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
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 proceeded 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 Phra-osot Phra Narai (King Narai’s Pharmacopeia), Tamra Ya Silacharuek Wat Phrachetuphon (Phrachetuphon Temple’s Medical Inscriptions), Tamra Phaetsat Songkhro (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

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  
2) Mo Somsak Kantimun  
3) Mo Thatchai Thananchai  
4) Mo Pinkaew Tannuan

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 (*phithi 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.