner. After elaborating on this, the chapter shifts to an analysis of the core elements of morality that generally appear in the practices of other local healers and are claimed to bring about a good healing outcome.

Mo Somsak from Ban On Klang

The first time I went to visit Mo Somsak, it took me more than one hour to drive from the center of Chiang Mai to the house of the 44 year-old healer who resides in Ban On Klang, Mae On district. He invited me to the second floor of his house, which from the outside did not look much different to the houses of most villagers living in rural areas. But inside, where I was sitting, it was quite distinctive. In front of me was a large number of religious statues and pictures (of the Buddha and well known monks), as well as various kinds of amulets and ritual accessories. I saw a picture of Mo Somsak’s late grandfather, who had been a male folk midwife, hung up with two healing swords on the wooden wall. Some medical scriptures lay near some white plastic bottles, on the labels of which were written the names of herbal drugs. The office of Mo Somsak looked almost like a shrine in a temple.

We were sitting on the floor ‘which once was stained with blood and pus of many AIDS patients,’ Mo Somsak said. ‘At that time, the villagers feared AIDS and hated HIV and AIDS patients. My wife could not continue her small noodle business here. She had to change to sewing since then.’

Mo Somsak has provided care and cure for HIV and AIDS patients for nearly two decades. It is quite an ordeal for an ordinary villager to have persisted with such a risky and objectionable task for such a long period of time. Mo Somsak himself never imagined beforehand the extent to which he would involve himself in this hard job. To better understand the motivations that urged him, we need to explore his life story in some detail.
Illustration 17. Mo Somsak sitting in front of the shrine

Like many ordinary rural boys in Thailand, Mo Somsak finished his studies at grade four and was then ordained as a young novice for seven years. During the period of his ordainment, Nen (a person who has been ordained as a novice) Somsak was attracted by the ancient knowledge regarding charms, amulets, and magic. This interest remained even when he left his noviceship to marry and work as a motorcycle repairman. Indeed, family life with his wife and lovely daughter could not distract him from practicing magic. Noi (a person ordained as a novice) Somsak still wanted to try out whether his amulets gave him the expected magical powers. ‘I had to control strictly my personal conduct in accordance with the method to make powerful amulets, which was taught since generations. Sometimes, I made them in the night at the village cemetery, where I could perform intently meditation and incantation,’ said Mo Somsak, recalling his boldness.

Learning how to treat HIV/AIDS patients by trial and error
In 1993, when Noi Somsak was twenty-eight, his motorcycle repair business was facing trouble. At the same time, Yot, his nephew, who lived in the same village, fell sick from an unknown disease. He was discharged from the district hospital even though he still had a bloody cough. The doctor only told him that his blood was ‘positive’ for an incurable disease. Yot had no other choice than to ask for assistance from Noi Somsak, in the hope that he could discover a way to cure the disease. Noi Somsak decided to set aside his career and spend his time helping his ill nephew.

Using information from the hospital and the mass media, Noi Somsak learned that his nephew might be ill from an HIV infection, the typical symptoms of which he learned are coughing up blood, loss of weight, skin papules, diarrhea, loss of appetite, and oral thrush. He looked again at the knowledge of medicinal plants that he had gained during his ordainment and searched in old medical scriptures for traditional drugs that could eradicate these symptoms, some of which he dispensed to Yot.

After a year of treatment, Yot’s major symptoms had disappeared – only some skin papules were left – and he was able to do his work as usual. Thinking that he had already
recovered, Yot ate grilled meat and drank spirits during a party at a building site where he worked. This caused him to have acute fecal blood for ten days, after which he died. Noi Somsak learned from this case that HIV/AIDS is a new disease, and that the traditional drugs from his medical scriptures alone could not cure it.

The second HIV patient who sought help from Mo Somsak was San, who devoted himself unconditionally to becoming the object of the healer’s trials. San was a native of the same village as Mo Somsak, though two years younger. His elder sister was a friend of Mo Somsak, so they had been acquainted with one another since they were young. San and his wife, a Burmese immigrant worker with whom he had lived since 1990, had moved to another district where they found jobs. In 1993, something unusual happened to them. After his wife had had an annual health check-up, she did not receive the results from the factory where she worked and no explanation was given.

One afternoon, San fainted and lost consciousness after he had eaten pickled wild boar meat at lunch. He was taken to a hospital and treated until he recovered. Before he was released from the hospital, a doctor told him to have more blood tests at a hospital close to where he lived, but did not explain why. Not long afterwards, his wife became chronically ill with severe coughing and weight loss. When she died, San knew that he had AIDS and thought of committing suicide, but the thought of his children and parents changed his mind, and he decided to fight the disease.

When San came to see Mo Somsak, to whom a relative had recommended him, the sick man asked the healer not to feel constrained in prescribing him any medicines for experimentation, because he would die from AIDS anyway. San complained of symptoms ranging from chronic headache, occasional diarrhea, weight loss, and whitish stains on his tongue. He had fever when he returned from catching fish, and another time he passed out for half a day in the rice fields when spraying insecticides. He could not take a bath in cold water, and if he ate bamboo shoots he would develop a ‘snake blow’ (ngu sawat) or herpes zoster.

After trying a number of traditional drugs for one year, Mo Somsak and San finally found formulas which could cure illnesses caused by eating improper food. Together they compiled a list of forbidden foods that HIV/AIDS patients should avoid if they want to improve their condition. Additionally, they experimented with formulas that acted as blood tonics and with recipes that normalized inner elements. They found that these medicines could lessen the negative effects of the ingestion of improper foods. San learned that drinking beer would give him severe headache, while local spirits were refreshing and had no bad effects. After three years of these trials, San regained his health, although the results of his blood tests from the hospital showed that he was still HIV positive.

Meanwhile, San took a second wife. The couple had a troubled relationship, which worsened when she ran away with another lover. San went after them and brought her back. The woman was also infected with HIV and was being treated by Mo Somsak, but she was

1 From now on, I will use Mo (doctor) Somsak instead of Noi Somsak, since at this point he started to act as a healer.
not very cooperative in the treatment. The couple often had quarrels and the healer had to mediate between them. There was also a time when San got into trouble with a neighbor. The man, seeing San helping to cut the meat to be cooked for the village’s merit making activity, lashed out at him: ‘You have AIDS. What is your business chopping meat here?’ San was enraged and punched him in the mouth. When the neighbor filed a complaint with the village chief, Mo Somsak had to intervene to settle the dispute.

To help San reduce his stress and prevent him from becoming suicidal, Mo Somsak asked him to work as his assistant. San proved to be very useful and was able to share his mentor’s workload. He helped with all sorts of work, including harvesting medicinal plants in the forest, then washing, cutting, and drying them, before grinding them into powder. At a certain point, he became familiar with all the herbs. Whenever Mo Somsak earned some money, such as medicine fees paid by well-off patients, gifts from study tour groups that visited his practice, or payments when he was invited somewhere as a resource person, he would give half of the money to San. If San had no money left over to buy rice, the healer would share his meal with him. Mo Somsak also had San’s old pickup truck overhauled and paid the gasoline when it was used for his work. When the two went off to the forests to collect herbs, the healer would buy fresh food and ask his assistant’s wife to prepare food for their trip.

San had been both a patient and assistant of Mo Somsak for eight years when another disaster befell him. San’s second wife took her own life by hanging herself in the bathroom. Deeply depressed, San took to drink, and for two months he stopped eating food and taking medicines. His condition deteriorated, and Mo Somsak could do nothing to save his life. San once told his healer that when he died, he wanted to be cremated with wood that made such an intense heat that it would destroy even his bones and leave nothing but ashes, because the torment he suffered due to the disease was so great that he did not want to be reborn. Despite this, at his last moment, San grasped Mo Somsak’s hands and said with his dying breath: ‘See you in the next life, Doc.’

Since San’s death, Mo Somsak has gone every year to pay his respects to San’s mother. On special occasions, such as the start of the Buddhist Lent, the local New Year’s Day, and Tan Khao Mai Day, the healer makes merit and dedicates it to San to show his gratitude to the man who had been his helper as well as his ‘teacher.’ Mo Somsak said that San was a ‘living school’ from which he learned how to treat the deadly disease, and he had given his own life to prolong others. This gave the healer strength to continue in his dedication to help people with HIV and AIDS.

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2 The Thai belief in rebirth is based on Buddhism and Brahmanism. Every being is wandering in the continuous flow of life. This is called samsara — the cycle of birth, life, death, and rebirth or reincarnation. From this point of view, life does not start with birth and end in death, but is a continuous life stream from past to present and beyond.

3 Tan Khao Mai Day is, according to the lunar calendar, the full moon day of the fourth month when the in-season rice has already been harvested. Northerners celebrate this traditional event by donating cooked rice and other food on behalf of the deceased ancestors who once possessed the rice fields, and by feeding the monks.
Aside from learning from his patients, other events made it clear that Mo Somsak is an enthusiastic learner. In 1996, he participated in a class conducted in the district hospital to provide knowledge of traditional Thai medicine. The course intended to prepare students for the national license examination. Mo Somsak was one of the students who succeeded in passing the examination. He told me that he wanted to better understand the principles of traditional medicine so that he would be able to formulate the proper traditional drugs for his patients. He learned how to differentiate between hot and cold qualities of the materia medica and their effects according to taste and quality. He also learned from other more experienced healers how to identify medicinal plants in the jungle. All these learning activities occurred after he had been inspired by his inner calling to search for ways to help his patients.

During the period of my fieldwork, I learned that only eight HIV positive patients still had contact with Mo Somsak. The number of his patients had gradually decreased after the arrival of free ARVs. This change lessened the time that Mo Somsak spent on his healing activities, because he kept close contact with only a few patients. Although some patients had changed to taking ARVs, they nevertheless still had a good relationship with him.

**Compassionate care: Its development and limitations in the case of Mo Somsak**

As mentioned in the previous chapter, helping patients is a kind of merit making. Local healers in Northern Thailand always consider it to be a core value of an ideal healer. This traditional value, however, has to compete with the new values of modern society in the local world of the villagers. The HIV/AIDS epidemic is a crisis that is perceived as a danger that can threaten the villagers’ way of life. HIV positive people are frightened that they will become isolated from normal relationships with their neighbors. At the beginning of the epidemic, many villagers were scared and refused to help others, even family members. This situation greatly shaped the ways in which HIV positive people and other villagers related to one another, and brought about many problems, among them a moral one.

The HIV/AIDS epidemic affected the social and moral life of the villagers in Ban On Klang so much that Mo Somsak could not ignore it. Nevertheless, he actively involved himself in caring for HIV and AIDS patients. Starting from a place of a complete lack of knowledge about HIV/AIDS, he gradually searched for, tried, and evaluated several healing methods step by step. The question may be raised, however, of why he immersed himself so strongly in this mission for over a decade. The following will explain how the HIV/AIDS epidemic urged the healer to play a role and adopt such a responsibility. The Buddhist concept of compassion (*karuna*) and the concept of moral sensitivity can be applied to explain how Mo Somsak treated his healing as a moral mission in which the activity of merit making in helping others is the core moral value.

Compassion in Buddhism is the desire to help others to be free from suffering. According to the Dalai Lama (2005: 49), ‘genuine compassion must have both wisdom and loving kindness. That is to say, one must understand the nature of the suffering from which we wish to free others (this is wisdom), and one must experience deep intimacy and empathy with other sentient beings (this is loving kindness).’ Compassion is not sympathy or empathy.
alone, but rather an empathetic altruism that actively strives to free others from suffering. True compassion has therefore no expectation of reward. Moral sensitivity means attention to the moral values involved in a conflict laden situation. It is a capacity to feel and to sense the moral significance in a situation that requires a decision, so that the process of moral deliberation can begin. It is also a cognitive capacity to distinguish whether or not it is a moral problem, and a self-awareness of one’s own role and responsibility in the situation (Lützén et al. 2006).

The analysis of the case of Mo Somsak shows that compassion is a moral disposition that grew from the moral training that he received and the meditation he engaged in during his ordainment. Such a disposition was also internalized through learning from the conduct of his grandfather, who was also a healer. Intimacy between a healer and his patients, either through kinship, neighborhood, or collegiality, serves as a proximate condition for the manifestation of compassion. Compassion accounts, to a great extent, for the ability of Mo Somsak to sympathize with his patients’ feelings, especially when they are suffering. It directs his attention to the search for ways to help his patients.

Compassion promotes the emergence of other kinds of moral dispositions. When Mo Somsak sympathized with patients’ suffering and learned about their troubled situations in the community, he found it very difficult to let the situation be without any attempt to deal with it. He thought about his inability to help his nephew since he lacked the necessary knowledge about HIV/AIDS. However, he decided that as a relative who had learned local healing knowledge, he had a responsibility toward him. This decision, which came in part from his moral sensitivity, brought a great change to Mo Somsak’s life, and he has conducted healing practices as his life’s mission ever since. At the same time, compassion, which incorporates the idea of no expectation of reward, led him to conduct his healing mission in the way of merit making, as it was always done by his ancestors.

The various moral dispositions that emerge from compassion continuously guide Mo Somsak in the evolution of his healing practice. They consist of the will or ambition to help his patients, his efforts to search in traditional medical scriptures for possible ways to help patients, the conducting of trials, the thoughtfulness to observe and analyze the results, and his reflections on how to improve the healing procedures. In Buddhist teaching, this set of mind qualities is named the Four Paths of Accomplishment (ithibat si). Other moral dispositions that should also be mentioned are hospitality, gratitude, and the feeling that one has to reciprocate with regards to the person from whom one has received some benefit.

The wisdom aspect of compassion enables the healer to go beyond the realm of disease treatment. All sentient beings who struggle in samsara – the repeating cycle of birth, life, death, and rebirth – have their own suffering and inescapably face suffering from birth, aging, sickness, and death. The healer enters the realm of caring not only as a healer but also as a neighbor and fellow human being. The shift from viewing ‘a patient in the healing setting’ to considering him as ‘a being in samsara’ broadens the scope of sickness in such a way that it encompasses aspects other than physical suffering. Healing thus requires that the healer sympathize with his patients’ feelings and care for them as fellow beings in the
world. Mo Somsak demonstrated this attitude when he helped San in the fight for his life, as he provided all possible kinds of support. Even after San’s death, Mo Somsak carried on actively providing spiritual support to him, to ensure a good next life for his patient. In addition, he extended his healing to other HIV/AIDS patients beyond his relations of kinship and neighborhood.

The scope of Mo Somsak’s actions, resulting from compassion and their consequent moral dispositions, was limited, however, by burdens that the healer and his family had to bear – both material and non-material. His material limitations were the lack of outside financial support and his inability to commercially exploit his healing. Mo Somsak depended on the help of patients who paid their respects to him. The stress from difficult cases also restrained his healing activities, since it often disturbed him psychologically. I observed that he often immersed himself in the suffering of his patients and developed feelings of tension. For example, he became sad when he received a call from an HIV patient whose family life had been disrupted. Sensitivity to the tragedies of his patients made him vulnerable to stress. Mo Somsak therefore had to limit the amount of patients he could see so that he could treat them well. The decision to limit his healing activities was, therefore, the result of self-reflexivity that Mo Somsak practiced, to adjust himself to a situation of mental constraint and limited support for his healing activities.

The core moral elements experienced as meaningful aspects of healing

The life history of Mo Somsak, as presented above, as well as the story of Mo Boon, as presented in the previous chapter, illustrate that in difficult times the compassion of healers can initiate their moral sensitivity and lead to decisions about their appropriate roles and responsibilities. As a consequence of this compassion, the growth of other moral dispositions needed for a healer’s meritorious healing practices is also affected. The extent to which healers can practice their healing relies on the extent to which they can arrange the related moral dispositions in a proper manner. It also rests on the ability of healers to reflect on themselves and their ongoing circumstances.

When healers practice meritorious healing, both they and their patients may experience something that is meaningful. In what follows, I will present the moral elements that healers and patients experience as meaningful: faith-related trust (khwm chuea thue sattha), the power of virtue (khun), and merit (bun). This experience can be considered a core component of local healing, something which apparently fosters and facilitates its effectiveness.

**Faith-related trust (khwm chuea thue sattha)**

Faith-related trust is a kind of trust that a person confers on somebody who is respectable and faithful. Trust is conventionally viewed as fundamental for a successful doctor-patient relationship. The need for interpersonal trust appears particularly necessary where there is uncertainty and risk regarding the performance of the practitioner on whom the patient has to rely, vulnerability associated with sickness, and the presence of an overwhelming amount of complex medical information. Trust mediates healing processes and indirectly
influences health outcomes through its impact on patient satisfaction, adherence to treatment, and continuity with a provider. Trust encourages patients to access health care and facilitates the disclosure of important medical information so that an accurate and timely diagnosis can be made (Rowe and Calnan 2006: 4). Although the significance of trust and its role in the health care system has been well studied, studies on trust in local healing are rare (Ahern and Hendryx 2003; Gilson 2003). Loss of trust is caused by medical errors, drug side effects, and the poor adoption of evidence-based medicine and clinical guidelines.

Further analysis of Mo Somsak’s treatment method can partly fill this gap. Mo Somsak and San grew up in the same local world and therefore shared the same moral values to a great extent. San had been acquainted with Mo Somsak for so long that he believed in him. He made himself available for a healing trial, not only because he had no other choice but because he believed that the healer would act in his best interest or at least not harm him. The patient-healer interpersonal engagement that takes place in a local world where fundamental moral values are shared can create faith-related trust when the healer performs altruistic behavior according to the expectations of the patient. Faith-related trust can be counted as altruistic trust, which is morally praiseworthy when its ends are correspondingly praiseworthy (Mansbridge 1999).

Another example is offered by Mo Boon. He was, in contrast to Mo Somsak, never ordained as a novice when he was young. He spent his adolescence and early adult years like other lay persons. What he shared with Mo Somsak before becoming a local healer were the fundamental moral values of the local world, which are based upon local Buddhist culture (as elaborated on in Chapter 6).

Both Mo Boon and Mo Somsak belong to a generation whose local moral world underwent a process of change. People around them have gradually adopted values that represent a compromise between Buddhist teachings and materialism. The expectation of material wealth and merit are unified into a new dominant value. The healers realize that the new values have the potential to radically undermine their healing tradition. The only thing that they can do is to prove themselves in the eyes of the people. Mo Boon, however, had an advantage over Mo Somsak. Both his grandfather and father were famous healers in the region. Furthermore, his father had been insistent in teaching him that the aim of being a healer is to accumulate merit. Among the main points, healers must not ask for fees for their services, for if a healer works for financial gain, this will diminish the merit that he gains from his practice. Mo Boon’s father taught not only by words, but lived by what he taught.

If we look back at Mo Boon’s healing activities in the abandoned temple during the HIV/AIDS crisis, we can see clearly how this teaching became concrete. He succeeded against all odds to set up a healing center for HIV and AIDS patients at the deserted temple. While he lived modestly in a small house, he was able to accomplish a great task by raising a large amount of money for the project. To show his integrity, he did not handle the donations himself but appointed a committee of respected elders to oversee it. The healer also sold his medicines at a low price. Through these practices, Mo Boon earned faith-related trust from the villagers, who regarded him as a virtuous local healer.
A healing practice such as Mo Boon’s removes all doubts that a patient may have about the healer’s motives and assures him that the healer will do his best to cure his illness, since his purpose is to help others and not to trade his services for money. The tradition, in which healing practices are held in high esteem as meritorious acts, therefore implies the idea that trust seems to develop naturally. In the following, I will show, from the perspective of the healers, the role that faith-related trust plays in the healing process.

During the life of Ui Ta Kham, Mo Boon’s paternal grandfather and a local healer, Chiang Mai was ravaged by an outbreak of smallpox that killed a large number of the local population. At that time, the McCormick Hospital was the only place where patients could seek modern medical treatment against the disease, thus most of those afflicted had to find a way to care for themselves. Patients flocked to Ui Ta Kham to seek his care in such large numbers that the space inside his house could not accommodate them all. Many had to lie in the yard using banana leaves as mats. The results of his treatment were mixed. Many patients were cured while some perished. Several survivors, now at a very advanced age, still live in the village. Recounting their stories, they attributed their recovery to the fact that they had complete trust in Ui Ta Kham and followed his instructions faithfully, whether he prescribed certain medicines or forbade them to eat certain foods. The patients who succumbed to the disease, they said, had failed to take his prescriptions seriously, and some had left him too early to seek treatment from other healers.

One may argue that such a view unfairly blames the patients as being responsible for treatment failure, and gives all the credit to the healer for every instance of successful healing. Yet we should consider that in local healing, patients voluntarily seek and get treatment for their illnesses; they themselves decide whether to continue with a healer or to switch to another. Arguably, a healer will have the most powerful healing effect when a patient willingly and continuously accepts and commits himself to his treatment. Furthermore, a good healer will refrain from persuading his patients to come to him for treatment, because such an act could be seen as serving his own self-interest rather than demonstrating a sincere desire to help the sick.

This was a lesson that Mo Boon knew from experience. A patient with HIV once asked him to come to a friend’s house to treat the person, who was also infected with the virus. The man’s family, however, accused Mo Boon of tricking them into buying medicines. Since then, the healer has made a rule for himself that he will never go to treat a patient at the patient’s house if he does not know him well, and will only help persons who come for care to his own house or with whom he is well acquainted.

Similar rules have been made by other local healers. Mo Som of Ban Mae Pha Haen asks new patients to come to his house first and pay homage to the healer teachers before he begins treatment. Mo Somsak evaluates the patients’ trust the first time they meet and if he senses any lack of confidence he will not offer his help, even though he has the ability to do so. This is a common practice among healers faithful to the Northern healing tradition, Mo Somsak said. If the patients do not approach the healer first, the healer will not offer his care.

I witnessed this practice at the National Herbal Medicine Expo, when Mo Somsak was
approached by a woman who asked for his prediction on the longevity of her 13 year-old daughter, whom she had brought along. Upon examining the girl’s hands, Mo Somsak realized that she was probably very sick from cancer. With the girl present, however, he was reluctant to tell this information. Seeing the healer’s awkwardness, the woman asked a relative to show her daughter around the exhibition. When they were alone, the woman told Mo Somsak that her daughter had just been treated with chemotherapy. He felt pity for the sick girl and wanted to help. But since her mother did not ask for his assistance, he told her that it was difficult to say how long her child would live, and that it would depend on the girl’s merit.

The information provided above about the practices of Mo Boon and Mo Somsak shows, firstly, that healers who are concerned with the interests of patients will start the healing process only when they are sure that the patient trusts them. Healers’ insistence that patients from outside their village must first visit their house is significant. This act familiarizes the patient with the life of their would-be doctor, his living conditions and status. Thus it will inspire their faith and confidence before the treatment starts. Secondly, a healer who conducts his life within the bounds of morality, as is expected for his status, will earn faith-related trust. In contrast, it would be difficult to establish trust if the healer strays out of the bounds of morality or trades his services for too much material gain. Thirdly, for local healers, patients’ trust is very important for successful healing. It can foster the full confidence and compliance of the patient and contribute to the effectiveness of the healing.

**Power of virtue (khun)**

As mentioned before, both local healers and their patients, whose worldviews are embedded in the same local world, see local medical knowledge as something that belongs to the healer teachers who have passed it down through the generations. Therefore, when any healer applies this knowledge to healing, he acts as a medium of the healer teachers. Moreover, the medicines he dispenses have to be blessed in order to generate their power of virtue or power of moral goodness (see Chapter 5). In this respect, successful healing can be ascribed not only to the healer’s treatments and the medicines he prescribes, but also to the power that the medicines receive when they are blessed.

The power of the healer teachers in healing is recognized, indirectly, through the healer’s behavior towards his teachers. If he treats his teachers respectfully, his practice will produce good results for the patients. Vice versa, improper behavior towards the teachers can have adverse effects on patients. Ultimate respect is paid to the healer teachers in the ritual and process of the preparation of medicines, when the power of medicines and healing are requested by the healer in front of the shrine of the healer teachers and other sacred objects. It is believed that the demand can be answered only when the healer is confident that he leads a

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4 I translate *khun* as the power of virtue or power of moral goodness. This translation differs from the one given by Mulder (1979), since he separates power (*decha*) from moral goodness (*khuna*). In the context of healing, *khun* or *khuna* express their effects in the form of power. Therefore, when villagers mention the *khun* of something, they intend to mean both power and moral goodness.
moral life that corresponds with the moral values of his healing tradition. The request is also made by the patient, but mostly in front of the Buddha statue in his or her house. Reciting mantras and holding religious precepts are also recommended to cultivate the mind of the patient, so that the virtue of Buddha and other sacred objects, as well as the result of this merit making, can protect the patient from bad things and help him or her to recover from the illness.

For patients who have recovered from illness, in order to express their gratitude for the power of virtue that they have received they should pay their respects and deference to the healer teachers as the source of medical knowledge, to the healer as the medium through which the knowledge was transmitted, and to the medicines that originate from the healer teachers. Patients whose lives have been saved should regard the healer teachers, the healers, and the medicines as their benefactors and life givers, to which they should be grateful for the rest of their lives.

Belief in the power of virtue of the healer teachers, the medicines, and their impact on the effectiveness of healing can still be found among middle-aged Northerners such as Yada (see Chapters 4 and 5), Sathit (see Chapter 5), and the grandfather who visited Mo Boon (mentioned also in Chapter 5). These people were born and grew up in times when the local cosmology, as embedded in customs and traditions, still had an influence on their ways of thinking and living. The power of virtue was part of that reality. Patients of younger generations, residents who have migrated from other areas or visitors from other parts of the country are, in contrast, not familiar with this belief. The power of virtue means little or nothing to them. They do not appreciate the connection between the healer’s morality and conduct and the virtue of the teachers and the medicines. For instance, they will not keep their medicines on the shelf with the Buddha images or pray for the healing power of the medicines. Rather, they believe more strongly in the potency of the material substances present in herbal medicines. Spiritually, they prefer to meditate to ease their minds rather than to pray to sacred beings or objects.

In sum, from the perspective of healers and patients who share belief in the power of virtue, medical knowledge, morality, and the effectiveness of healing are inseparable. Through the concept of khun – the power of virtue of the teachers and sacred things – people involved in local healing can make the connection between morality and healing power. That is to say, moral behavior strengthens the ability of the healer to deal with sacred power and to harmonize this power with his medical knowledge in order to achieve effectiveness.

**Merit (bun)**

Most activities at Mo Boon’s healing center at the deserted temple – for example, the construction of the building, the ceremony to install a Buddha statue in the shrine hall, the opening ceremony, vocational training, and free lunches for orphans with HIV – were accomplished with the participation of villagers and communities through volunteer labor and donations. These activities were made possible because they were inspired by merit. Believing that helping others is a means of making merit, Mo Boon has proved this through his actions. To implement his project, the healer appealed to the Northerners’ benevolent
disposition derived from the belief in merit and he succeeded in rekindling the spirit of mutual help in the community for the benefit of people in distress.

Through his healing, Mo Boon educated his patients and the people in the community, and he corrected their misinformation about HIV and AIDS. They learned that having the disease did not necessarily lead to death; HIV/AIDS patients could recover and continue to live a healthy life. Gradually, the healer was able to dispel the fear of contracting the disease from the patients, as the villagers began to understand how the disease was actually transmitted. With this support, the beneficiaries of the center knew that they would not be neglected, and this reassured them of their own worthiness and strengthened their will to live.

Mo Boon’s initiative illustrates that in modern society, where health problems may give rise to social conflicts such as the stigma of HIV/AIDS, healing activities associated with merit can keep alive the function of ritual healing to resolve social conflicts stemming from illnesses such as AIDS, and thus alleviate patients’ suffering.

Merit also promotes the confidence of the healer and his family in dealing with deadly diseases. In caring for HIV/AIDS patients, Mo Boon had to come into closer contact with HIV/AIDS patients than anyone else in the village, yet he did not contract the disease himself. This was seen as proof of his family’s belief that merit protects people against deadly diseases:

In former times, people didn’t go to McCormick Hospital. They came to [my grandfather] Pho Ui to be treated for chicken pox or smallpox. The house was thronged with patients. But no one in our family caught smallpox. In my father’s time, there was [an outbreak of] cholera. He treated those who had cholera, but again no one in our family suffered from it. It seemed as if merit protected us.

Belief in merit was instilled in Somsri, a woman with HIV mentioned in Chapter 4, even though she was not a native of the North. Somsri survived in her struggle with AIDS after losing her husband and daughter to the disease between 1995 and 1996. She gave a few reasons for her recovery: her will to live on for her remaining twin sons, the use of herbal medicines, and merit making by means of practicing meditation and helping other HIV/AIDS patients. She was a volunteer in a district hospital in Chiang Mai, paying visits to patients’ houses: ‘I feed them water and foods till their ends, one by one,’ she said. It was, in her words, ‘merit extending merit,’ which means that the merit she made by helping patients kept her alive so that she could take care of her two sons and continue to offer help to others.

Surang, another woman with HIV, contracted the virus from her husband, who died in 1995. After his death, she had a dream in which she met dead people. She woke up feeling very frightened. The dream worried her so much that she went to see a nun at a meditation center and asked her to explain it. The nun said: ‘Your spirit is ready to leave. The life you were given is expiring. You must come right away to practice dharma. Only merit can extend your life.’ Surang wanted to stay alive for her two school going daughters. For a week she took a retreat at the meditation center, where she observed the eight precepts and practiced meditation. Back at home, she continued these practices, and then sought Mo Boon and took traditional drugs for five years. In 2006, she started taking ARVs and was then diagnosed with third stage cervical cancer. Nevertheless, when I met her in 2008, she looked healthy and was able to do normal work.
With both Surang and Somsri, the belief in merit played a significant role in the healing process. However, it was not imposed on them by the local healer, since the belief has permeated Thai society for a long time. When in trouble, many Thais will naturally think of making merit. Generally, people will choose to make merit through various forms of giving, among them offering alms to monks and freeing captive animals. A form of merit making that is more concerned with mental development is to stay at a temple or a meditation center for activities such as observing the precepts, reciting mantras, and practicing meditation.

The question of whether merit affects the results of healing is more difficult to answer because it involves the complexity of karma – the law of cause and effect – a Buddhist principle that explains that there are causes for all phenomena. If one attempts to determine the effectiveness of healing on the basis of merit and karma, one will realize that the possibilities of the outcome are infinite. When the merit and karma of the healer, the patient, the medicines, the healing methods, and so on are included in the equation, the problem is too complex for humans to solve. Instead of trying to analyze the impossible, what is possible to understand and practice is that everyone who is involved in the healing process – the healer, the patient, relatives – tries his utmost to do noble deeds, make merit, and produce the conditions that cause relief and heal sickness. Then they will let the law of karma take its course and accept whatever comes. From this perspective, the patient’s noble actions performed before and during the healing will influence the healing’s effectiveness. The extent to which meritorious actions and good deeds can produce positive results for each patient depends on his or her own actions, in the past and the present.

In sum, due to the fact that merit extends the capability of a healer to care for his family and patients, the career of a healer is mostly aimed at amassing merit – that is, helping others without expecting anything in return; offering things, including teaching and support that relieves patients’ suffering; and training himself in a religious way to strengthen his mental and spiritual capacities. For patients who believe that a person who is ill and near death has spent all his merit in this present life, the moral aspect in this difficult time is always concerned with making new merit to extend his or her life. These moral aspects influence the process of healing with the strong hope that merit will function in the end according to the law of karma. This explanation is still alive among the healers and patients who value merit as a thing that matters in their lives, not only in this current life but also in the next ones.

**Conclusion**

This chapter has demonstrated that the compassion of a particular healer, Mo Somsak – developed as the result of an intimate relationship with his patients and a process of moral socialization – is the significant moral disposition that facilitates the occurrence of moral sensitivity. Compassion, together with other related moral dispositions, enables Mo Somsak to perform meritorious healing, the components of which enhance the effectiveness of his healing.

This chapter concludes that faith-related trust, the power of virtue, and merit are meaningful core components of local healing and contribute to its effectiveness. This insight
comes from the analysis that shows that trust is the result of the relationship between healers and patients that is developed during the healing process, when the healer follows the moral conduct that is based on both parties’ shared moral values. This relationship can create full confidence in a patient towards his or her healer and thus his or her full compliance in the treatment. A healer’s moral behavior also empowers him to deal with the power of virtue that belongs to the healer teachers and other sacred objects. In the healing process, he exposes this power to his patients. The moral experiences of the healer and the patients, which aim to make merit, come from the same religious foundation, but they have different objectives. For the healer, making merit is to accumulate *bun* so that he can protect and support his family and patients more adequately. For patients, the objective is to extend their own lives, which, they believe, are nearly at an end.
Chapter VIII

The ambiguous role of secrecy in health and healing
HIV positive people in Northern Thailand, like in many other parts of the world, have a number of reasons for wanting to conceal their HIV positive status from others. This chapter presents the main ones reasons, with the help of case studies. The case studies simultaneously illustrate what the negative consequences of disclosure are, particularly for women who have a subordinate status in society as compared to men. The wish for concealment and the frequent lack of confidentiality in modern health care services make people eagerly turn instead to the mass media and modern telecommunication for information about the possibilities of local healing in case of HIV/AIDS, and they may use modern telecommunication technologies to access healing and support remotely. These new communication media are easily available and affordable. They also function as channels in the search for individually tailored health care provision and advice seeking from local healers, but at a distance, and individually attuned health advices by local healers. This healing from a distance evokes positive social memories of past healing practices as well as popular social representations of knowledgeable and benevolent local healers, both of which contributes to people’s beliefs in the effectiveness of today’s local healing from a distance.

Nevertheless, while patients do benefit in various ways from local healing under conditions of secrecy – healers respect confidentiality, alleviate the negative psychological effects of concealment, and do successfully treat symptoms of HIV/AIDS – the maintenance of secrecy by patients also has a negative impact on their health, which I will demonstrate in this chapter.

In order to understand patients’ wish for secrecy, I first explore the impact on a person of the fear of stigmatization by family and community and the threat of abandonment by husbands that would result from the discovery of a person’s HIV positive status. I then discuss patients’ appreciation of local healing from a distance and the ways in which they benefit from it. Finally, I identify and discuss the limitations of patients’ health seeking behaviors in the context of more or less self-imposed secrecy, and the implications of this secrecy for the effectiveness of local healing and for patients’ health.

**Fear of stigmatization**

HIV and AIDS-related stigma exists in all regions of the world (Aggleton and Parker 2002; Malcolm et al. 1998). It has deep social origins and is closely related to sexual relations, gender relations, ethnicity, and class (Parker et al. 2002). It varies in terms of risk factors, modes of transmission, and the type of society where one lives, whether this be industrialized or non-industrialized (Lyttleton 2000). The roots of stigma lie in the prominent combination of shame and fear: shame because the transmission of HIV involves sex or the injection of drugs, which are surrounded by taboo and moral judgment, and fear because it involves a deadly contagious disease (Piot 2001, quoted in Aggleton and Parker 2002; Parker et al. 2002). Lack of awareness of stigma and its harmful effects, fear of acquiring HIV through everyday contact, and linking persons with HIV to behavior that is considered improper or immoral are the three main causes of HIV and AIDS-related stigma (UNAIDS 2007). The development of effective treatment, for example through ART, has the potential to change
the perception of HIV and AIDS as a death penalty and reduce stigma (Preston-Whyte 2003; Weiss and Ramakhrishna 2006).

Some scholars, however, warn that HIV and AIDS may differ from other diseases that were for a long time associated with stigma – cholera, for example – but which experienced the reduction or complete disappearance of this stigma after widespread improved understanding of the disease and the availability of effective treatment (Herek 2002: 600). Two studies reveal that the stigma of HIV/AIDS has in fact increased in recent times, despite the increased accessibility of ART. In one study conducted two years after the introduction of free ARVs in a rural ward of North Tanzania, community leaders believed that persons on ART were spreading the disease because, due to their improved health and lack of symptoms, they had increased their sexual activity and mobility as if they were no longer HIV positive (Roura et al. 2009). In another study, carried out in Cape Town in 2003 and 2006, the researcher suggests that despite the introduction of ART, young adult respondents were still likely to associate HIV positive persons with people who were dying of AIDS. Thus the general association between HIV and illness/death persisted, reinforcing the fear of HIV and perpetuating negative moral judgments towards HIV positive persons. It is therefore difficult to foresee how attitudes and stigma towards HIV and AIDS will change over time (Maughan-Brown 2010).

The situation in Thailand before 1990 was similar to that in other countries where stigma against persons with HIV and AIDS was reinforced and legitimized by the government (Parker et al. 2002: 1). The information that was disseminated through the initial country-wide campaigns conducted by the government horrified the public. AIDS, as a deadly disease, was represented using images of Satan or a skull and cross bones, as well as through pictures of AIDS patients in their last stages, with thin and dark skin covered with pustules (Bang-on 1992; Mathurot 2001: 3, 33). AIDS soon came to be associated among the population with drug addiction, promiscuousness, and immoral behavior (Saowapa 1998: 123; Yingyong et al. 1999; Lyttleton 2000). Persons with HIV became stigmatized, especially in the workplace, educational institutions, and their home environment. Neighbors interacted with persons with HIV with disgust and fear (Saowapa 1998; Chaiyos et al. 1994; Yingyong et al. 1999).

This current study also observed in the narratives of informants a strong stigma against persons with HIV and AIDS in Northern Thailand during the early period of the epidemic. Although the extent of stigmatization seems to have subsequently declined, it still exists, even after the introduction of ART, which is consistent with the stigma index survey in Thailand conducted by the Foundation for AIDS Rights (National AIDS Prevention and Alleviation Committee 2010: 200-207). The difficulties in identifying and contacting persons with HIV and AIDS, who often conceal their status from their families, society, and formal health services, is the main reason for the paucity of research on fear of stigma among this group.

In this study, by going through local healers I was able to contact some HIV positive persons and collect valuable data on this phenomenon. The data are presented below in the form of the life stories of persons with HIV. Each story brings out the fear of stigmatization and its consequences, as related to the specific life situation of the person in question.
Together, the stories point to the impact of the stigmatization of HIV/AIDS in society – namely that HIV positive people wish to keep their status secret – and the ways in which this determines their health seeking behavior and healing process. The first two stories are about women who earn their living through employment outside their home and are thus not economically dependent on a husband, while the second two stories are about women who are economically dependent on their husbands. After the presentation of the four stories, I single out the various issues that are at stake.

**Four case studies**

*Ampha, a housekeeper: Concealment of morally unacceptable behavior*

Ampha, a 55 year-old housekeeper, has been Mo Boon’s patient since 1996. I met her for the first time at her house, where her eldest daughter and two sons-in-law also lived. As I learned that nobody in the house knew about her status, an open conversation with her would have been inappropriate. I therefore made another appointment with her at Mo Boon’s healing center where we could talk freely. What follows is Ampha’s story, collected through four in-depth interviews.

As a married woman, Ampha lived with her husband at his parents’ house. Their life as a couple was not smooth. Ampha worked hard to feed the family, but nevertheless was not appreciated by her idle husband or her father- and mother-in-law. Three years after the birth of her eldest daughter, 27 year-old Ampha decided to leave her daughter with her mother, abandon her husband who had turned to marry another woman, and look for work in Bangkok. She received training from an employment agency and became a housekeeper in the capital. Later, she was sent to work in the household of a famous general in the Thai army, caring for the child of the family, and he paid her a salary of 500 baht (approximately 12.50 euro) per month, plus some extra rewards and an annual bonus.

After almost five years of work in Bangkok, Ampha returned to Chiang Mai as she had promised her daughter, who then was in grade one. She spent all the money she had earned to buy a piece of land and began to build a hut for herself. During this time, her husband returned to her. Later, she gave birth to another daughter, but her family life was problematic once again. She could no longer tolerate her husband, who drank a lot, gambled, and had several sexual relationships outside the marriage. To seek revenge on her husband, she entered into a secret sexual relationship with one of his friends, which lasted three years. This lover turned out to be the first person in the district to die from AIDS. Soon Ampha herself developed symptoms associated with an HIV infection, such as fever, severe chronic diarrhea, anorexia, weight loss, weakness, and dark skin.

Ampha became very worried when her husband began to suspect that she was being dishonest. He started to call her ‘i-et’ – a derogatory phrase (i) used to label a woman with AIDS (et) – expressing his feelings of contempt and insult. This treatment was not limited to her husband; many people at her work were also disgusted by her. She changed her work and became the maid of an infant in a neighbor’s family so that she could escape the social blame. Meanwhile, she learned about traditional drugs from a neighbor who was also HIV positive.
Ampha asked this neighbor to buy traditional drugs from a local healer in Ban Denchai, Nong Tong subdistrict, whom she later learned was Mo Boon. To keep her sickness secret, Ampha told the neighbor that her nephew was HIV positive and needed the treatment.

After she had changed her job and taken traditional drugs, Ampha felt calmer and could enjoy her work. Her symptoms also gradually disappeared after three months of taking the traditional medication. Three years later, the person who used to buy the drugs for Ampha died from AIDS. Now Ampha herself had to go to see Mo Boon to get the drugs and continue her treatment. It was around four o’clock in the morning that Ampha went to Mo Boon’s house for the first time. Mo Boon was frightened when he saw Ampha’s white face; she looked like a ghost standing in the darkness in front of his house. However, through her early morning visits to Mo Boon, Ampha succeeded in continuing her medication without arousing the suspicions of others.

Ampha had been taking traditional drugs for twelve years when I first met her. She paid around 500 baht a month for the drugs. Despite the introduction of free ART, Ampha still adhered to local healing. She never visited any formal health care agencies, either for an HIV test or to access ARVs, for she was unsure of the confidentiality of the treatment in hospitals. She said:

My neighbors work in the district hospital. If I go to seek care there, they will know about my illness and then everybody in the community will know about it. So I had to search another way to seek care, and Mo Boon is a person who can help me.

It is apparent that Ampha’s illness is due to a secret sexual relationship that local people would consider immoral. To conceal her illness has therefore been her most important concern over the years. Like other people with HIV, fear of discrimination has prevented Ampha from revealing the truth to others. She guessed that if her illness was disclosed, it would have a huge negative impact on her life: ‘My daughters will not accept the truth, and I will have problems at my work.’

Ampha’s fear is not difficult to understand. First, since she had left her eldest daughter when she was very young to go to work in Bangkok, a distance had developed between them. Ampha felt that her eldest daughter disliked her. She complained that she never received any support from her, either psychological or financial, which differed from how the daughter behaved towards her father. Because of these predictable but hard to manage threats and the very delicate situation within her family, which was unable to support her, Ampha was not able to raise her head above the parapet. Second, Ampha’s jobs always required cleanliness and hygiene regarding food, clothes, and children. Without a doubt, if she could not keep her status secret, it would seriously affect her career, and if she was compelled to resign from her work, it would become extremely difficult for her to support her two young daughters.

If Ampha would be unable to conceal her illness, she feared that the negative consequences would be serious enough to destroy her social and family life. If the secret of her morally unacceptable behavior was disclosed, it would bring shame to her family. Her daughters’ lives would be affected, since their mother would be perceived as sexually promiscuous. She would be condemned by her husband and would be shunned by her neighbors. The
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Ampha, a farmer: Concealment for the sake of life protection

Ampha was a 30-year-old farmer from a small village in the northeastern part of Thailand. She was married to a farmer who worked in the same district. She had three children, the second of whom was a daughter who had been born with HIV. Because of this, her husband would gossip about her. A denial of employment would follow. Such a difficult situation, which might lead to the loss of what matters most to her, was the reason why she refused to have an HIV test and to seek care in the formal health care sector, and why she sought a form of health care that guaranteed confidentiality.

In her situation of despair, local healing was the only resort for Ampha, and it fit her needs very well. She not only benefited from the pharmacological effectiveness of the traditional drugs she took, but also from the fact that the nature of her illness could remain undisclosed. She could take her medicines every day without raising suspicion among her family members, since these particular herbal medicines looked identical to general herbal household remedies, and this made it easy to tell her family members that they were only medicines to cure wind and muscle diseases. Her herbal medicines had a completely different appearance to ARVs.

Wipha, a teacher: Concealment for the sake of job security and social status protection

Wipha is a 40 year-old teacher with a master’s degree who works at a school in a district of Chiang Mai. She became unwittingly infected with HIV by her husband, whom she later divorced because he had betrayed her and continuously courted bar girls. In 2006, four years after her divorce, three holes developed under the skin of her back. She went to see a doctor in a clinic, who diagnosed neurofibromatosis. The physician told her that it could not be cured by medicines or an operation, but that she had to be aware of the food she consumed, and that stress could aggravate the disease.

When she remembered that her divorced husband had once talked about germs with a neighbor who worked in an AIDS orphanage, she decided to go to a hospital to check whether the neurofibromatosis was associated with an HIV infection. Even though she had health insurance coverage to visit the hospital in her neighborhood, she chose to go to another hospital as she thought that this one would keep her secret better.

The positive result of the HIV blood test was disclosed to her in the company of a group of medical students, whom she had permitted to observe her initial reactions in the examination room. Even though she had prepared herself for this eventuality, she felt frightened but tried to control her mind. The doctor told her that her CD4 count was 350 and advised her on how to take care of her health. After this event, she never went to the hospital again. She said:

I’m not ready to seek care at this hospital. I don’t want to reveal myself. The hospital didn’t protect me. When I went there, they stamped on my documents ‘infected patient’… ‘infected patient’… ‘infected patient.’ It would not only be hard to live in society, I had also to deal with this system. I would meet a clerk who has been my student, or my relatives or my friends. I must feel hurt.

Wipha was worried about her future and about how long she could conceal her illness from her family, colleagues, students, and the seniors who supported her. She had to find a solution otherwise she could not continue. At that time she felt depressed, desperate, and hopeless. She constrained herself by keeping a low profile and avoided talking with colleagues. She
became weak and thin, and developed a dark lip, a dim face, and diarrhea. Wipha followed the advice of her close neighbor and went to a province in the Northeast to seek healing from an elderly healer, who in some respects looked like a chi pa khao (a white robed ascetic). Each time she visited she stayed for nearly a week. For three days she was treated with a very bitter decoction, after which she had a green mucous stool. When her feces became normal again, she took a mixture of egg albumin and herbal medicine. About three hours after taking this, stool like a red ant egg was purged. The explanation given to her was that the HIV was being steadily expelled from her body. She had to do this repeatedly until this kind of stool disappeared completely. If she managed to get that outcome, it would mean that she had been cured.

After she had been to this healer about three or four times over a period of three months, she went to an anonymous clinic to check her blood. The result of the test showed that she was still HIV positive. She decided to stop the treatment even though she had not completed the course. Problems with the cost of the treatment and the difficulty of traveling there, as well as the side effects of a numb tongue, pale skin, and thin body, also led her to this decision.

For six months she turned to another method of healing and tried a product made of Lingzhi mushrooms. She also took other nourishments and fruit extract products. After this trial, her CD4 count went up to 460 and her weight increased. For these expensive products, however, she had to spend half her salary.

Later, Wipha met Mo Boon through an HIV positive friend. She contacted Mo Boon by mobile phone many times before she finally decided to visit him at his healing center. She had to be sure that he would guard her secret. Even to me, Mo Boon did not tell her story before he had obtained her permission. At Mo Boon’s healing center, there were no formal documents that she had to fill in, no clerks, and no other patients who would gaze at her when she arrived. It was only Mo Boon who knew her name and status.

After three months of treatment, Wipha felt satisfied with the results of the healing. The papules on her skin reduced and her complexion improved. She said that aside from taking meditation, complete rest, drinking citrus juice, and eating nutritious foods, the drug she had taken to cleanse the blood had played an important part in healing her dark skin and papules – the problems about which she had always worried the most, since when they worsened her colleagues would become suspicious about her health.

Wipha’s situation may be considered particular, since she is a person with a relatively high social status. Furthermore, as a divorced woman living alone in a small district, she tended to attract people’s attention. She did not consider seeking care from local formal medical services – either a district or urban hospital – to be an option, since there is no assurance of confidentiality; this is the case despite the fact that secrecy should be guaranteed by the systems and codes of conduct of the practitioners in such institutions. Having her sickness treated at such a place may have resulted in Wipha having to face defamation, which would lead to loss of work and status, a risk that she certainly did not want to take.
**Prani, a lesser wife: Concealment out of fear of abandonment**

Prani is a 47-year-old Tai Yong woman who, together with her mother, son, and nephew, moved from Burma to settle in Chiang Rai. She had been the lesser wife of a local businessman and became infected with HIV through him. Her husband died in 1995. Due to poverty and having to bear the burden of being the family leader, she moved to a province near Bangkok, where she worked in a massage house. Seven years later, she met a local contractor there and became his lesser wife, but she never told him about her HIV positive status.

Following the recommendation of a friend who was HIV positive and who had been treated by Mo Somsak, in 1993 Prani went with another friend to see the healer. At that time, she had some skin papules and got a fever when she ate certain foods. She started taking the traditional drugs which Mo Somsak prescribed, and regained her health. But in 2002 she decided to stop taking the drugs because she could no longer afford the expense (500 baht per month). Since 2006 she has been taking ARVs, since she could access them free of charge. When she started to take them, she had no symptoms which were not HIV-related, aside from hypertension.

In 2007, before I started my fieldwork, Prani complained to Mo Somsak about abdominal pain, which she thought was a side effect of the ARVs. She asked Mo Somsak to dispense some herbal medicine to alleviate the pain, but Mo Somsak did not have the medicines to respond to her needs.

In April 2008, Prani suffered a severe shock from a drug allergy and was admitted to hospital. After surviving the most critical period, the physician changed her to another ARV cocktail. Prani had to think of Mo Somsak and called him for a consult. Mo Somsak sent her three kinds of traditional drugs. She took only one kind, however, and gave the rest to her husband, telling him that they were a tonic to reduce back pain and promote immunity. She thought that they could help him to become strong enough to be protected against HIV.

I met Prani and her husband in September 2008 at a famous temple in Central Thailand, when I accompanied Mo Somsak there. We simply greeted them and talked about her general well being. I asked her husband how he felt after taking the traditional drugs and he replied that they were good. We were not sure whether he had any suspicions about Prani’s illness and her treatment with traditional drugs.

Prani felt that she might be committing a sin towards her husband and his principal wife because she was still not able to arrange any protection when she had sexual contact with him. She said:

> Once I told him to use a condom. He refused and said we didn’t have any problems, why he had to use it. If something occurred, let it be, he was already old. I didn’t dare to tell him the truth. He likes to visit prostitutes without using a condom, but he said he had a negative HIV blood test.

For Prani, insisting on condom use was thus not a realistic option to protect her husband against HIV. This is not only because of her husband’s attitude towards condom use but also because of her powerlessness due to her economic dependence on him. Since she is poor and has to depend on her husband for her own living and that of her family, telling the truth...
might affect her family drastically. She decided to conceal her illness, despite her feelings of guilt. The best thing she felt she could do was to compensate for this fault by giving him the traditional drugs, which had once helped her to become healthy. This strategy used to conceal her illness is, however, likely to diminish the effect of the remaining drugs that she took herself.

**Chinda, the wife of a Westerner: Concealment based on fear of marriage failure**

Chinda is a 44 year-old Northeastern woman, who had been taking care of her son alone after her first divorce. She became infected with HIV unknowingly through her second husband, who passed away in 2000 from AIDS. She kept her husband’s cause of death secret, however, even from her family members. She did not take a blood test but decided to start a new life in a Southern province of Thailand, where she and a friend set up a Thai massage house. Unfortunately, the business failed. While Chinda was burdened with economic difficulties, she met a *farang*, the Thai word for a Westerner. John was a 57 year-old retired man from Europe who visited her workplace. He had been injured in a car accident while working as a truck driver in Europe. John chose Southern Thailand as the place for his rehabilitation and sought a Thai woman who could take care of him. He stayed in a touristic town and had already married a Northern Thai woman, but later the woman had returned to her hometown. John then sought another Thai woman and Chinda became his target. After a period of friendship, Chinda decided to marry him, and moved in with him in 2001. In the beginning, the marriage went well. John showed his willingness to live with her by conducting wedding ceremonies at her house in the Northeast and in their current province. He also took her to visit his cousins and friends in his country.

In 2007, Chinda became ill and suffered from chronic diarrhea, weight loss, and papules. She went to a private hospital in the province where she worked, and there she was diagnosed as HIV positive. The physician advised her to start ARVs. However, since the laboratory examinations showed that her liver function was not good enough to begin ART, she had to take blood and liver tonic medicines first. Even though she took these medicines as prescribed, her liver function did not improve.

While waiting for ART, Chinda learned by chance about Mo Somsak from a National Broadcasting Television program on the local wisdom of traditional medicine. The program caught her attention, since she had once had a good experience with traditional drugs when her mother, who had lymph node cancer at the third stage, was treated with drugs that were acquired from a Buddhist temple in the South. She immediately phoned Mo Somsak. After that she started to treat her liver problem with Mo Somsak’s traditional drugs, together with the medicines from the hospital.

One month later, her liver function value had improved and she could start ART. Along with the ARVs she took Mo Somsak’s traditional drugs without informing her physician. Four months later she stopped taking the ARVs but continued with the traditional drugs until she became healthy. The reason she stopped the ARVs was due to their adverse effects, which affected the appearance of her body and thus risked disclosing her illness to her family.
At the end of July 2008, Chinda got pneumonia and was treated with antibiotics in the hospital. She believed that her refusal to comply with the traditional drug regime was the cause of her latest illness: she had been taking three kinds of traditional drugs for a certain period and had felt healthy, so she stopped taking two of them. The main reason for this was that it was inconvenient to boil the crude herbal medicine and take it every day for a long period of time without raising her husband’s suspicions. She also feared gaining weight as a result of the drugs. But her non-compliance with the medicines was not the sole cause of her latest sickness. Before she became ill, she was suffering from stress because she had been cheated by a debtor; her body was not strong enough to cope with this emotional strain. These conditions together drove her to illness once again.

Chinda was also always worried about her pimpled skin and asked Mo Somsak for a way to treat it. However, although taking drugs and avoiding forbidden food could minimize the problem, she could not completely omit the forbidden food because she had to eat seafood when she went with her husband to Southern style restaurants.

In January 2009, John, who was gradually becoming more suspicious about her chronic illness, forced Chinda to have a blood test or else she would have to leave his house. During this time, Chinda phoned Mo Somsak and me to consult about what to do. I supported her by recommending that she control her mind, and told her that the consequences would not be as bad as she expected. Mo Somsak showed great empathy and told her to calm her mind. The event revealed a bond like that of close relatives between Mo Somsak and Chinda, even though they had never met in person. She also told us that she had asked her personal physician to tell the truth to her husband, because she did not dare to tell it to him directly. We cheered her up and encouraged her to confront what would follow.

A week later, Mo Somsak managed to contact Chinda by phone. She told him that her husband had been very angry and did not want to talk to her as usual. Moreover, she had not received her normal monthly allowance, though she still lived with him. She therefore could not pay Mo Somsak for the costs of the traditional drugs. The healer told her that he did not mind about the money, and that she could pay whenever was comfortable for her. Later, Mo Somsak informed me that Chinda and her husband had traveled to Europe in June 2009. For a long time, we could not get in touch with her. The most recent news that he had was that her husband had cut her allowance from 15,000 baht to 10,000 baht (approximately 250 euro) per month, the reason being that his own worsening health required more expenses than before.

Rather than urging her husband to pay her the same allowance, Chinda chose to start working again. She opened a roadside restaurant and spent her time taking care of the business after finishing her housekeeping during the day. This change liberated her from her economic dependence on her husband. Even though her business was doing well, however, it caused new problems: her husband asked for a divorce. Although John’s blood test proved negative for HIV, he accused her of both concealing her HIV positive status from him and abandoning him. Chinda finally got divorced, but she enjoyed her new life and working environment.
Issues in the case studies that matter

Gender asymmetry

The gender issue is relevant in my study since nearly all of the women participating in this study had been infected by their deceased husbands. All of them said that they were not angry with their husbands and did not condemn them when they first learned about the infection. The reason for this is that at the time that they contracted the infection, nobody knew about HIV and AIDS; furthermore, for a man to have temporary sexual relationships with other women is, as long as he is still responsible for his family, not an immoral affair. (Conversely, if a wife is said to be the source of the infection within a couple, it is seen to be the result of morally unacceptable behavior.) So the infections that occurred to these women’s husbands were considered more a misfortune than the result of bad behavior. Some women cleared their deceased husbands of guilt by putting the fault on the women who seduced them.

Gender issues that are found to be relevant worldwide with regards to HIV infection and its consequences are also found in Northern Thailand. Let me first present some general information about gender and HIV/AIDS, and then return to an analysis of the case studies.

Gender is a conceptual tool that provides an approach to understanding the structure of relations between men and women. Such an approach differentiates a person’s power, opportunities, roles, responsibilities, and obligations. Previous studies on gender and HIV/AIDS have dealt with issues such as gender inequality and discrimination against women, social and cultural determinants that put women at a higher risk of HIV infection, and the impact of gender relations on HIV and AIDS prevention and care (Dowsett 2003; Türmen 2003). It has been suggested, however, that the focus on gender overshadows other structural causes, such as inequality between developed and developing countries, poverty, mass migration and refugee movements, war, and social and cultural transitions brought on by globalization. We must therefore analyze gender relations among the other structural forces that underpin the size and impact of the HIV/AIDS epidemic (Dowsett 2003).

In almost every country that has the data, gender relations with regards to HIV and AIDS appear to be at a disadvantage to women (Bila and Egrot 2009). Laws and local customs in many societies limit women’s access to resources, including income, education, and other assets (Türmen 2003: 414). Poverty and lack of employment and education prevent women’s empowerment and increase their vulnerability to HIV. Gender norms, customs, and beliefs, (systematic) violence against women, and women’s economic dependence can also put women at a greater risk of contracting HIV (Rodrigo and Rajapakse 2010).

A study in Burkina Faso, however, revealed that HIV positive women might actually face fewer difficulties accessing health services than men (Bila and Egrot 2009). Women’s task of ensuring the survival, upbringing, and education of children, and their status as a wife, allow them to access health care facilities more easily than men. Women were also found to be able to seek assistance or receive donations from others without shame, since they were eager to maintain good health so as to be able to care for their children and improve the socio-economic situation of their families. Conversely, the feeling of shame associated with
help seeking – financial or health-related – appeared to be very significant among men, who consider such behavior disgraceful and undignified.

The case studies in this chapter indicate that there is not much differentiation in terms of fear of stigmatization among women according to education, socio-economic situation, and class. The story of Wipha illustrates that this fear can be particularly strong even among well educated persons with a high status in the local community. They have to do everything they can to conceal their HIV positive status in order to preserve their position in the community and keep their job. The stories of Prani and Chinda, as examples of women who were economically dependent on their partners and had to bear the burden of maintaining their original families after remarriage, show that such women have to cope with the fear of abandonment by their partners and therefore choose not to tell them the truth about their HIV status.

In the eyes of people in her environment, Chinda was considered someone who had great success in family life after her marriage with a farang. Revealing the truth to her husband would not only make him angry and lead to the failure of the marriage, but it could also affect her financial ability to support her son, who was studying at a technical college in her hometown. Keeping her illness a secret was therefore very important for her.

For Prani, she was powerless to request an allowance from her husband since she was the lesser wife and her husband was, as she always complained to Mo Boon, very frugal. She felt unable to tell her husband the truth about her status, although she did once try to ask him – unsuccessfully – to use a condom. Having failed to inform him of her status or protect him through condoms, she tried to compensate for her sin as much as she could by giving him some of her traditional drugs against HIV. Her husband always had unsafe sexual relations with other women, including his principal wife and prostitutes, but Prani still felt guilty and found herself in a bind. As in many other countries, condom use in Thailand is unpopular among couples. It is not only associated with a decrease in sexual pleasure but also with prostitution, and the desire to use condoms may be interpreted as an indication of adultery or promiscuity. Furthermore, asking to use a condom implies the risk of being suspected by one’s partner of already being infected with HIV (Bruyn 1992: 256). For this reason, insisting on condom use may have jeopardized Prani’s position as a wife. Despite being only a lesser wife, this status nevertheless gave her some economic security.

Family burdens further worsen the situation of some women with HIV and may lead to problems that are difficult to solve. Some women who are HIV positive need someone to help them bear the burden. If the women do not dare to tell the truth about their status to anyone, the stress of keeping this secret may cause family disunion and increase the likelihood of their partners engaging in risky sexual contacts outside of the marriage.

In the case of Chinda, local healing, which was used to cover up her illness, had a temporary positive effect in the beginning, even though her illness worsened at the end. While Prani received a benefit from traditional drugs for a long time, her situation worsened when she stopped taking the medicines and found a new husband. Many factors might account for the failure of these two women to keep up with the traditional medicines, and
their subsequent health decline, such as financial problems, the inconvenience of taking the drugs in the presence of their husband, guilt about hiding the truth, and the progression of the disease itself.

The stories of Chinda and Prani may lead to the preliminary conclusion that the use of local healing to cover an HIV infection will not improve the situation under all circumstances. As in the two above examples, these women had to live under the control of their (new) husband, had to rely mostly on him, and had to bear the burden of caring for their original family. They were not completely free to seek proper care and would go through any potential healing process with a feeling of insecurity. It is no surprise that constraints such as these can seal the fate of such women in terms of their health seeking behavior.

This forms a contrast with women who are free and self-reliant – such as Ampha – who choose to liberate themselves from their husbands and earn their own living. As described above, Ampha succeeded in seeking proper care and kept her disease secret from her family members, both of which alleviated her difficult situation. However, there is also a negative side to Ampha’s story. Her story confirms what many other studies have found, which is that fear of stigmatization and rejection within the family prevent persons with HIV from disclosing their HIV positive status to their family members (McGrath et al. 1993, quoted in UNAIDS 2000: 14). The main reason for this stigma and rejection is the connotation of misconduct, such as promiscuity, that HIV and AIDS carry (Mujeeb 1999, quoted in UNAIDS 2000: 15). Another issue that Ampha’s case illustrates is that fear of negative social consequences and fear of violence and abandonment can prevent persons from even taking an HIV test. These fears form a further barrier to receiving support from family or friends and gaining access to social, psychological, health, and other services (Maman et al. 2003; CAPS 2006; Natapakwa et al. 2006: 691; Smit et al. 2011).

In other words, it is asymmetry in gender relations that accounts for women’s fear of family disunion and leads to their attempts to keep their HIV positive status confidential. Women’s feelings of insecurity and guilt, and their reduced opportunities to access quality care – whether from local healing or modern medicine – thus diminish the effectiveness of any healing that they are able to access. In this case, local healing may help these HIV positive women to extend their lives, but it remains uncertain for how long, since the problem of gender asymmetry is not properly solved.

Hospital services and lack of confidentiality

Parker et al. (2002: 6) conducted a review of several studies into patient confidentiality in health care facilities across the globe, and documented many failures. Such failures included the open identification of patients with HIV and AIDS, exposure of a patient’s HIV positive status to relatives without prior consent, and the release of information on a person’s HIV status to the media or police. The study also found another form of poor maintenance of patient confidentiality, which was illustrated in the case of Wipha, one of the respondents in my study. Wipha stood out in this study as having responded to the local health services in a particularly negative manner. Fear of stigmatization seemed to make her sensitive to how
the practitioners and other personnel in the local hospital had and would act towards her. The labeling, which was visible by the stamping of the stigmatizing words ‘infected patient’ on her documents, had embarrassed her, since it already changed her identity into a full ‘HIV infected person.’ This transformation took place amidst witnesses who all were strangers. She became an object in a clinical examination for the benefit of medical students, who wanted to observe her initial reaction to the news that she was HIV positive. Despite the fact that she had given her consent for their presence, Wipha felt that she did not receive their respect and that her confidentiality was not protected. This kind of stigma can be seen as the unexpected or unwitting result of any routine HIV clinical encounter in cases where concern for the patient is not prioritized.

**Psychological well being**

The four case studies confirm the results of an earlier study in Thailand by Li et al. (2009), namely that stigma has a negative impact on the psychological well being of persons with HIV and AIDS. The occurrence of stigmatization in a community is associated with depressive symptoms among HIV positive persons, and the effects of stigma may be indirectly exacerbated through a lack of social support. The negative psychological impact may be greater in persons who conceal their status than in those who disclose it (ibid.). The story of Wipha shows that before seeking any form of health care, she only disclosed her status to one neighbor. This means that she had only one person who could offer her emotional and social support. It is therefore not surprising that she was suffering from depressive symptoms at the time. Searching for local healing was for her not just a way to heal her physical symptoms, but also a way to receive emotional and social support from the healer.

In providing psychological support, a local healer seems to assume more the role of a relative than a professional authority. It is precisely the informal verbal communication and the family-like relationship in local healing that have attracted people with HIV who felt alienated from the formal health services. The psychological support a healer is able to give help to prevent or relieve depressive symptoms, which often occur among persons with stigmatized illnesses.

A healer expresses directly his sympathy with what the patient feels (see Chapter 7). As a fellow feeling human being, the healer can earn the trust of the patient and succeed in establishing proper confidentiality. However, only those affairs of the patient that can reasonably be touched are associated with the healing. It might be a limitation of healing, for instance, that it cannot touch seriously asymmetric gender relations. Intervening in other people’s families in Thai society is, however, considered very problematic and no one wants to get involved. This restriction is even stronger when the couple lives in a nuclear family or is experiencing a tense situation. This also accounts for our limited knowledge about those persons with HIV in Thai society who marry again, especially when they do not disclose their positive status to their new spouse.
**Healing from a distance**

One finding of this study that has so far received relatively little attention in the literature is the phenomenon of local healing from a distance, which emerged in the stories of Wipha and Chinda. These stories show that the advances of mass media and telecommunication technologies have opened up new opportunities for seeking care for people with HIV and AIDS. Through such technologies, local healers and their patients are able to conduct a form of non-face-to-face healing that goes beyond the frontiers of locality. This new arena of local healing requires some explanation in order to understand the changes that occur in the traditional healing process and how the outcome may differ from usual local healing practices. This topic is addressed in more detail in the next section. The section starts with a case study, in which the topic is prominently presented.

**Telemedicine**

Lawan, a 48 year-old housewife, was diagnosed in 2004 as HIV positive. Her husband, a senior local government officer in a Northeastern province, was already sick from HIV-related illnesses. Since her husband was a well recognized person in the province, her search for treatment had to remain top secret. The provincial hospital, which provides tertiary level care, was not attractive to her. She had personally observed the service system of the HIV and AIDS section in the hospital and knew that if she were to seek treatment there, acquaintances would get to know about her – and thus her husband’s – status. Lawan and her husband therefore went to a neighboring provincial hospital, around 110 kilometers away, where confidentiality was assured. When they first went for a check-up, her husband’s CD4 count was extremely low, only 17, so the doctor immediately prescribed him ARVs. Lawan, on the other hand, had no symptoms and her CD4 count was 280, above the threshold of 250, which is determined as the criterion for receiving ART. She therefore received only vitamin pills.

One day in 2004, Lawan found Mo Boon’s name in the book *Folk wisdom: Cultural aspects of treatment of AIDS patients in Northern Thailand* by Rangsan (2004). She wrote him a letter to consult him about her problems and asked for his phone number. Mo Boon responded with an encouraging letter and sent her a set of medicines with a value of around 500 baht, together with his mobile phone number, something he often does when a patient writes him and asks for help. Lawan called Mo Boon and had a talk with him. She appreciated the manner in which the healer approached her: honestly, sincerely, and cheerfully. She then decided to take Mo Boon’s prescription of traditional drugs and strictly adhered to it until her CD4 count reached nearly 500.

The biomedical doctor who cared for Lawan believed that the increase in her CD4 count was due to the vitamin pills, and did not agree with her use of traditional drugs, advising her strongly not to take them. Lawan did not follow the advice, however, and kept taking the traditional drugs until the day I first interviewed her in July 2008. However, when we spoke she admitted that over the last two years she had not taken the drugs as strictly as usual since it was a boring task, and furthermore she was still healthy and could do everything in her everyday life. She was satisfied with the results of Mo Boon’s traditional drug regimen.
Apart from the good result of her increased CD4 count, she had also recovered from allergic rhinitis, a disease she had regularly suffered from. She was also pleased with the counseling given by Mo Boon, as well as the friendship he offered, even though they had never met in person.

In July 2009, I received a phone call from Lawan. She said that she was worried about the recent result of her CD4 count, which was 133. The doctor was trying to force her to start ART, but she refused. The doctor intimidated her and said that she might die within six months if she did not take the ARVs. She was angry but did not respond in an emotional way. In the end, the doctor gave her a deadline: she should start the ARVs within the next two months. Nervously, Lawan called Mo Boon. The healer encouraged her to take the full dose of the traditional drugs and suggested that she call me to look for a place to have her blood examined.

Lawan was confused about what to do. We had a long talk together, after which she decided to keep on taking the traditional drugs as well as complete rest. About one and a half months later, I received a call from Lawan again. She was delighted about the result of her recent CD4 count, which was 350: above the threshold to start ART. This result was also a surprise for her doctor. She said that since then, the doctor no longer forbade her to take traditional drugs.

Lawan told me that with the exception of her husband, the doctor, and the nurse who took care of her, Mo Boon and I were the only persons who knew about her illness. She had therefore only a few persons to whom she could complain when she was not satisfied with the formal medical services she received. She said that she was lucky to know Mo Boon. Even though she had never met him and they resided in different parts of the country, after talking with him many times she had learned that he was an honest person and a funny speaker. When she was bothered about something in her daily life, she liked to call him. After feelings of familiarity had developed between them, Lawan invited Mo Boon to visit her at her home in the beginning of May 2010. Her family, her husband, and her youngest daughter also welcomed his visit.

The case of Lawan reveals that the effectiveness of local healing can be achieved even in an atmosphere of great secrecy, since a healer can arrange for great flexibility in responding to the specific needs of his patients. Modern telecommunications allow the healing to remain confidential beyond the frontiers of a locality. This enables the healer to adapt his role easily to the new situation. It also sheds light on a gap in the formal health care system, where the rigidity of the health care institutions and their exclusive attachment to ART cause patients to worry about the adverse effects of ARVs and to look for alternatives elsewhere.

Lawan, Chinda, and Wipha were all eager to seek out information about alternative ways of healing, which are often available only at a faraway place. This search led to a form of ‘shopping around’ behavior, for which patients are blamed by most formal health personnel. Consequently, they prefer to conceal their experiences with alternative healing from biomedical doctors. Lawan might be an exception, since her husband was receiving care from a biomedical doctor from whom she also received treatment. However, she managed to...
defend her decision to use traditional drugs when she was able to raise her CD4 count above the critical threshold. This result may have caused her doctor to lift his opposition to her using traditional drugs, but it is unlikely to have had any effect on the health care system in general, since it would probably be considered a rare and special case.

I argue that the formal health care system should learn more from these shopping around experiences, rather than responding to them as if they are immoral affairs, or simply assuming that eventually all patients who shop around will end up taking ART. A better understanding of such behavior, which would make patients feel comfortable to disclose the full extent of their health seeking behavior to their biomedical doctors, would be, I believe, a key to success in dealing with patients’ suffering and addressing their real needs.

**Telemedicine in the light of tradition**

I would like to offer a cultural interpretation of the phenomenon of healing from a distance, since it is nurtured by certain thoughts that villagers often have about esoteric traditional healing. In ancient times, if a person wanted to become an expert healer, he often had to travel to remote areas to learn the healing traditions from local masters. Mo Pinkaew, the healer introduced in Chapter 3, still followed such a learning path. For him, the Karen spiritual practice in Mae Hong Son, a remote province located at the Thai-Burma border, is still authentic. Buddhist ascetic practices are well founded in some schools in Central Thailand, but for most Thais the spiritual practices from Khmer and other ethnic groups are considered more effective than those of the Thai themselves.

Lawan, who lives near the border between Thailand and Cambodia, admitted that Khmer magic is powerful. Despite not fully believing in it, she did not want to disparage it. Northern Thai culture, she posited, was older and stronger than her own – what she considered loose – Northeastern culture. She noticed that Northern people had their own way to preserve their values and that their local culture still maintained its moral values. This is totally different from her own Northeastern people, whom she considered less conscious of their own culture. When I asked Lawan what she was looking for when she searched for a healer in Rangsan’s book, she replied that she appreciated what the book said about Mo Boon since he seemed to be a good person, and his photograph taken with his father and an HIV patient guaranteed that his practices had really been passed down from his ancestors and that the benefit of his healing had been experienced by other HIV patients. In short, the representation of Northern culture, the story and the image of Mo Boon, and the imagination of a form of healing situated in a place that was rich in culture, constructed for Lawan the meaning associated with healing at a distance, as a practice for curing diseases that local forms of healing had failed to treat.

It is not only books but also television programs that play a role in enhancing people’s perception of the heterogeneity of the various forms of healing in the country. Such programs convince the public that the local wisdom regarding health that has been passed down through the generations has its own value. For some, its validity has been proven by scientific methods, for others by experience. These representations also transmit the importance of
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the value of returning to nature and require that all local healing is free from any synthetic chemical materials. Northern Thai healers appear to the public via television programs in local costumes and with charming accents, and they are often presented as modest persons who are knowledgeable in local wisdom.

A social memory that acknowledges the capacity of distant knowledge to cure illness, and a social representation of local healers that impresses the public with their sophisticated and benevolent outlook, thus form a part of the potential of contemporary local healing to transcend its territorial frontiers. Under these social conditions, local healing at a distance might therefore be an attractive alternative for persons with HIV and AIDS who want to avoid the adverse effects of modern medicines and hide their illness from neighbors and communities.

One may argue, however, that while HIV positive patients who pursue local healing at a distance may receive the abovementioned benefits, eventually they might suffer from the absence of an immediate relationship with the healer, which is an important aspect of the healing process and its success. The relationship between Mo Boon and Lawan reveals that this drawback can be acceptable as long as daily communication and the building of trust and intimacy are not obstructed. This good relationship can be maintained when modern and affordable technology is in the hands of everyone and the healer is able to preserve the heart of the healing tradition, namely faith-related trust, the power of virtue, and merit (as explored in Chapter 7).

Health and healing compromised by secrecy

Despite the availability of free ART in Thailand, local healing is still an alternative that many HIV and AIDS patients use to conceal their illness from others. The following section sums up the benefits of such healing in terms of its ability to preserve secrecy, but also outlines the limitations of the continuous search for healing in secret, which may eventually have a negative effect on a patient’s health.

As I showed in the above cases, formal health care services, in Thailand and elsewhere, are not always able to assure some persons with HIV of confidentiality. This is due in part to the fragmentation of the service system that allows people with HIV to journey through each section of the hospital. The more contacts they have with various health service personnel, the greater the risk that their secret will leak out. In contrast to formal health care services, the services of local healers accommodate the needs of patients to maintain confidentiality, along with the need to solve their physical ailments.

From the perspective of maintaining secrecy, another attractive aspect of local healing is the difference between herbal drugs and ARVs. The specific characteristics and side effects of ARVs make it easier for a person’s family and those in their surrounding environment to discover that they are HIV positive. To continuously take odd shaped pills at an exact time every day is a difficult task for persons who want to conceal their infection from their family. Likewise, the appearance-related side effects of ARVs, such as a lean face, hollow
eye sockets, a big belly, and black nails, are easy to observe. Certainly, these new marks of an HIV patient worry those who want to keep their illness secret and thus they try to avoid them with traditional drugs.

Nevertheless, confidentiality limits the possibility for HIV patients to exchange experiences about the use of local healing among themselves. They avoid any contact with other persons with HIV, especially those who reside near to them. Channels of reliable communication through which persons with HIV could comfortably exchange their healing experiences exist only in limited number, and there exists no forum for local healers who treat HIV patients. Local healing for the treatment of HIV and AIDS therefore seems, to date, to be a secret affair that is known only among a select group of people.

It is, however, incorrect to assume that the exchange of experiences between persons with HIV does not occur at all. Due to the benefits of mobile telecommunications, some healers have used this media to facilitate the exchange of experiences between persons with HIV. This happened in the case of Wipha. On the suggestion of Mo Boon, she had the chance to talk via mobile phone with Ampha, who had good experiences with the use of local healing. This example suggests that there are ways to facilitate sharing and exchange, while maintaining confidentiality as the primary concern.

The wish for secrecy may also limit a person’s possibilities to take advantage of all available health services. The need for confidentiality may make some persons with HIV anxious about accessing a blood examination at a formal health service unit, since they do not have sufficient trust in the service. Due to this limitation, the outcome of local healing among some HIV patients can only be evaluated by symptom observation. This is a weak point in the overall provision of care for HIV positive persons, and is logically attacked by some citing the criticism that it may leave HIV patients vulnerable to developing opportunistic infections due to undetected low CD4 counts. This issue became a new challenge for Mo Boon when Lawan, after she became more familiar with him, suggested that he should advise all his HIV patients to have routine blood examinations, to make his evaluations and treatment more effective.

**Conclusion**

The fear of stigmatization as a result of HIV still exists in Northern Thailand, especially among people who contracted the virus through what is considered morally unacceptable behavior, or people who are well educated or have high social status.

The cultural role of women in taking care of their parents and being responsible for their nuclear families have worsened the situation of some women living with HIV, in particular those women who financially depend on their husbands. The fear of blame, rejection, or abandonment, and the fear of negative domestic and social consequences, often prevent many such dependent women from disclosing their HIV positive status to their husbands.

Fear of stigmatization and its consequent effects, such as abandonment, family disunion, and loss of work, prevent many persons from taking HIV tests, disclosing their HIV positive status to others and thus receiving support from relatives or friends, and accessing health
services. These fears also appear to influence their adherence to therapy. Not only is their access to physical treatment affected, but the lack of social support means that these persons also run the risk of suffering from depressive symptoms.

The various fears also affect the health seeking behavior of some persons with HIV, who prefer to seek health care services in confidential settings. Local healing is one of the attractive alternatives to the formal health care system, since its flexibility guarantees confidentiality.

The current widespread distribution of mobile telecommunications facilitates access to local healing from a distance, and makes the traditional healing process both easily accessible and confidential. This potential of contemporary local healing to transcend territorial frontiers is founded on a social memory that believes in the power and effects of special knowledge from distant places, and on social representations of local healers who impress the public with their sophisticated and benevolent outlook.

The effectiveness of local healing in the treatment of persons with HIV – for whom keeping their HIV status secret is a top priority – is not confined to the ability of healers to cure the physical symptoms related to HIV and AIDS. Through the informal verbal communications and the family-like relationships built up during the treatment, local healers can also prevent or treat depressive symptoms. Furthermore, traditional medication is attractive to HIV positive persons since they no longer have to fear the physical appearance-related side effects of ARVs that can put them at risk of exposing their secret.

There are, however, limitations arising from such an atmosphere of secrecy. The possibility of HIV positive patients sharing experiences among one another is rare. Some patients fear undergoing an HIV test, which makes disease diagnosis unclear and can cause delays in seeking the most appropriate treatment. Furthermore, patients may be at a heightened risk of developing an opportunistic infection due to a low CD4 count, if regular blood tests and proper treatment are not sought in time.
Chapter IX

Clinical research on the effectiveness of local healing
This final chapter on my research findings addresses the question of whether, in the case of HIV and AIDS, clinical research can contribute to the formal recognition of the effectiveness of local healing, and whether such recognition could play a role in the more comprehensive care of HIV/AIDS patients. I will focus specifically on clinical trials, since they are at the heart of all medical advances. In order to reach some answers to the question of the role of clinical research in evaluating the effectiveness of local healing, I first present two clinical trials conducted in Thailand with the purpose of studying the efficacy of traditional drugs in the treatment of HIV/AIDS patients. I then analyze the implications of these results for the care of patients with HIV/AIDS. After a subsequent presentation of the perspectives of local healers on clinical trials, I reflect on the differences between the evaluation of efficacy of traditional drugs through clinical trials as compared to the evaluations proposed by local healers.

**Clinical research on traditional drugs for HIV/AIDS in Thailand**

Clinical research is a branch of medical science that aims to generate generalizable knowledge in a systematic way to improve medical care or public health. It involves the development of safe and effective medicines, devices, diagnostic instruments, and treatment regimens intended for human use (Gallin and Ognibene 2012). A clinical trial is a planned experiment designed to evaluate the efficacy of a treatment in human beings by comparing the outcome in a group of patients treated with the test treatment with those in a comparable group of patients who receive a control treatment; patients in both groups have to be enrolled, treated, and followed over the same time period (Meinert 1986).

As I have indicated in previous chapters, medical doctors and health personnel in Thailand tend to ignore all forms of lay experience and types of care from medical traditions other than biomedicine. This was particularly the case before the establishment of the Department of Development of Traditional Thai and Alternative Medicine in 2002. Medical research also mostly ignores lay experience. Before the age of ART, the popular use of herbal medicines – a term I use for medicines composed of medicinal plants, whether or not they have been compounded according to a traditional formula – among persons with HIV had little influence on biomedical research aimed at finding an effective treatment for HIV and AIDS. The two national research projects that did study the efficacy of traditional drugs had a limited impact in terms of serving the needs of patients and did not lead to further clinical research on the treatments provided by local healers.

The first of these two projects focused in 2000 and 2001 on a traditional drug that had been used among persons with HIV in Chiang Mai since 1993. It was known as the medicine of Mae (mother) Kim (ya sut maekim), receiving its name from the old woman who possessed the formula for the medicine. Later it received the brand name GPO Natureplex. The second project, which ran from 1997 to 2003 and was run by the Department of Medical Sciences, was focused on a drug named SH medicine. I will first present the research designs of both research projects, before I discuss their limitations in terms of the actual and beneficial use of these drugs among the Thai population in real life situations.
Two national research projects on traditional drugs to treat HIV and AIDS

Both research projects presented below were conducted according to the protocol for new drug development, which includes an in vitro study of an herbal extract (e.g. testing anti-HIV activity, its effect on opportunistic micro-organisms, lymphocytes, and so on; and a chronic toxicity test in animals) and a clinical trial among HIV/AIDS patients.

Research on the medicine of Mae Kim

The research project on the medicine of Mae Kim was conducted by the Research and Development Institute of the Government Pharmaceutical Organization. Research publications present the composition of the medicinal plants used in the decoction and the results of a toxicity test and the in vitro effect on lymphocyte proliferation. They reveal that the extract of five medicinal plants, given orally at various doses – one dose over a period of six months and a higher dose over a period of nine months – was not toxic to Wistar rats (Pranee et al. 2000). The extract was further observed to enhance the proliferation of lymphocytes, suggesting that it has a possible stimulating effect on the immune response (Government Pharmaceutical Organization 2007).

In the next research phase, a non-comparative clinical trial of this traditional drug was conducted to test its efficacy. The description of the traditional drug, according to the United States Patent ID No: 6485759, reveals that the botanical combinations help to maintain the Karnofsky Score (KS) or Karnofsky Performance Scale at a high level. This scale, ranging from 0 to 100, measures patients’ general well being and activities of daily life. A score between 80 and 100 indicates that the patient is able to carry on normal activities and work, with no special care needed. The 25 AIDS patients who participated in this study scored at

1 The Mae Kim traditional drug used in this clinical trial comprised: (1) herbal compositions consisting of dried plant extracts, in fixed amounts, of five traditional Thai herbs: Randia siamensis Craib. (khat khao), Combretum quadrangulare Kurz. (sakae), Minmusops elegi Linn. (phikun), Houttuyenia cordata Thunb. (phlu khao), and Borassus flabellifer Linn. (nguang tan); and (2) herbal compositions consisting of the lyophilized or spray-dried powder of aqueous or aqueous organic solvent extract of plant material Houttuyenia cordata Thunb. in a fixed amount.

2 The Karnofsky Score (KS) is recommended in the WHO Regional Office for South-East Asia document The use of Antiretroviral Therapy: A simplified approach for resource-constrained countries (2002), as an optional tool for the clinical monitoring of the clinical status of an HIV patient, and complements some of the clinical indicators of response to therapy, i.e. gain in body weight and decrease in the frequency and severity of opportunistic infections. KS is designed to classify the physical ability of patients in relation to functional impairment. The lower the KS, the worse the patient’s survival chances for most serious illnesses. Thus KS = 0 denotes death; KS = 10 indicates that the patient is comatose; KS = 20 means the patient is moribund and needs hospitalization with full medical treatment; KS = 30 means the patient is totally dependent, requires hospitalization, but is not facing imminent death; KS = 40 means the patient is dependent and requires specific care; KS = 50 means the patient is partially dependent and requires further medical treatment; KS = 60 means the patient is partially independent; KS = 70 means the patient can perform basic activities of daily living; KS = 80 means the patient is independent, though this requires effort, and is still symptomatic; KS = 90 means the patient is independent with minimal symptoms; KS = 100 indicates the patient is normal.
a range between 90 and 100, with a mean CD4 count of 420 over a 100 week period. Most patients noted a slight increase in body weight, while some gained significant weight. A follow-up result 100 weeks after treatment with the traditional drugs showed that all patients could live a normal life and were free of opportunistic infections. They had no undesirable adverse effects or new AIDS defining events such as the development of AIDS dementia complex or other cerebral disorders. The effects of this traditional drug are believed to be the result of the anti-infectious activity and appetite stimulation of some of the herbal components of the formula.

GPO Natureplex, the brand name for this herbal product, has been registered as a dietary supplement in Thailand since 1998. Furthermore, since 2002 a patent for this invention has been issued by the United States Patent Office as a botanical combination for treating AIDS and immune deficient patients in order to maintain good health. In 2005, it was launched on the market in Thailand and promoted as an immune system booster suitable for persons who have immunodeficiency signs, such as frequent colds and flu, a herpes infection, allergies or urticaria (hives), weakness and fatigue, or fungal infections. The cost of this product is 300 baht per month (approximately 7.50 euro).

Research on SH medicine
The second research project was conducted by the National Institute of Health of the Department of Medical Sciences, which is a Thai-Chinese collaboration project on traditional medicine. The drug that the research focused on is called SH medicine. It is composed of five medicinal plants and was developed from an ancient Chinese medicine by the Kunming Institute of Botany. The National Institute of Health was responsible for conducting both the in vitro part of the research and the clinical study.

The phase II clinical trial, which was conducted in 2000 in the Sanpatong Hospital of Chiang Mai, achieved a satisfying result. From 28 HIV positive patients who received the SH medicine, 12 patients (42.86%) showed a decrease in viral load (in at least one of the laboratory examinations) compared to before taking the medicine, 13 patients (46.43%) demonstrated no change, while viral load increased in 3 patients (10.71%). The results of the physical and laboratory examination revealed that the SH medicine produced no severe side effects. In conclusion, the SH medicine is, at least in the trial dose, safe for HIV patients (Anchalee 2002).

The phase III trial was conducted from September 2002 to February 2003. The Thai Minister of Public Health said that the result was very satisfying, and no side effects were reported during the trial (ASTV Phuchatkan Online, 23/06/2003). In 2006, the Thai News Service (1/11) reported worldwide that SH medicine was shown to reduce the viral load of HIV patients by 43%, but that it does not eliminate the need for standard ARVs. Thai and

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3 The medicine combines three medicinal herbs from China and two from Thailand: *Artemisia capillaris* Thunb. (*yingchen*), *Astragalus membranaceus* Bge. (*huangqi*), and *Glycyrrhiza uralensis* Fischer (*ganchao*) with *Morus alba* L. (*pluak rak mon*, mulberry root bark) and *Carthamus tinctorius* L. (*dok kham foi*, safflowers).
Chinese authorities planned to distribute this medicine within the three months following this report as an immune system booster for persons with HIV.

In 2007, a researcher of the Kunming Institute of Botany revealed the result of the clinical trial, which showed that the use of SH medicine with standard ARVs not only reduces the viral load and promotes the number of CD4 cells but also cleanses the body of ARV deposits (ASTV Phuchatkan Online, 31/01/2007). The SH medicine has been registered as a traditional drug by the Thai Food and Drug Administration and is recommended to be taken alongside standard ARVs. It is available in the Thai market under the brand name ‘SH Instant’ and costs 1,000 baht (approximately 25 euro) per box (one box includes 21 packages and the recommended dose is one package two times a day).

**Limited relevance of the clinical trials for the treatment of HIV/AIDS patients**

The two research projects presented above were studies aimed to develop new drugs from medicinal plants according to biomedical theory. Healers were not involved in any stage of the research projects and the healing process was excluded as a focus of both. The final evaluation of the research projects was that the researched herbal medicines could be used as immune enhancing products to complement ART.

As described earlier, all patients in the GPO Natureplex clinical trial project were evaluated as being able to carry on daily activities; they needed no special care. All were free of opportunistic infections and experienced no undesirable adverse effects during a 100 week period. However, the findings derived from the CD4 counts in this study revealed that of the 25 patients, 11 patients (44%) showed an increase in their CD4 count, while 9 patients (36%) showed a strong decline and 5 patients (20%) a slight decline in their CD4 count. This variability in terms of CD4 count made the result unexplainable within the current biomedical theory on AIDS. It also raises the question of whether a CD4 count in HIV positive people treated by traditional drugs remains a good predictor of the immediate risk of opportunistic infections and complications.

With regards to the medical treatment of AIDS, currently only a CD4 count and plasma HIV RNA level or viral load are accepted as the major indicators for evaluating the efficacy of any medical intervention. Medicines that are not able to increase the CD4 count and that decrease the viral load are not approved as a drug regimen for HIV/AIDS treatment. Both traditional drugs that were researched in Thailand have only been identified as complementary treatment to ART since they do not tackle the underlying cause of AIDS. This justification is based on biomedical theory, which assumes that HIV, the agent that destroys human immunity, is the cause of AIDS. To successfully treat AIDS, drugs are needed that can suppress or eradicate HIV, and this result can be detected through the plasma HIV RNA level (viral load) and the restoration of T helper cells, the lymphocytes in the immune system that are shown in the laboratory examination results of a CD4 count.

As long as CD4 count and viral load remain the primary predictors of clinical outcome and the immediate risk of opportunistic complications, evidence for creating a good quality of life through the use of traditional drugs alone will be insufficient to prove a drug’s efficacy. This
indicates that the verification of efficacy does not rely solely on reliable evidence but also on the mainstream theoretical explanation used. Traditional drugs, which have been empirically proven in real life practice as being effective, run the risk of failing to prove their efficacy in the realm of biomedicine. Biomedicine’s perspective on reliable evidence is theory laden and leaves no room for different kinds of evidence that are based on other theories.

The biomedical perspective on which the two research projects were based led to marked consequences. The first one is concerned with the drug registration system. Even though the two national studies showed that these medicines lead to a better quality of life for HIV patients due to the improvement in their immune system, proponents of the drugs cannot claim this effect if they are both registered as traditional drugs. According to the Thai Drug Act 1967, it is not allowed by the Thai Food and Drug Administration to add any new indications to the traditional drugs submitted for approval, even if these indications have been proven by scientific research. Both medicines can thus only be registered as a dietary supplement or a traditional tonic.

The second consequence concerns the selection of new drugs in the Thai National Health Security System, as well as certain prescribing restrictions. In order for a person with HIV to access free of charge medicines, he/she has to be diagnosed by a physician, who will then prescribe ARVs and possibly some related medicines from the list of drugs approved by the system. Traditional drugs and dietary supplements are currently not on this list of approved medicines for HIV patients. Therefore, persons with HIV who want to use herbal products have to pay for them themselves, a condition that has restricted the use of such medicines among this group. It is therefore not surprising that the market position of GPO Natureplex is currently advertised not according to its benefit for patients with HIV/AIDS (as focused on in the clinical trial), but as a dietary supplement suitable for “adults combating stressful, fatigued, and weak conditions due to restlessness, for those who are athletic or hardworking, or even for patients during rehabilitation” (Government Pharmaceutical Organization 2007). The lesson learned from both cases is that if the health system remains solely committed to the biomedical theory of HIV and AIDS, medicines that are developed through other medical theories will face difficulties in acquiring evidence to guarantee their efficacy. My research brought to light a type of evidence that differs from the evidence grounded in the biomedical theory of HIV and AIDS. It is based on traditional medical theory and has some characteristics similar to the Karnofsky Score.

**Effectiveness according to the Karnofsky score**

According to traditional medical theory in Northern Thailand, as described in Chapter 3, AIDS is a khang disease or a kind of disease that is caused by minute pathogenic organisms. In the case of AIDS, these pathogenic organisms are acquired through unacceptable sexual behavior. Since it causes abnormalities in the blood, it is identified as khang associated with blood (khang lueat). Improper diet, especially the eating of raw meat, raw fish, or liquor, can activate illnesses related to HIV/AIDS. The principal forms of treatment according to this theory are to stop eating forbidden foods, to use the right medicines to cure bad blood
and normalize blood and wind in the body, and to nourish the body. From this perspective, the presence of HIV is not more significant than the (in)ability of the body to maintain its normal functions. A CD4 count and viral load are therefore not the indicators of a successful outcome. The Karnofsky Score, which is used to measure quality of life, would be more appropriate.

The following two case studies present the experiences of two women with HIV who have been treated with local healing for many years and have remained healthy. Both women exemplify persons who would have achieved a Karnofsky Score of between 90 and 100 – and this for at least ten years – if this tool had been used to evaluate the outcome of the healing that they followed.

Chomchan left her hometown in Northeastern Thailand 20 years ago to accompany her relatives to Chiang Mai, where she started to work as a construction laborer. She married a colleague and in 1996 gave birth to a daughter. One year later, her husband lost his sight. He went to a hospital in the city but no treatment was offered. After staying at home for a week, he died from a fungal brain infection. Following his death, Chomchan had an HIV blood test, but the result was negative. In 1998, she was introduced to Mo Boon by an HIV positive friend when she joined a group that made lemongrass candles, an activity conducted at the deserted temple of Ban Denchai to support the income of persons with HIV. At this time she had started to develop skin papules. Mo Boon gave her an oily medicine for topical use and other traditional drugs. He also advised her to cleanse the body with lemon juice and alum when bathing, and to stop eating forbidden foods. Soon after following the healer’s advice, the papules disappeared. Thereafter Chomchan continued to take traditional drugs and remained healthy for a long time. In 2003, she began a new career at her home as a mulberry paper maker, since her body could no longer tolerate the tough work in construction. She earned 1,200-1,500 baht (approximately 30 to 37.50 euro) per month and received a subsidy of 1,500 baht per quarter from a fund of Princess Somsawalee.

In 2006, Chomchan’s mother-in-law and sister-in-law persuaded her to access the ART service at a district hospital. This time, the result of the HIV blood test was positive and her CD4 count was 109. The doctor suggested that she start ART. Despite the fact that she felt healthy, she decided to take the ARVs because they were free of charge; if she used them she could save around 100-200 baht (approximately 2.50-5 euro) per month compared to the costs of taking traditional medicine.

Unfortunately, Chomchan’s first experience with ARVs was troubling: she developed acute diarrhea, dizziness, hair loss, and detached skin. The drug allergy was so severe that she had to be admitted to hospital. The second drug regimen gave her as many difficulties as the first. After a few trials, a combination comprising four ARVs was found suitable for her. All of the drugs were made by transnational companies and were quite expensive, and the cost of 6,000 baht (approximately 150 euro) per month was supported by the Program for HIV Prevention and Treatment. At the date of our interview, her CD4 count had increased to 425.

It was evident that after taking Mo Boon’s traditional drugs, Chomchan felt healthy. Indeed, she had no AIDS-related symptoms and suffered from no opportunistic infections
until she took the HIV test, at which point it was determined that her CD4 count was lower than the critical level at which ART is advised, and she decided to start taking ARVs. As far as Chomchan was concerned, the alternation of treatment from traditional drugs to ARVs was the result of economic problems and her belief in the fact that there are specific medicines for treating HIV/AIDS which have been proven effective by modern medicine. According to biomedical criteria, Chomchan needed ART because her CD4 count was so low that she would be susceptible to opportunistic infections. From the prescribing doctor’s perspective, therefore, starting ARVs and stopping to take the traditional drugs took place due to a necessity that was determined by medical criteria and not by apparent AIDS-related symptoms.

The case of Chomchan differs from that of Lawan, a woman with HIV who featured in Chapter 8, in that Lawan insisted on continuing with local healing even though she had been biomedically defined as in need of ART. As mentioned in the previous chapter, her husband was diagnosed as HIV positive in 2004. A year later, she started with traditional drugs that were dispatched through the post by Mo Boon. After three years of treatment, Lawan’s CD4 count increased to 478. But in 2009, when she was under stress from her business and had discontinued use of the traditional drugs, her CD4 count decreased drastically to 133. Although she did not have any symptoms, the doctor urged her to start ART. She was in doubt about what to do next in terms of treatment, but ultimately refused ART because she was afraid of the visible physical side effects. Instead, she changed her lifestyle, started to take care of herself, and once again took the traditional drugs regularly. A few months later, her CD4 count was no longer at a critical level: in mid 2010, it was up to 480 again.

In order to account for biomedically unexplainable or unpredictable outcomes among HIV positive patients, it may be argued that some people’s latency period for HIV (the time after infection in which the virus remains inactive) may be longer than has been previously thought; or that the rates of disease progression differ among HIV positive persons (World Health Organization Regional Office for South-East Asia 2002); or that most patients remain well for many years without ART (World Health Organization Regional Office for South-East Asia 2002); or that CD4 counts vary due to a variety of demographic, environmental, immunological, genetic, and behavioral factors (Taylor et al. 1991; Raboud et al. 1995; Chirenda et al. 1999; Prins et al. 1999; Anzala et al. 2000; Kassu et al. 2001; Lugada et al. 2004; Mair et al. 2007). These observations, like the findings from the abovementioned cases, deserve to be taken into account. However, I would like to emphasize that the perspective of local healing aims to improve quality of life rather than increase CD4 count. From this perspective, local healing has achieved, to some extent, a restoration of the health of HIV patients by normalizing the internal body elements. This makes patients feel healthy and extends the time that they are able to spend with their families. It also changes the way they live, eat, think, and relate to others for the better. Patients become more aware of the meaning of life in the midst of a once seemingly hopeless situation and with limited resources, even if this positive impact may not in every case increase their number of CD4 cells.

The healers in this study were always confident that the healing package that they provide their HIV/AIDS patients causes fewer adverse effects than ART. The anecdotal cases that
the healers selected for my study are cases that not only showed success but also induced me to study them further. As a researcher, I developed a close rapport with the healers. In some degree, they expected me in turn to help them conduct research that could answer the question that is always posed by persons with HIV, namely whether local healing really benefits HIV/AIDS patients and under what conditions. Although the research design of my study does not serve this purpose, some of the contributions of this study could pave the way for clinical research that does aim to answer these questions. Below follows the healers’ point of view, which may be helpful for the design of clinical research that is more appropriate for local healing than that which is based on a biomedical perspective.

Healers’ perspectives on clinical trials

If clinical trials have limitations such as those pointed out above, why then do healers not participate in a clinical study to deliver the evidence that would support their healing effects? In this section, I present two healers who have some experiences in dealing with local health authorities regarding their practices and clinical research. In addition, I present the vision of two healers on the methodology of clinical trials. Internationally, there are many debates on the research methodology of clinical trials among traditional and alternative medicine practitioners and their proponents, anthropologists, and other social scientists. Yet only limited space has been provided for the voice of local healers. On a very modest scale, I will begin to fill in this gap in this section.

Mo Boon said that he was very pleased to cooperate with public health authorities in order to promote comprehensive care for HIV/AIDS patients. But from his experience, local health officers had ignored his attempts to help HIV/AIDS patients, and sometimes he received negative reactions from medical staff. He had a bad experience, for instance, when he was invited to a district hospital to teach persons with HIV about medicinal plants. Many patients were interested in what he taught, but a member of the medical staff prohibited them from using any herbal medicine. According to Mo Boon, this was because the herbal medicine had not passed the fungal contamination test. Another event happened at an exhibition held in the city of Chiang Mai. A public health officer berated Mo Boon over the poor hygiene of his medicine preparation and referred to the names of the medicines in an offensive way. Mo Boon expressed his discontent in one of our conversations:

I am a poor villager who wants to help my neighbors with the knowledge transmitted from my ancestors. I do not have enough funds to improve the preparation of medicines according to the official standard. I am now not able to provide a neat and separated location, and suitable equipment for the production of medicine.

As mentioned, Mo Boon prepares his medicine with simple and cheap equipment. He mixes the powder of medicinal plants and puts it into gelatinous capsules. Sometimes I noticed that his neighbors and clients did it by themselves. All the work is done in the healing center on a floor covered with brown linoleum. This place is also used for all other activities of the center. As a pharmaceutical science graduate, I can say that his medicine preparation is
The ambiguous role of secrecy in health and healing

unacceptable when compared to official manufacturing practices. It is, however, the best that Mo Boon can offer with his limited resources.

Mo Pinkaew differs from Mo Boon in this aspect. He asked for a huge payment from a health officer who wanted the formulae of his medicines to use in conducting an HIV/AIDS research program. When the negotiation failed, Mo Pinkaew stopped cooperating with the officer. Instead, he collected funds from his family and friends and obtained a bank loan to set up a standard traditional drug factory. He sells his products for a higher price than Mo Boon. Some of the profits have been used to improve his business. Mo Pinkaew is thus independent of government funds. Unfortunately, however, this development goes against the attempt to make the medicines affordable to the poor; I calculated that an HIV patient would have to pay around 2,000 baht (around 50 euro) per month for Mo Pinkaew’s medicines.

Despite the different experiences that Mo Boon and Mo Pinkaew had in dealing with biomedical personnel, both healers shared the same feelings of frustration over the actions of official authorities. Instead of supporting research on local healing for the treatment of HIV and AIDS, biomedical authorities have carried out research on modern medicines that have numerous side effects and a high price tag. This criticism corresponds to the notions of two leaders of HIV self-help groups with whom I spoke, who actively participated in the national campaign for ARV access. They said that the lack of scientific evidence on traditional healing has had a negative influence on the confidence of persons with HIV who want to use herbal medicines. Without reliable studies, these people cannot be sure that taking herbal medicines together with ARVs will not cause harmful drug interactions. These two group leaders also hoped that research on herbal medicines for HIV and AIDS would benefit those who refuse ART due to its side effects, and those who have not yet started. Although herbal medicines – like ARVs – cannot kill the virus, their effect can postpone the moment at which a person needs to start taking ARVs and should therefore be worth the investment.

When I asked the healers Mo Boon and Mo Somsak what they would do if they were invited to participate in a clinical trial in a hospital in order to evaluate the effects of traditional drugs in a systematic way, they responded in different ways.

Mo Boon promptly answered that this is something he would like to do. To Mo Boon, proving the effects of traditional drugs to the medical doctors in the hospitals would be a way to legitimize local healing. It would also be of great benefit to the villagers. But he could not agree with some of the concepts of placebo control groups, because he felt it is immoral to offer patients something that is known to be ineffective. He could accept it if the comparative study was conducted in such a way that the patients had the choice between ARVs and traditional drugs. To assess the outcome of the healing, he proposed a comparative evaluation of both the desirable and adverse effects.

Mo Somsak hesitated to make a decision, since he was not sure of the consequences of conducting research on local healing practices in a hospital setting. This hesitation might be related to the difference in perspective on illness and healing between local healers and medical doctors. He understood that the importance that biomedicine attributes to the chemical substances in herbal medicine, its emphasis on the human biological process, and the further development of these drugs in the service of the drug industry, are totally
different from the approach of the traditional way of healing. For him, the mass production of traditional drugs to make profit from patients is prohibited. The aim of traditional healing is to relieve the suffering of other human beings. Thus, if the research was conducted for the purpose of exploitation, it would be unacceptable to him.

The next question posed to the healers was what they would think if the clinical trial only aimed to evaluate the effects of the medicine, and therefore separated the healer from the healing process. Mo Boon replied that such an approach could be effective to some extent, but that it would not be as good as when the healer was involved in the healing process. Local healing is an experiential activity that uses medication that is individually adjusted by the healer for each individual patient. In addition, the healer also plays an important role in changing the ideas of the patients regarding their way of life and behavior, which can influence their illness. If he had the choice, Mo Boon would prefer a research methodology that is similar to the healing process he practices in everyday life. That is to say, it is conducted in his healing center, and the healer is involved in the whole healing process, i.e. diagnosis, drug dispensing, counseling, as well as social and spiritual support.

Mo Somsak answered that if it was necessary to do research on his medicines, he would first have to tell the healer teachers the purpose of the trial. This would be in order for him to pay his respects to the healer teachers, who are the source of his knowledge and who protect both healer and patient from inauspicious events. Nevertheless, he could not guarantee the outcome of the trial because determining the appropriate traditional drugs and doses for each patient is a complex affair. It requires a deep analysis of the patients’ problems thorough observation of changes in symptoms and progression of the disease. Furthermore, the healing procedures need to be adjusted for each state of the patient.

The ideas of Mo Boon regarding participation in a clinical trial are based on the assumption that nowadays, the decision regarding legitimacy of healing is based on modern medicine rather than on the judgment of communities, as it was in the old days. Denying collaboration with modern medicine is thus not advisable for healers, since they may be accused of fearing verification by scientific methods. Regarding the use of placebos, however, he believes in the moral value of compassion. This does not allow for a search for the truth that reduces patients to experimental objects randomized into a control and a treatment group, especially when they are in a life threatening situation. This idea does not differ from the ethical concerns outlined in clinical trials, namely that it is inappropriate to conduct placebo controlled trials under conditions in which delay or neglect of proven effective treatments would increase mortality or irreversible morbidity in a patient (Temple and Ellenberg 2000: 460).

Mo Somsak’s views pay more attention to moral values. For him, because of the different moral concerns of each healing system, the use of traditional drugs in biomedical treatment and research is something that has to be carefully deliberated. Mo Somsak would feel guilty if things he had done were to affect a patient in an adverse way. To make medicine available for the conducting of research was a new idea to him. He wanted to be sure that the patients, and not only the commercial drug industry, would also benefit from a clinical trial. Finally, the clinical trial should preserve the moral values that have always been the object of his concern.
Clinical trial versus research from the perspective of the healer

It is manifest from the above examples that verifying the efficacy of traditional drugs using a clinical trial protocol would involve use of an evaluation method in the manner of biomedicine, which is not in accordance with the traditional concept of local healing. Clinical trials are in conflict with and undermine the value system and healing process as practiced by local healers in three different ways.

First, in clinical trials the medicine is separated from the healer, healer teachers, healing environment, and other aspects of the medical regimen such as dietary control and ritual healing. These excluded aspects, however, are considered by local healers to be essential parts of the local healing process. A clinical trial based on biomedicine is furthermore always associated, either intentionally or unintentionally, with a modern hospital environment. In such an environment, it becomes difficult to associate the medicines that are used with the traditional values that may benefit the patients.

Second, a clinical trial based on biomedical science requires medical doctors to be the leading professionals in the research team. Medical doctors are always placed at the top of the research team and are fully responsible for the healing procedures provided to the patients. In case local healers were to participate in clinical research, such a hierarchy within the research team would make it difficult for them to develop a relationship with the patients, such as is done in their own healing setting. For them, it would also be much harder to perform certain rituals, such as worshipping the healer teachers. This is one of the main reasons why the healers would prefer to conduct such research in their own healing setting, where they are, with the consent of their patients, fully responsible for the course of the healing.

The final conflict has its roots in the values that underlie the intention of doing the research. Successful verification of the efficacy of a medicine creates a commercial potential, because the product can be used independently of the healer and the healing context. Commoditization of traditional medicine, which is one of the three parallel developments of traditional medicine in Thailand as described in Chapter 1, may divert the use of traditional drugs from their intended purpose – to relieve the suffering of human beings – to the purpose of maximizing profit.

In sum, the gap between what is constructed in conventional clinical trials and what is expected as an appropriate clinical study from the point view of the local healer results from the reductionist characteristics of clinical trials, which are in conflict with the nature of local healing. The unequal power relations between biomedical staff and local healers also contribute to this distance. The intention to do research that is in conflict with local healers’ values may, for the healer, be a reason not to participate in such a study.

From this analysis, the questions that need to be considered further are: What is the proper research methodology whereby healers, their medicines, the relationship between healers, patients, and healer teachers, as well as the surrounding healing environment are taken into account? How should one deal with the inequality of power relations in clinical research? How can a research project be adjusted to achieve the purpose of verifying the effects of medicines while maintaining the values held by the healers? This research has tried
to contribute some answers to these questions. I will present a summary of this contribution in the next and final chapter.

**Conclusion**

A proof of efficacy that is based on a biomedical disease theory has its limitations when it is applied to traditional drugs. The development of and the discussion about two clinical research projects on traditional drugs to combat HIV/AIDS in Thailand were presented above to illustrate these limitations. It was demonstrated, for instance, that some of the biological parameters used to indicate the proof of drug efficacy in these trials could not explain appropriately the health status of persons with HIV who had taken the traditional drugs. This limitation was the result of the research design that aimed to answer whether the traditional drugs are effective according to the biomedical theory of AIDS. In addition, it was shown that when the efficacy of traditional drugs in treating HIV/AIDS is evaluated in a clinical trial, it is not only reliable evidence of the healing outcome that is required, but that the outcome also has to be explainable within the present biomedical theory of AIDS. From this theoretical perspective, local healing that has been proven effective in practical experience runs the risk of failing to prove its effectiveness in a clinical trial.

This analysis leads to the controversial question of what kind of clinical research is appropriate to the nature of local healing. This question would be well treated if the views of the healers were included, and when the following (as examples) are taken seriously: opinions countering the reductionist characteristic of clinical trials; the inequality of power relations within the research; and the values held by local healers that forbid the inappropriate commoditization of traditional drugs. My attempt to answer the question raised above is presented in the concluding chapter, in which my findings are summarized as an answer to the research questions.
Chapter X

Conclusion
The study presented in this book used HIV and AIDS as an example to develop a comprehensive understanding of the effectiveness of local healing in Northern Thailand based on the perspectives of both local healers and their patients. In the 1990s, HIV and AIDS severely affected many people in Thailand, particularly those in the North. It differed substantially from other contemporary life threatening diseases – since it was a new disease, both fast spreading and initially untreatable – and made many of its victims desperate. At the same time, the threat it posed actually helped to revitalize many capacities of local communities. One of these capacities was local healing.

My study was inspired by the fact that local healers in Northern Thailand have played a crucial role in the treatment of HIV/AIDS since the early phase of the epidemic. In order to understand contemporary local healing, I documented and interpreted the healers’ experiences and lessons learned in the development of treatments for HIV/AIDS, as part of their efforts to fight the epidemic in their communities. My study attempted, therefore, to differ from other studies on traditional healing that commonly focus either on proof of the efficacy of traditional drugs or on the symbolic effect of the rituals performed by healers. Instead, it has been my intention to explore both the experiences of healers and patients, as well as the explanations that they present for their experiences, which are based on local disease theories and worldviews. I found it necessary to pay detailed attention to the socio-cultural and historical context that nurtures the core of local healing and to the different ways in which healers maintain their healing tradition. Such a perspective is often missing in current research on traditional medicine. My main focus, in contrast to other studies, was on the practices, negotiations, meaning transformations, and decision making of both healers and patients while they are involved in healing.

The data of this study is based on intensive contacts with a small number of local healers treating HIV/AIDS patients in Northern Thailand, as well as with some of these patients. The healers who participated in my study represent only those local healers who still follow the code of conduct inherited from their ancestors, even though they have adapted their practices in response to this newly emerging disease; a disease that in its initial stages formal health services could not effectively handle.

The qualitative character of the methodology I used for my study and its focus on details enabled me to develop comprehensive insight into the characteristics of Northern Thai healing as well as the perspectives of patients and healers on the effectiveness of local healing. Most of the evidence of this effectiveness is based on subjective experiences. This implies that my study cannot answer the question of whether, according to biomedical theory, the healers really do treat HIV and AIDS successfully. For this, a different kind of methodology would be required. The subjective empirical evidence that I collected was sometimes indistinct and difficult to verify. This made it impossible to prove convincingly whether a certain medicine used by patients on prescription by their healer really could ‘cure’ AIDS, as some healers and patients suggested. Furthermore, this study was not able to recruit patients who did not comply with local healing, and could not follow up on all of those who sought the treatment of healers during the height of the HIV/AIDS epidemic, but subsequently switched to formal
chapters. The patients in this study are therefore not representative of all HIV/AIDS patients who have sought care from the local healers involved in my study.

In this concluding chapter, I will explain in the first section how healing practices are embedded in the local world and how they can be experienced as meaningful by healers and patients. I will address those components that structure the context that supports the practices of healers and patients. These practices are then addressed in the following sections, in which I will attempt to formulate relevant answers to the three research questions. I will clarify how healing is practiced by showing how the healers approached a new disease, how they prepare their medicines, how they offer advice to patients, and how patients seek healing. This corresponds to the first research question: How is local healing practiced by healers and patients? The practice of evaluating the effectiveness of healing is then discussed in the next section. Against the background of these practices, I will present the perspectives of healers and patients on the effectiveness of local healing, and following this provide a comprehensive overview of effectiveness from both emic and etic perspectives, which together formulate the answer to the second research question: What are the perspectives of local healers and patients on the effectiveness of local healing? Lastly, I will present some lessons learned from this study with regard to clinical research on the effectiveness of local healing, which concerns the third research question: Based on the answers to the above two questions, how can clinical research that is appropriate to local healing be conducted?

The local world enabling meaningful practices

My study shows that the healing practices of the local healers and their patients are meaningful when understood within the framework that structures their local world, a framework that consists of traditional medical knowledge, local cosmology, and local morality. Despite a changing social context, these components have been maintained and reproduced, and are continuously adapted. These dynamic characteristics of the local world nurture the emic point of view of healers and patients and enable their meaningful practices.

Traditional medical knowledge is founded on local disease theory and Buddhism. This knowledge attributes AIDS to a blood disorder, which results from an abnormality of the inner body elements that is generated by germs and improper food or conduct. It is therefore treatable. Based on this assumption, local healers have developed a holistic approach to healing as well as a variety of healing practices, such as symptomatic treatment with specific herbal medicines, normalization of inner elements, excretion of germs and toxins, dietary control, lifestyle changes, and detachment from the causes of suffering.

Facing the discourse of biomedicine that dominates government supported health research and services in Thailand, local healers have been forced, however, to develop new interpretations of their traditional knowledge. The notion of germs, for instance, has influenced the healers’ thoughts and practices in a certain way. A germ is explained in analogy to minute organisms, as formulated in traditional medical texts, and some medicines are therefore called anti germ drugs when they are dispensed to HIV patients. Furthermore, when the local healers were faced with the fast acting effects – both desired and adverse – of
modern medicines such as ARVs, they responded by claiming that their own medicines are safer and work gradually yet effectively to attack the cause of disease.

Local cosmology, which assumes a hierarchy of beings, moral values, and symbols, also plays a role in the meaningful practices of healers and patients in the healing process. The shared idea of meritorious persons provides someone who can associate himself with the merit of the Buddha or local sacred beings with an opportunity to turn himself into a person who can emancipate villagers from certain forms of suffering. This occurred in local communities with local healers during the height of the HIV/AIDS epidemic in Northern Thailand. In this way, Mo Boon, a normal villager from a family of local healers, was able to transform himself into a healer committed to the fight against HIV and AIDS. This event had both psychological and social meaning, since it was associated with symbolic devices that expressed the emergence of a meritorious person. It also led to financial and other contributions from the community. The meritorious healer further enhanced the results of his healing through activation of the power of Khruba Siwichai, a recognized regional spiritual saint and teacher. The endeavors of Mo Boon, and other healers like him, reveal the capacity to reproduce local cosmology, which in this case has led to a revitalization of local healing in the community.

Local morality, which is based upon the cosmology as described in Chapter 6, was, in a strategic way, also involved during the peak of the HIV/AIDS crisis. Helping HIV/AIDS sufferers was explained as a merit making activity. The moral idea that a person can reach the ultimate goal in Buddhism by amassing merit through helping others, without any expectation of material reward, was activated by local healers in the context of HIV/AIDS as the expectation to help those suffering from the disease. This enabled healers to be active in communities even though discrimination and stigmatization against sufferers of the disease were prominent, especially in the early phase of the epidemic.

When a moral value is translated into a code of conduct, it can become relevant for traditional medical knowledge. Such codes of conduct for local healers include a healer not persuading a person to be his patient; not requesting higher symbolic fees to honor the healer teachers than what was determined by his previous teacher who transmitted the knowledge; and not requesting fees for services, but accepting only payments depending on the patient’s ability. The code of conduct is pronounced and passed on orally, making it convenient to adapt to a changing context. Although it may appear in different forms, the aim of a code of conduct remains the same, namely to assure that a person who makes use of traditional knowledge, such as a local healer, will morally follow the path of his predecessors – the healer teachers – who are the origin of medical knowledge. This association is emphasized in the rites that are always performed as a major part of the healing process as well as in the annual ritual to pay respect to the healer teachers. Part of this code of conduct is also embedded in everyday life. In this sense, traditional medical knowledge and moral values form an indivisible feature of the local healing tradition.

Although shared traditional moral values are an essential part of the local healing tradition, it is a real challenge to maintain the survival of these values in the present time. Healers might have to remake their moral lives and even overcome moral breakdown that
results from moral contradictions between their own traditional values and the prominent values of the contemporary world; for example, the contradictions between merit making with no expectation of reward versus the materialist aims of modern consumer society. It becomes even more difficult to stick to traditional values when social changes take place that threaten the social recognition and prestige of the local healing tradition. I view this struggle against the encroachment of the modern world at the local level as a way of maintaining local morality, since this is a crucial part of the local world upon which this healing tradition is founded.

In depth insight into the three components – traditional knowledge, local cosmology, and local morality – that structure the local world of healers and patients will help us to determine how the legitimizing context that nurtures and supports local healers is fertilized and maintained, so that healers can maintain their healing tradition on the basis of their own culture and knowledge system.

**How do healers and patients practice local healing?**

This study explored how local healers practiced healing for a new disease that neither they nor their patients had experienced before. It found that most healers began the process of finding a way to heal the new disease of AIDS by locating the disease within the local disease system. After that, they would estimate the possibilities for treatment according to theoretical principles and the experience accumulated through the generations. Many healers returned to their scriptures and analyzed the medicine formulae to search for drugs with the potential to cure the disease. Following this, they considered the practical aspects: whether all of the herbs in the formula could be acquired, and whether the patients could afford the drug and comply with the regimen. When they were convinced that in principle all practical problems had been solved, they started a trial. During the trial period, assessment and monitoring of the healing outcome was closely and intensively conducted.

When preparing the medicines, the healers always carefully collect and mix the ingredients, and subsequently pray to make the drugs more powerful. These three stages of collection, mixture, and prayer must be conducted in the proper way, according to the teaching of the previous healers who have transmitted the knowledge. Healer teachers and other local sacred beings are often involved in these stages. They are expected to protect the patients and healers from inauspicious occurrences and to grant them good things.

All medicines used by the local healers for the treatment of HIV/AIDS are traditional drugs designed for many purposes: symptomatic treatment, normalizing inner elements, treating blood disorders in various ways such as cleansing blood, nourishing blood, and creating new blood, as well as killing germs and excreting toxin and germs. Each healer uses readymade formulae rather than tailor-made prescriptions.

Aside from medications, the healers provide relevant advice in their healing practices, such as omitting prohibited foods and following proper living conditions. To detach patients from fear, despair, and other negative emotions, the healers conduct counseling and use local proverbs, metaphoric teaching tools, photographs, and meditation.
For patients who share the same local world with the healer, local healing is a form of healing that has been experienced by their ancestors for generations. It implies a choice of disease treatments that are locally known. In case of a new disease that has not been encountered before, the patients learn, along with the healer, the extent to which local healing can resolve it. If the disease affects many aspects of life, as in the case of HIV/AIDS, the patients will look for solutions from various sources in the region. One such resort is local healing, which patients hope can treat the ailments that formal health care services cannot.

The kind of healing that patients select differs from person to person. Patients who choose local healing may try traditional drugs dispensed by the healer, practice meditation, omit prohibited foods, and conduct healthy behavior that promotes body immunity. Some practice what seem to be new alternatives such as yoga, and search for herbal products and dietary supplements that are advertised in the mass media. Some patients may turn to religious practices and local rituals to relieve and overcome suffering from their disease. Other patients may seek additional social support elsewhere. Some may seek care from formal health care services in case they have to be treated for physical ailments or need biomedical examinations that local healing cannot serve them with.

How do healers and patients evaluate the effectiveness of healing?

Local healers evaluate the effectiveness of healing mainly through observation and inquiry. The evidence they use as evaluation comes from the signs and symptoms that their patients present. They look for instances of a patient’s ability to practice their daily life activities in good health, before and during treatment. Healers also ask patients for their perspective on the effectiveness of the healing. Healers did not refuse evaluation methods based on biomedical laboratory examinations, such as HIV blood tests, CD4 counts, and viral load checks, although some local healers knew little about these examinations. Moreover, some healers have adopted certain medical devices in order to evaluate the general health status of their patients and investigate the presence of certain chronic diseases. These devices include thermometers, sphygmomanometers (blood pressure meters), or home blood glucose monitoring kits. The purpose of using these devices is to find more evidence to support the evidence that they already have. However, some of these devices are costly, and thus the local healers use them only when necessary.

The five indicators that healers use to evaluate the effectiveness of their healing practice are: (1) a patient’s inner sense of a positive initial outcome; (2) recovery from symptoms of illness; (3) improvement in overall appearance; (4) the ability of the patient to tolerate prohibited foods that once worsened the illness; and (5) restoration of daily life activities. These indicators are not a replica of what is written in traditional medical texts. Rather, healers have developed them on the basis of patients’ subjective experiences during the healing process. These include positive sensual perceptions – whether this be an initial sense of vitality, a visceral sense of relief from illness, or the visual appearance of being healthy – and the regaining of a patient’s ability to conduct daily activities, work, and live healthily in his or her social environment after the treatment. In this respect, the indicators held by the
healers closely aim at general well being rather than only the removal of symptoms. Furthermore, according to the healers, their evaluations are not only limited to the assessment of the outcome of the healing process, but also consider the process itself: whether each procedure has been conducted properly; whether the relationships between the healer, the patients, and healer teachers have been arranged in accordance with moral values; and whether at least some of the procedures have maintained traditional moral values amidst changing socio-economic conditions.

Patients’ criteria for self-evaluation of the effectiveness of healing are similar to those of the healers. In their self-evaluations they observe bodily changes in everyday life, both in situations of good health and illness. They have learned from the treatment of HIV/AIDS that annoying symptoms such as chronic headache, diarrhea, and itchy sores from skin papules can be relieved and slowly disappear if the right medicine is administered and the proper behavior is conducted. The illness will relapse if they take prohibited foods or liquor, are exposed to the wrong smells, or become involved in situations of stress. Patients also observe emotional and inner changes after taking traditional drugs, and learn that these changes are associated with the desired effects of medicines.

**Effectiveness of healing: Emic and etic views**

The evaluation of the effectiveness of local healing by healers and patients, as described in the previous section, shows that what is observed as a desired outcome is empirical in nature. From my point of view, a perspective oriented at practical experience opens up space for healers and patients to adopt knowledge from other medical traditions into their own practices. This becomes evident when the healers consider the cause of a disease. The knowledge that HIV has been scientifically proven to be the cause of AIDS has influenced to some degree the ideas and practices of local healers. Knowledge of germs provoked the healers to review local disease theory in order to deal with the virus appropriately. Germs received a place in the local disease theory by associating them with the minute organisms in classical texts. Anti germ traditional drugs and the traditional drug to excrete germs were thus created to fight HIV/AIDS. This adaptation is not seen by the healers as malpractice or diversion from the healing tradition, since the drugs are used according to local knowledge and have specific positive effects on the treatment of the disease.

When the healers treat patients, they tend to rely more on their own practical experience than on the figures from the laboratory, such as CD4 counts and viral load. The latter, according to their experience, may not correspond with the apparent health status of a patient. When their experience has convinced them that traditional drugs have been effective in the case of a patient with a very low CD4 count, they assume that the effectiveness of healing rests in the fact that the drugs normalize the function of inner elements rather than correct the CD4 count. This interpretation is possible because the former can be related to local disease theory while the latter is unimaginable.

In addition, however, the idea that HIV causes AIDS has influenced healers and patients’ concerns about treatment methods. This study found that healers and patients are most
concerned about the material treatment methods. The pharmacological effects of the material substances in traditional drugs form the center of their explanation of the effectiveness of healing. This explanation is, however, given in a way that corresponds to local disease theory. The effectiveness of healing is then based on the question of whether the medicines can produce the expected pharmacological effects.

Aside from the effects of the medical substances of traditional drugs, some patients perceive the symbolic effects of traditional drugs through the names of the medicine and through bodily sensations that are meaningful within local disease theory. The healers and some patients also concern themselves with the effect of the virtue inside the medicines that creates symbolic power. This power is closely related to the virtue of the healer teachers and local sacred beings. It can be called up by a healer who follows the proper moral conduct and acts as a medium to channel this healing power. Since we have seen that this perspective on the effectiveness of local healing is founded on local cosmology and morality, we might assume that only persons who share these ideas will be sensitive to this power.

Effective local healing implies a concern with mental healing and social support. Although specific rites to resolve the mental health problems of HIV and AIDS patients were not conducted by the healers participating in this study, all healers are nevertheless concerned with their patients’ psychological well being or mental status. The procedures they conduct are viewed by the healers as a way in which to detach patients from their suffering. This can also be seen, I argue, as a way in which to provide a form of social support to help patients overcome their suffering.

The merit building events that Mo Boon, one of the healers in this study, organized in the community also helped the community to deal with persons with HIV in a constructive way. I argue that this success can be partly seen as the result of the reliance on the merit of a local spiritual leader, Khruba Siwichai, through which community events were transformed into part of a healing process that aimed to resolve AIDS-related social conflict in the community. Seen in this way, the effect of local healing can be extended to the realm of social dimensions.

From my point of view, the way in which the local healers in this study have dealt with HIV/AIDS, on the basis of local disease theory, has changed the meaning of the disease from an untreatable one into a treatable one. This has affected the patients’ way of life in line with traditional ideas of dietary control and leading a proper lifestyle. All healers and most patients attribute part of the healing effect to the control of prohibited foods and consider it an essential element of healing. For this reason, I suggest that the effectiveness of local healing is also related to the meaning that patients give to their sickness and their ability to change their lives.

Both healers and patients attribute the effectiveness of local healing to moral elements in the healing process, such as compassion, faith-related trust, the power of virtue, and merit. This study has shown that compassion enables a healer to perform meritorious healing. Trust promotes faithful confidence and compliance, and assures patients that the healer will do his best to cure their illness and not trade his services for money. The power of virtue – the external force from the sacred world – can protect patients from bad things and the malevolent
forces of evil spirits that are believed to cause sickness; it also provides power to medicines, making them more potent. Accruing merit – the result of good karmic actions – extends the ability of a healer to protect and care for his family and patients, and is also supposed to extend the life of a patient facing a life threatening disease.

From the perspective of the patient, local healing has an advantage over biomedicine in terms of assuring secrecy. This is made possible through the capacity of the healer to adapt his healing to the needs of the patient. The findings show that the widespread use of mobile phones makes this flexibility in healing even more convenient, and furthermore facilitates access to local healing from a distance. Moreover, the fact that traditional drugs have no obvious physical side effects helps patients to keep their HIV status secret, since a change in bodily appearance, as is often caused by ARVs, may raise suspicions among those in their environment.

Patients view local healing as one of the many healing procedures that may serve their needs in different circumstances. I argue that the effectiveness of local healing therefore has to be seen in connection with the idea of complementarity. The local concept of disease provides room for multiple causes, such as karma, spirits, misfortune, germs, inner elements, or bad conduct. Many ways can therefore be invented to treat new and mysterious diseases. Even though HIV is the recognized cause of AIDS according to scientific evidence, the other causes are not ignored because they function on a different level of disease etiology. The complementarity of healing practices includes the idea that healing has a synergistic effect and enables the effective treatment of a disease on different levels. How these levels are integrated can differ from one patient to another. It is therefore difficult to determine the singular effect of one specific healing procedure in the absence of a well designed study.

When we consider the effectiveness of treating HIV/AIDS in Thailand from a historical perspective, we are able to distinguish different sets of meaning transformations. At the very first stage of the HIV/AIDS epidemic, being able to localize AIDS within the theoretical framework of traditional medicine, and make the mysterious disease comprehensible, was already effective. Later, effectiveness came to mean the ability of persons with HIV/AIDS to regain a certain quality of life. That persons with HIV/AIDS were no longer stigmatized but became socially accepted is also viewed as part of the effectiveness of healing in this period. Finally, when ARVs became nationally available free of charge, effectiveness of local healing was redefined by persons with HIV/AIDS as the ability to keep up their CD4 count.

In sum, I argue that the effectiveness of local healing is evaluated in terms that are inseparably embedded within local disease theory, local cosmology, and local morality. Local healing has the capacity to be successful when it is conducted in the following ways. First, it should perform the right methods to correct a disorder corresponding to its cause within local disease theory. Second, throughout the healing process it should deal properly with the sacred entities in local cosmology. Third, it should be conducted in accordance with the moral elements that are needed for meritorious healing. Lastly, it should be adapted to serve the needs of patients who have a choice between various forms of health care and who live in a changing society.
The identification of moral elements as the core component of local healing is an important contribution to the anthropological study of traditional medicine. In other cultures, different moral elements that contribute to the effectiveness of healing may be identified, both from the healers and patients’ perspectives. Healers and patients’ moral commitment to the healing process can make policy makers and those who promote local healing aware that any measure to evaluate local healing has to be sensitive to the local world that supports meritorious healing practices.

Finally, with respect to HIV/AIDS patients, the above findings can help us to formulate interventions to support local healers who treat HIV/AIDS patients as well as serve the needs of patients for confidentiality regarding HIV tests and CD4 counts. Persons working in health care institutions should be aware of those aspects of local health services that do not create trust among or foster confidentiality for patients who are sensitive to the fear of stigmatization.

**Recommendations for clinical research on local healing**

At the end of this research project, I would like to conclude with some recommendations for future studies on the effectiveness of local healing, whether they are focused on the healing of HIV and AIDS or other diseases. The main recommendation based on the outcomes of the study that I conducted is that such studies should pay attention to the significance of the three components – traditional knowledge, local cosmology, and local morality – that structure the local world and contribute to the effectiveness of healing.

As emphasized before, my study on the effectiveness of local healing was conducted among a relatively small sample of healers and patients. It nevertheless provides relevant guidelines for studies undertaken among a larger population with a similar objective as mine. In such large population studies, some basic studies would have to be conducted as the initial step. The major aim of these basic studies would be the clarification and verification of the local disease theory for the disease under study. To serve this aim, studies would have to include two major steps: first, make a clarification of possible theories regarding the disease, as proposed by acknowledged healers; and second, the proposed theories should be analyzed by systematically examining the signs and symptoms of patients, and evaluating the outcome of treatments specifically designed for individual patients.

This current study could only make a beginning with the first step. To complete this first step, it would have been necessary to search for other theories proposed by other healers. Regarding the second step, this study could not verify the theories proposed by the healers in a systematic way since for that purpose a proper methodology for clinical investigation would have been required.

Aside from studying local disease theories and clinical practices, an anthropological study on the effects of local healing should also be conducted. It is necessary to clarify the symbols that mediate between the practices of healers and patients on the one hand, and the cultural meanings to which the effectiveness of healing refers on the other. The process, in which the healer and the medicines are empowered by sacred entities or the abstract ideas of
local cosmology, is an essential part of this clarification. From the study of local morality, we have to identify moral values that play an important role in the healing, moral dispositions that enable the healer to perform meritorious healing, and moral elements that encourage a good relationship between healer and patient. All of these are necessary to assess how these components of healing affect its effectiveness. This study could meet these requirements only on a small scale. To repeat these tasks on a larger scale, it would be necessary to calibrate the tools used in collecting data and interpret the findings across different research settings.

A methodology that is in line with this approach may include: research in a practice setting; evaluation of the entire traditional care package rather than only the medicines; evaluation of the state of disease and the healing outcome for each patient by extensive indicators, whether bodily, sensational, emotional, or instrumental; and evaluation of patients’ cultural background, and the meaning that patients give to their life and each element in the healing process. In addition, the participation of local healers and researchers would be crucial for such a systematic study, as would a careful selection of biomedical markers and examinations of the disease state.

The proposed methodology should be followed with the awareness that it will be possible to construct other medical theories aside from those of biomedicine. Human sensation is an important part of knowledge building and interactive learning in the healing process, to the benefit of both healers and patients. The experience of healers and patients of clinical practice and everyday life should thus be considered invaluable for the creation of new knowledge and new medical theories.
Glossary

ahan salaeng  prohibited foods
akatsa that  the element of air
ao en  a style of folk massage
ao man  a style of Burmese massage
baisi  a food offering decorated with banana leaves and flowers, topped with a boiled egg
barami  the stages of spiritual perfection achieved by a bodhisattva on his path to Buddhahood
bhavana  mental development
bodhisattva  one who has strong intentions to attain enlightenment in order to help his fellow beings or to be a candidate for Buddhahood
bucha thian  worshipping with candles
bud-dho  Buddha or the Enlightened One
Buddha khun  the virtue of Buddha
bun  merit
chao thi  the spirit that protects the place
chet haek  a technique to expel poisonous illness by rubbing betel leaves, a knife, or a wild animal’s canine tooth dipped in a herbal solution on the affected person’s body, while chanting mantra
chop pit  a technique to extract poison in case of poisonous fever and pain by touching the client’s body with a boiled egg
dam hua  the rite of expressing gratitude
danna  giving or generosity
decha  power
Dharma khun  the virtue of the Buddha’s teaching
du sombat tai din  the ancient practice of looking for underground treasures
duang chata  the fate of the individual
farang  the Thai word for a Westerner
fi hai  severe abscess
fi mamuang  a type of venereal disease
fi san buam phong  abnormal collection of tissue under the skin
hong khwan  a rite of calling mind-soul
hua wat  the system that creates relations between people from different villages through religious events
ithibat si  Buddhist teaching of the Four Paths of Accomplishment
kae ban  the senior leader of the domestic division
kae kluet  a rite of undoing khuet
kae mueang fai  the senior leader of the irrigation division
kae wat  the senior leader of the religious division
kam kin  practices regarding dietary control
kam yu  practices regarding living conditions
Glossary

kan plong  detaching oneself from something that causes suffering
khai e-suk e-sai  chicken pox
khai fai lam thung  erysipelas
khai kan  black fevers
khai ngu sawat  herpes zoster
khai nkea  the Northern fevers
khai ok hat  measles
khai phit  poisonous fevers
khai raksat  typhoid fever
khai wat noi  cold
khai wat yai  influenza
kham ba kao  local proverbs
khang lueat  a blood disease originating from khang
khang muttakhuet  a type of venereal disease related to a blood disorder
khap chuea  excreting germs
khap phit  excreting toxin
khatha  a set of words that offer mystic power
khatha suep chata  a verse for extending fate
khau tan  a money tree, whereby bank notes are attached to split bamboo branches
khi sak hong ya  people who have been previously treated with various medicines in hospital but with no effect, or who have been discarded by the hospital
khaew khlat  helping a person to escape from danger
khon suk  literally a ‘ripe’ person, a person who is ordained and who follows the proper conduct in accordance with the way of Buddha’s teachings
khong krpan chat  making a person invulnerable
khro  a bad situation or the experience of misfortune
Khruba  the title that Northern Thai people confer on monks, usually of old age, who are highly venerated for their sanctity and personal charisma
khuen thao thang si  worshipping the angels of four directions
khuet  prohibitive rules concerning action which may result in bringing bad luck to an individual or the community
khun  the virtue or good quality of persons, deities, abstract entities, or things deserving respect
khun phra si rattanatrai  the virtue of the triple gems – Buddha, Buddha’s teachings, and the community of Buddhist monks
khun sai  black magic
khun ya  the virtue inside medicines
khwak sui a technique to heal a broken bone with mantra, medicinal oil, and bamboo splints
khwam chuea thue sattha faith-related trust
khwan the abstract part of a human being that maintains the will power of a person and brings about prosperity and well being in life
kimichat pathogenic worms or parasites in the body
kin phit eating improper foods
klin chun a stinky odor
klin khao a fishy odor
kratung khai pushing out fever
kratung phit khai pushing out febrile toxin
lom phit duean postpartum syndrome, a syndrome that often occurs in mothers after childbirth when they ingest improper foods or smell the wrong odors
luang pho the title that Thai people confer on elderly monks
ma khi spirit mediums
mae chang midwives
maha amnat barami bringing great power
maheng tum fai a chronic skin disease with vesicles
mahok lueat internal hemorrhoid
mantra a word or phrase repeated by a priest, healer, or a person who performs a ritual and other religious practices
mara a devil
mareng chronic sore
metta maha niyom (regarding a charm) the effect of making other persons fall in love with the wearer or for the wearer to become popular among others
mit mo the healer’s knife
mo kae khun sai a healer who corrects black magic
muat ban domestic division
muat mueang fai irrigation division
muat wat religious division
muttakhuet a disease category comparable to that of venereal disease or sexually transmitted diseases in biomedicine
naksat the twelve year animal cycle
nam pu a popular fermented food made from local crabs
nan a person who was once a monk
nang prok sitting in meditation
ngan khuang phaya the Northern healing wisdom festival
ngan poi luang a communal event to celebrate the inauguration of a new structure of a Buddhist temple
ngu sawat literally snake blow, or herpes zoster
Glossary

noi  a person who has been ordained as a novice

Orahant  a Buddhist saint

Orahant khao sing  a person who is inhabited by a Buddhist saint

pat khrro  wiping out misfortune

pen tum pen huean  leprosy with pustules

pha bangsukun  sets of readymade dresses that the Buddhists offer to monks

Phaya Wan Day  the start of the Northern New Year event, which falls on April 15th

pha yan  pieces of sacred cloth inscribed with various symbols and ancient alphabets arranged in different patterns

phansa  Buddhist lent

phaya  intellectual, insightful, and deep existential understanding

phaya in  the chief of angels

phi ba  a person who becomes possessed by an evil spirit

phi chao ban  the house guardian spirit

phi chao nai  spirits of late local rulers who were heroes or well respected

phi fai  spirits that guard the dikes

phi ka  persons accused of being ancestral spirits of the maternal lineage that have become malevolent

phi khun nam  spirits that guard water from the mountains

phi phrai  the spirit of a woman who has died during childbirth, which haunts a weak person in order to eat the raw meat or internal organs of the host

phi pu ya  ancestral spirits that protect and govern the descendants of the maternal lineage

phi suea ban  the village guardian spirit

phi suea wat  the temple guardian spirit

phithi hae mai kam  the rite for a procession of tree props

phithi suat bangsukun dip  the rite for a person assumed to be dead to extend his/her fate

phithi wai khru  the ritual of paying one’s respects to the spirit of the healer teachers

phra khrueang  small images of the Buddha or a Buddhist monk made from metal or other materials

phra that  relics of the Buddha or Buddhist saints

phrai  evil spirit

phrai ban  ordinary villagers

phrai mueang  people living in towns

phrom  noble beings in the high heaven

phum  the capability of the body to tolerate pathogens, allergic agents, and toxic agents

phum khum kan rok  immunity

pi mai mueang  the Northern New Year event

pradong  skin disease with hot itching
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>prap that</td>
<td>normalizing the inner elements of the body</td>
</tr>
<tr>
<td>prasa phew phai nok</td>
<td>externally applying a decoction</td>
</tr>
<tr>
<td>punnakiriya-vatthu</td>
<td>the three bases of meritorious action</td>
</tr>
<tr>
<td>raksarok</td>
<td>curing diseases</td>
</tr>
<tr>
<td>rap chok (lap)</td>
<td>bringing good luck</td>
</tr>
<tr>
<td>ritsiduang</td>
<td>the name for the category of diseases that all have protruding tissues in common</td>
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<tr>
<td>ritsiduang chamuk</td>
<td>ritsiduang in the nose</td>
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<tr>
<td>ritsiduang ta</td>
<td>trachoma</td>
</tr>
<tr>
<td>ritsiduang thawan</td>
<td>hemorrhoid</td>
</tr>
<tr>
<td>rot man</td>
<td>a fatty taste</td>
</tr>
<tr>
<td>rot nam mon</td>
<td>sprinkling holy water</td>
</tr>
<tr>
<td>ru khun</td>
<td>recognizing the virtue of the giver</td>
</tr>
<tr>
<td>sado khro</td>
<td>diminishing khro</td>
</tr>
<tr>
<td>samathithan</td>
<td>meditation of the nine bases</td>
</tr>
<tr>
<td>samsara</td>
<td>the repeating cycle of birth, life, death, and rebirth</td>
</tr>
<tr>
<td>san</td>
<td>cancer</td>
</tr>
<tr>
<td>san khanthamala</td>
<td>a sort of san disease that develops in the form of lumps along the tendons of the neck</td>
</tr>
<tr>
<td>sang (khang)</td>
<td>a local disease concept based on the assumption that every infant has an innate possibility to fall ill from a specific disease depending upon his/her day of birth</td>
</tr>
<tr>
<td>sak muek</td>
<td>a traditional practice to make a tattoo, which is believed to make the skin impenetrable and invulnerable</td>
</tr>
<tr>
<td>sang nam</td>
<td>water sang</td>
</tr>
<tr>
<td>Sangkha khun</td>
<td>the virtue of the community of Buddhist monks</td>
</tr>
<tr>
<td>santathat</td>
<td>the name of a pathogenic worm in a child born on Monday</td>
</tr>
<tr>
<td>sap phit</td>
<td>smelling the wrong odors</td>
</tr>
<tr>
<td>sek khatha</td>
<td>chanting the sacred words</td>
</tr>
<tr>
<td>sita</td>
<td>observing the precepts or codes of moral conduct</td>
</tr>
<tr>
<td>song khro</td>
<td>the ritual to send away bad things after a person has experienced a bad situation that leads to unexpected results</td>
</tr>
<tr>
<td>song nam phra that</td>
<td>sprinkling water on the Buddha’s relics</td>
</tr>
<tr>
<td>song pu ya thaen</td>
<td>sending offerings to the Sky God</td>
</tr>
<tr>
<td>suep chata</td>
<td>extending fate</td>
</tr>
<tr>
<td>suma kaeo thang sam</td>
<td>asking for forgiveness from the three gems of Buddhism, namely the Buddha, the Buddha’s teachings, and the community of Buddhist monks</td>
</tr>
<tr>
<td>takrut</td>
<td>a kind of amulet made of metal sheets rolled in a tubular shape</td>
</tr>
<tr>
<td>tan chon</td>
<td>the result of changes in a child’s diet after the sang period</td>
</tr>
<tr>
<td>tan khan khao</td>
<td>offering food to ancestors and the dead who used to be enemies</td>
</tr>
</tbody>
</table>
Tan Khao Mai Day
- the full moon day of the fourth month when the in-season rice has already been harvested

Tap khaeng
- cirrhosis

Thaen
- the Sky God in heaven

Tham bun
- merit making

That
- the basic element according to Buddhism

That din
- the element of earth

That fai
- the element of fire

That lom
- the element of wind

That nam
- the element of water

Thep
- angels

Thet maha wibak
- a particular sermon regarding the story of a frugal millionaire suffering in hell

Tnehada
- angels

Thon khet
- withdrawing khuet

Thot pha pa
- a religious event held to offer essential necessities to monks

Thu nam phihat satcha
- the royal ceremony of the Oath of Allegiance

To chata
- extending one’s fate

Tok sen
- a physical treatment of tapping away tension in muscles and tendons with special wooden instruments

Top thaeen bun khun
- rewarding the virtue of the giver

Trai lakkhana
- the three signs, namely impermanence (anicca), state of conflict (dukkha), and not-self (anatta)

Tu chao
- the term that villagers in Northern Thailand use to address Buddhist monks

Wihan
- the building within a temple complex where the Buddha image is located

Ya anantakrailat
- the drug of the eternity of Krailat mountain

Ya ayu watthana wiset
- the special drug for rejuvenation

Ya bamrung lueat
- the drug to nourish blood

Ya bamrung rang kai
- the drug to nourish the body

Ya benchakun
- the drug to nourish the four inner elements

Ya chakkrawan fa khrop
- the drug of the heaven of the universe

Ya daeng luang
- the red drug to treat fever

Ya daeng luang phama
- the great red Burmese drug

Ya daeng noi
- the drug to treat headache

Ya dam
- literally black medicine, the drug to normalize blood and wind and treat skin papules

Ya fok lueat
- the drug to cleanse blood

Ya fon
- ground or crushed medicine
ya hanuman chong: the drug of Hanuman taking the road and closing the ocean
thanon pit samut: the drug of Hanuman taking the road and closing the ocean
ya pit pak luang: the great drug to excrete poison
ya prap that: the drug to normalize the inner elements of the body
ya kae chuea ra: the drug to cure fungal infection
ya kae ha ton: the drug comprised of five plants
ya kae kin phit: the drug to treat dizziness and diarrhea from ingesting improper food
ya kae lueat phikan: the drug for treating blood dysfunctions
ya kae puat hua: the drug to cure headache
ya kaew ha duang: a drug comprised of five valuable roots
ya kamlang ratchasi: the fabulous lion power drug
ya kha chuea: the anti germ drug
ya kha chuea neung: the anti germ drug number one
ya kha chuea song: the anti germ drug number two
ya khang lueat: the drug to cure blood khang
ya khap chuea: the drug to excrete germs
ya khap phit: the drug to purge toxin
ya khiao maha phrom yai: the great Brahma green drug
ya lom 80: the drug for eighty wind diseases
ya lom chiang tung: the Chiang Tung drug to treat wind disease
ya lom phit duean phama: the Burmese drug to treat disorders after childbirth
ya lueang wayo phinat: the yellow drug that destroys wind
ya narai prasit: the drug that gets its power from Narai, a Brahmin god
ya phra in-suan: the drug offered by I-suan
ya phutthachaiya: the winning Buddha drug
ya prap chomphuthawip: the drug that subjugates everything in the Indian subcontinent
ya sa lueat: the drug to cleanse blood
ya sang lueat: the drug to create blood
ya sang nam lueang: the drug to create lymph
ya thai: the purgative drug
ya thai khang: the drug to purge khang
ya that: the drug to normalize the inner elements
ya thip rot: the divine tasting drug
ya tom pot: the drug to treat lung infection
ya wiset langka: the special drug from Sri Lanka
ya yen: cold drugs
yam khang: a massage in which a healer warms his feet on hot charcoal before pressing them on a client’s body
yan: mystic symbols inscribed on cloth, paper, leather, or metal sheet, appearing in the form of lines, tables, ancient alphabets, and numbers; always used in Thai amulets
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The methods developed by biomedical science to evaluate the outcome of healing have been criticized as inadequate for application to other healing traditions. In particular, they are accused of ignoring what practitioners in other traditions consider essential for an effective outcome. By analyzing the role of local healing in dealing with the HIV/AIDS epidemic in Northern Thailand, the research presented in this book explores the possibility of assessing the effectiveness of traditional healing by taking the considerations of healers and the experiences of patients into account.

The overall objective of this research was to explain the recent revival of local healing in Northern Thailand and how this kind of healing has survived and been adapted over time to serve the needs of local people. The main research questions were: (1) How is local healing practiced by healers and patients in resolving health problems related to HIV and AIDS in local communities? (2) What are the perspectives of local healers and patients on the effectiveness of local healing? (3) Based on the answers to the above two questions, how can clinical research that is appropriate to local healing be conducted?

The fieldwork was ethnographic in character. It was carried out mainly in Chiang Mai, Northern Thailand, from February 2008 to May 2009. It focused on four selected local healers in Chiang Mai with experience in treating HIV/AIDS patients since the outbreak of the HIV/AIDS epidemic in the 1990s. Participant observation, in depth interviews, and focus group discussions were the three main techniques used to collect the data. Thirteen patients from three of the healers were willing to be interviewed. In addition, twenty-two other HIV positive persons, who were not patients of the local healers, were interviewed.

The healing practices of local healers and their patients become meaningful when they are understood within the framework that structures their local world – a framework that consists of traditional medical knowledge, local cosmology, and local morality. Despite changes in the social context, these core components of the local world have been maintained, reproduced, and adapted. Furthermore, they fertilize the legitimizing context that nurtures and supports local healers, and they influence strongly the perspective of healers and patients on the effectiveness of healing.

When local communities in Northern Thailand came under threat from the new life threatening disease of AIDS, the healers in this study sought to respond. First, they gathered a variety of information from both the local formal health authorities and villagers in the community. Then they turned to their medical scriptures and the knowledge that had been orally transmitted to them by their ancestors to search for answers and possible remedies. They conducted trials of the medicines that they had identified as potentially beneficial and developed explanations of the disease. Assessment of effectiveness was conducted throughout the healing process.

This research affirms that both healers and patients may view effective healing in a way that differs from the definitions used in biomedicine. The healers and their patients consider healing effective when the following five indicators are apparent: (1) a patient has an inner sense of a positive initial outcome; (2) there is recovery from the symptoms of illness; (3) a patient’s overall appearance improves; (4) a patient is able to tolerate forbidden foods
that once worsened the illness; and (5) a patient is once again able to undertake daily life activities. This can be achieved by means of symptomatic treatment, normalization of the inner elements of the body, excretion of toxin, dietary control, leading a proper lifestyle, and detachment from suffering.

The influence of biomedicine has shaped the practices of healers; for example, in their dealings with germs. The way in which healers and patients evaluate the healing outcome, however, is less concerned with the existence of germs than with a patient’s quality of life and ability to restore daily life activities. Furthermore, the healers assume that the effectiveness of healing results more from a normalization of the functioning of inner elements of the body rather than from an increase in CD4 cells. This is because the inner elements of the body can be related to local disease theory, while CD4 cells are incompatible with this theory.

Disease explanations based on local disease theory and the positive outcome of healing have facilitated the change in meaning of HIV/AIDS from a fatal into a treatable disease. The meanings that villagers attribute to healers and the healing setting are also part of this transformation process. Finally, these changes have led to the resolution of certain HIV/AIDS-related social conflicts in the community. The effectiveness of local healing is, therefore, related to the meanings that patients attribute to their sickness, to the healer, and to the healing setting, and it can even be extended to the social realm.

Local cosmology conveys the meaningful practices of healers and patients and strengthens the symbolic power of medicines. This power is generated by relating medicines to the supernatural supremacy of sacred entities and the healer teachers in local cosmology. It can be called up by a healer who follows the proper moral conduct when he acts as a medium to channel this healing power. This research found that only persons who shared the same local world with the healer were sensitive to this power.

Moral elements, such as compassion, faith-related trust, the power of virtue, and merit, can enhance the effectiveness of local healing. Compassion enables the healer to perform meritorious healing. Trust promotes faithful confidence and compliance, and assures patients that the healer will do his best to cure their illness and not trade his services for money. The power of virtue – the external force from the sacred world – can protect the patient from bad things and the malevolent forces of evil spirits that are believed to cause sickness; it also provides power to medicines, making them more potent. Merit – the result of good karmic actions – extends the capability of the healer to protect and care for his family and patients, and is also supposed to extend the life of a patient facing a life threatening disease.

The effectiveness of local healing can also be considered in terms of its success in helping patients keep their HIV status secret from others. This is made possible through the capacity of healers to adjust their healing to serve the needs of the patient. The widespread use of mobile phones has made this flexibility in healing even greater. It has also facilitated access to local healing from a distance. Moreover, the fact that traditional drugs have no obvious and identifiable physical side effects help patients to keep their illness secret, since a change in body appearance, as is often caused by antiretroviral drugs (ARVs), may raise suspicions among those in their environment.
In sum, this research argues that the effectiveness of local healing is evaluated in terms that are inseparably embedded within local disease theory, local cosmology, and local morality. Local healing has the capacity to be successful when it is conducted in the following ways. First, it should perform the right methods to correct a disorder corresponding to its cause in local disease theory. Second, throughout the healing process the healer and patient should conduct themselves properly with regard to the sacred things in local cosmology. Third, the healing should be conducted in accordance with the moral elements that are needed for meritorious healing. Lastly, the healing should be adapted to serve the needs of patients who have a choice of alternative forms of health care and who live in a changing society.

This research points out that in terms of evaluating the effectiveness of local healing, there is a gap between what is constructed in conventional biomedical clinical trials and what is expected as an appropriate clinical study from the point of view of local healers. This gap results from the reductionist characteristic of clinical trials, which is in conflict with the nature of local healing; from the unequal power relations between biomedical staff and local healers; and from the ultimate intentions of the research, which in the case of clinical trials is to find effective treatments that can be separated from the identity of the healer and his particular healing practice and thus independently reproduced and commoditized, an outcome that is in conflict with local healers’ values.

Before conducting an appropriate clinical study on the effectiveness of local healing, a basic initial study should be carried out as a first step, in order to clarify and verify the local disease theory regarding the disease under study. Evaluation methods should also include: (1) evaluation of the entire traditional care package rather than only the medicines; (2) evaluation of the state of the disease and the healing outcome in each patient, using a range of indicators related to bodily, sensory, and emotional processes, as well as those judged using medical instruments; and (3) evaluation of the patients’ cultural background, and the meaning that patients give to their lives and each element in the healing process. Finally, it is important to stress that the participation of local healers is just as crucial in such a systematic study as the careful selection of biomedical markers and examination of the disease state, and thus the research should ideally be conducted in the practice setting of the local healer.
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De methoden die de biomedische wetenschap ontwikkeld heeft om het resultaat van een behandeling te evalueren zijn volgens sommige auteurs niet altijd geschikt om op andere geneestradities te worden toegepast. In het bijzonder wordt deze methoden verweten dat ze voorbijgaan aan wat de beoefenaren van deze andere tradities zien als een wezenlijk onderdeel van een doeltreffend resultaat. Door de rol van lokaal genezen in de benadering van de AIDS epidemicie in het Noorden van Thailand te analyseren probeert het onderzoek dat in dit boek wordt gepresenteerd de werkzaamheid van traditioneel genezen vast te stellen door rekening te houden met de overwegingen van lokale genezers en de ervaringen van patiënten.

Het algemene doel van dit onderzoek was de recente opleving van lokaal genezen in het Noorden van Thailand te verklaren en na te gaan hoe deze vorm van genezen overleefd heeft en zich in de loop van de tijd heeft aangepast aan de behoeften van de lokale bevolking. De voornaamste onderzoeksvragen waren: (1) Hoe wordt lokaal genezen door genezers en patiënten toegepast bij het oplossen van gezondheidsproblemen met betrekking tot HIV en AIDS in de lokale gemeenschappen? (2) Wat is het perspectief van de lokale genezers en patiënten op de werkzaamheid van lokaal genezen? (3) Hoe kan op basis van de antwoorden op de twee bovengenoemde vragen klinisch onderzoek worden verricht dat afgestemd is op lokaal genezen?

Het veldwerk was etnografisch van aard en werd grotendeels uitgevoerd tussen februari 2008 en mei 2009 in Chiang Mai in het Noorden van Thailand. Het was hoofdzakelijk gericht op vier speciaal geselecteerde lokale genezers in Chiang Mai die ervaring hadden met het behandelen van AIDS-patiënten sinds het uitbreken van de HIV/AIDS epidemicie in de jaren negentig. De drie belangrijkste technieken van dataverzameling waren participerende observatie, diepte-interviews en focusgroep discussies. Dertien patiënten van drie van de genezers waren bereid te worden geïnterviewd. Daarnaast werden twee-en-twintig andere HIV-positieve personen geïnterviewd die geen patiënt waren van een van de lokale genezers.

De genezingspraktijken van de lokale genezers en hun patiënten krijgen betekenis wanneer ze worden begrepen binnen het kader dat structuur geeft aan hun lokale wereld – een kader dat bestaat uit traditionele medische kennis, lokale kosmologie en lokale moraliteit. Ondanks veranderingen in de sociale omgeving bleven deze kernelementen van de lokale wereld consistent gehandhaafd, werden ze gereproduceerd en waar nodig aangepast. Ze bevruchten bovendien de legitimerende omgeving die de lokale genezers voedt en ondersteunt; tegelijkertijd beïnvloeden ze in hoge mate het perspectief van genezers en patiënten op de werkzaamheid van genezen.

Toen de lokale gemeenschappen in het Noorden van Thailand te maken kregen met de gevolgen van de nieuwe levensbedreigende ziekte AIDS, probeerden de in deze studie participerende genezers daarop een antwoord te vinden. Allereerst gingen zij te rade bij de lokale formele gezondheidsautoriteiten en de dorpsbewoners. Vervolgens wendden ze zich voor het vinden van antwoorden en oplossingen tot hun medische schriften en de kennis die mondeling aan hen door hun voorvaderen was overgeleverd. Ze probeerden de medicijnen uit waarvan ze verwachtten dat die mogelijk een heilzame uitwerking zouden hebben en ontwikkelden verklaringen van de ziekte. De effectiviteit van hun genezingspraktijken werd vastgesteld in de loop van het genezingsproces.
Dit onderzoek bevestigt dat zowel genezers als patiënten een perspectief hebben op wat werkzaam genezen is dat verschilt van het perspectief op werkzaamheid dat gebruikt wordt in de biomedische wetenschap. Genezers en patiënten beschouwen de traditionele therapie als werkzaam indien de volgende vijf indicatoren vervuld zijn: (1) een patiënt heeft meteen een innerlijk gevoel van een positieve uitkomst; (2) er is sprake van het verdwijnen van ziektesymptomen; (3) er is een verbetering in het algemene voorkomen van een patiënt; (4) een patiënt is opnieuw in staat voedsel te verdragen dat daarvoor zijn ziekte verergerde; en (5) een patiënt is in staat dagelijkse activiteiten weer ter hand te nemen. Dit alles kan worden bereikt door middel van behandeling van symptomen, normalisatie van het functioneren van lichaamsinwendige elementen, uitscheiding van giftige stoffen, het volgen van een juiste levensstijl en het afstand nemen van lijden.

De praktijk van de genezers is door de biomedische wetenschappen beïnvloed; bijvoorbeeld in de manier waarop genezers over ziektekiemen spreken. De wijze waarop de genezers en de patiënten het onderzoek van het genezen evalueren is echter minder gericht op het voorkomen van ziektekiemen dan op de kwaliteit van het leven van een patiënt en zijn vermogen dagelijkse activiteiten opnieuw in staat te nemen. De genezers nemen bovendien aan dat de werkzaamheid van een therapie meer het resultaat is van een normalisatie van het functioneren van de lichaamsinwendige elementen dan van een toename van CD4 cellen. Dit is mogelijk omdat de lichaamsinwendige elementen met de lokale ziekte-theorie in verband kunnen worden gebracht terwijl CD4 cellen moeilijk met deze theorie te verenigen zijn.

Ziekteverklaringen die gebaseerd zijn op de lokale ziekte-theorie hebben samen met de positieve uitkomst van het genezen een verandering in de hand gewerkt in de betekenis van HIV/AIDS van een fatale in een behandelbare ziekte. De betekenis van de dorpsbewoners toeschrijven aan de genezers en aan de inrichting van het genezen maken eveneens deel uit van het genezingsproces. Deze veranderingen hebben bovendien geleid tot het oplossen van met AIDS samenhangende conflicten in de gemeenschap. De werkzaamheid van lokaal genezen hangt derhalve samen met de betekenis die de patiënten toeschrijven aan hun ziekte, aan de genezer, en aan de inrichting van het genezen en ze kan zich zelfs uitbreiden tot de sociale sfeer.

De betekenis die toegekend wordt aan de praktijken van de genezers en patiënten is onlosmakelijk verbonden met de lokale kosmologie en versterkt de symbolische kracht van de medicijnen. Deze kracht komt tot stand door de medicijnen in verband te brengen met de bovennatuurlijke macht van heilige wezens en de leraar-genezers die deel uitmaken van de lokale kosmologie. Ze kan worden opgeroepen door een genezer die het juiste morele gedrag volgt: dat wil zeggen wanneer hij handelt als een medium dat deze genezende kracht kanaliseert. In dit onderzoek werd geconstateerd dat alleen personen die met de genezer dezelfde lokale wereld gemeen hebben gevoelig zijn voor deze kracht.

Morele elementen zoals medeleven, op geloof gebaseerd vertrouwen, de kracht van deugd en verdienste kunnen de werkzaamheid van het lokale genezen verbeteren. Medeleven stelt de genezer in staat met verdienste – het resultaat van goede handelingen in de zin van karma – te genezen. Vertrouwen in de genezer versterkt het zelfvertrouwen en de bereidheid de
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genezer te volgen. Het overtuigt de patiënten dat de genezer zijn best zal doen hen te genezen en niet zijn diensten aanbiedt in ruil voor geld. De kracht van de deugd – de externe macht vanuit de sacrale wereld – kan de patiënt beschermen tegen slechte zaken en kwaadwillende machten van kwade geesten, waarvan men aannemt dat ze ziekte veroorzaken; het verschilt ook kracht aan de medicijnen en kan die zelfs vergroten. Verdienste vergroot het vermogen van de genezer zijn gezin en patiënten te beschermen en voor hen te zorgen. Verdienste, zo wordt verondersteld, zal eveneens het leven verlengen van een patiënt die geconfronteerd wordt met een levensbedreigende ziekte.

De werkzaamheid van lokaal genezen kan ook bekeken worden vanuit de hulp die ze biedt aan patiënten die de behoefte hebben hun HIV-status geheim te houden voor anderen. Dit wordt mogelijk gemaakt doordat de genezers in staat zijn hun behandeling aan de behoeften van de patiënt aan te passen. Het wijdverspreide gebruik van mobiele telefoons heeft deze flexibiliteit bij het genezen zelfs nog vergroot. Het heeft ook de toegang tot lokaal genezen op afstand vergemakkelijkt. Het feit dat traditionele medicijnen bovendien geen duidelijk zichtbare en herkenbare fysieke neveneffecten hebben helpt patiënten hun ziekte geheim te houden omdat een verandering in lichamelijk voorkomen, zoals vaak veroorzaakt wordt door antiretrovirale (ARVs) medicijnen, wantrouwen bij mensen in hun omgeving kan wekken.

Samenvattend stelt dit onderzoek dat de werkzaamheid van lokaal genezen beoordeeld wordt in onlosmakelijke samenhang met de lokale ziekte-theorie, lokale kosmologie en lokale moraliteit. Lokaal genezen heeft het vermogen succesvol te zijn als het op een van de volgende manieren wordt uitgevoerd. Allereerst moet het om een stoornis te corrigeren methoden gebruiken die gerelateerd zijn aan de oorzaak volgens de lokale ziekte-theorie. Vervolgens moeten tijdens het hele genezingsproces de genezer en de patiënt zich op de juiste wijze gedragen tegenover de heilige elementen in de lokale kosmologie. In de derde plaats moet het genezen worden uitgevoerd in overeenstemming met de morele elementen die voor verdienste-vol genezen vereist zijn. Ten slotte moet het genezen worden aangepast aan de behoeften van de patiënten, die kunnen kiezen uit verschillende vormen van gezondheidszorg en die in een zich veranderende maatschappij leven.

Het onderzoek laat zien dat er vanuit het gezichtspunt van de evaluatie van de werkzaamheid van lokaal genezen een kloof bestaat tussen wat geconstrueerd wordt in de gebruikelijke biomedische klinische experimenten en wat verwacht wordt van een klinische studie die adequaat is in de ogen van de lokale genezers. Deze kloof is het gevolg van het reductionistische karakter van klinische experimenten, dat in strijd is met de aard van lokaal genezen, met de ongelijke machtsrelatie tussen biomedisch personeel en lokale genezers en met de uiteindelijke bedoelingen van het onderzoek, dat in het geval van een klinisch experiment gericht is op het vinden van effectieve behandelingen die van de identiteit van de genezer en zijn bijzondere genezingspraktijk gescheiden kunnen worden en dus onafhankelijk gereproduceerd en verhandeld kunnen worden, een resultaat dat op gespannen voet staat met de waarden van de lokale genezers.

Voordat een adequaat klinisch onderzoek naar de werkzaamheid van lokaal genezen kan worden uitgevoerd, is allereerst een explorerende studie nodig om de lokale ziekte-theorie
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met betrekking tot deze te onderzoeken ziekte te verduidelijken en te verifiëren. De evaluatie moet inhouden: (1) een evaluatie van het gehele traditionele zorgpakket en niet alleen van de gebruikte medicijnen; (2) een evaluatie van het ziektestadium en het resultaat van het genezen bij iedere patiënt aan de hand van een reeks indicatoren die betrekking hebben op zintuiglijke, emotionele en instrumentele processen, maar ook aan de hand van indicatoren die afkomstig zijn van metingen met medische instrumenten; en (3) een evaluatie van de culturele achtergrond van patiënten en de betekenis die de patiënten geven aan hun levens en de verschillende elementen van het genezingsproces. Tot slot is het belangrijk te benadrukken dat de deelname van lokale genezers in een dergelijke systematische studie even essentieel is als de zorgvuldige selectie van biomedische indicatoren en analyse van het ziektestadium. Het onderzoek zou dus idealiter in de praktijk van de locale genezer moeten worden uitgevoerd.
The study presented in this book uses HIV and AIDS as an example to develop a comprehensive understanding of the effectiveness of local healing in Northern Thailand. It is based on the perspectives of both local healers and their patients and sketches the origin and historical development of Northern Thai society and its healing tradition.

The study describes how the local healers formulated their explanations of HIV and AIDS. It presents the healing process as a transformation of various kinds of meaning and introduces different aspects of the meaning attribution by healers and patients to medicines and their effects.

The local moral world is considered as enabling a local healer to continue with his healing practice in a moral way. The desirable effects of this moral healing are addressed in detail.

The limitation of clinical trials and the perspective of local healers on clinical trials is also discussed. The study finally suggests a proper methodology for research on the effectiveness of local healing.

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