Local healing in northern Thailand: An anthropological study of its effectiveness
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Citation for published version (APA):

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Chapter VIII

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

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

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

**Fear of stigmatization**

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

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

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

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

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

**Four case studies**

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

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

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

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

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

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

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

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

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

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

If Ampha would be unable to conceal her illness, she feared that the negative consequences would be serious enough to destroy her social and family life. If the secret of her morally unacceptable behavior was disclosed, it would bring shame to her family. Her daughters’ lives would be affected, since their mother would be perceived as sexually promiscuous. She would be condemned by her husband and would be shunned by her neighbors. The
community would gossip about her. A denial of employment would follow. Such a difficult situation, which might lead to the loss of what matters most to her, was the reason why she refused to have an HIV test and to seek care in the formal health care sector, and why she sought a form of health care that guaranteed confidentiality.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Gender asymmetry

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

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

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

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

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

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

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

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

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

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

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

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

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

**Hospital services and lack of confidentiality**

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

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

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

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

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

Telemedicine

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

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

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

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

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

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

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

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

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

**Telemedicine in the light of tradition**

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

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

It is not only books but also television programs that play a role in enhancing people’s perception of the heterogeneity of the various forms of healing in the country. Such programs convince the public that the local wisdom regarding health that has been passed down through the generations has its own value. For some, its validity has been proven by scientific methods, for others by experience. These representations also transmit the importance of
The ambiguous role of secrecy in health and healing

the value of returning to nature and require that all local healing is free from any synthetic chemical materials. Northern Thai healers appear to the public via television programs in local costumes and with charming accents, and they are often presented as modest persons who are knowledgeable in local wisdom.

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

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

**Health and healing compromised by secrecy**

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

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

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

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

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

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

**Conclusion**

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

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

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

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

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

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

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