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

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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 groups2 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

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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

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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).
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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.
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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 lakkhana): 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 (khi 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.
Figure 1. Numbers of symptomatic HIV and AIDS patients in Chiang Mai, 1988-2010
Source: Chiang Mai Provincial Public Health Office

Figure 2. Number of HIV and AIDS patients in Chiang Mai who died, 1988-2006
Source: Chiang Mai Provincial Public Health Office

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;
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/mm$^3$. 
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.