

Health and development: knowledge systems and local practice in rural Thailand



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Thus, while all public health campaigns can be defined as altruistic efforts to improve society, some - but not all - can also be defined as efforts by the system to control the locus of change in ways deemed desirable by the change agency.

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Abstract

The specific framing of health within a development context has implications for constructions of wellness and illness and how people react in times of ill health. In Thailand, recent national HIV/AIDS education-prevention campaigns commonly use top-down relay of public health information. This pattern replicates numerous development projects that aim to bring useful and beneficial knowledge to rural villagers. How villagers integrate this information depends, in part, on previous experiences with development programs in general and public health programs in particular. This paper considers the political economy of medical knowledge and multiple local health strategies in rural Northeast Thailand as a background to the contingent response to public health directives.

HIV/AIDS has urgently focused a spotlight on sexuality and sexual practice in societies all over the world. Social attitudes to illness and generalized health-seeking behaviour have received less attention as factors that influence education and prevention programs. In this paper, I explore the political economy of medical knowledge in rural Northeast Thailand (Isan) using data from two villages, Don Han and Baan Khem, in Khon Kaen province.¹ The intention is to provide a background to understanding how people respond to public health campaigns of which HIV/AIDS education is a recent high-profile example. This paper is not about HIV/AIDS transmission nor prevention campaigns *per se* but rather about the forms of knowledge Isan villagers have at their disposal when health issues are evoked.²

National health education campaigns in developing countries commonly follow patterns dictated by generic top-down development programs, that is, they provide information and the template for a course of action and people, it is assumed, will respond in the desired fashion. Frequently funding stipulations by international development agencies encourage

¹Ethnographic fieldwork was conducted in Khon Kaen for 18 months between 1991 and 1992 during which time I, and a research assistant, lived in each village for seven months. Data has were collected by participant observation, in-depth interviews and questionnaires. Both villages, whose names I have changed in this article, were roughly 35 km outside the provincial capital, had similar populations of around 900 and consisted of 148 and 194 households respectively. Research methodology is discussed in detail in Lyttleton 1994a.

²For a more detailed consideration of specific responses to the increasing presence of HIV and campaigns to prevent its spread in rural Northeast see Lyttleton 1994a,b, 1995b.

formula-driven program operations (Foster 1987; Escobar 1988). As has been widely documented, top-down development policies are not always effective. Since the early 1960s, Thailand has had numerous development projects many of which have been incorporated into successive Five Year Plans. In a wide-ranging study of Thai values and behaviour patterns, Suntaree comments on the frequent failure of these projects:

Take for example, in the Northeastern region which is the poorest and most arid region of Thailand, the peasants perceived water resources as their first priority development need, the government officials perceived public health as top priority, and so forth. It is evident that even the local government officials who were close to the reality, still showed a differential perception, let alone those development policy makers in Bangkok, who hardly set their foot in the rural community. It is therefore understandable, when asked about the impact of development projects, whether development projects have reached the village community, and whether they were congruent with what the peasants need, the results show about 40% replied that development projects did reach the community but were not needed (Suntaree 1990:240).

For decades, villagers in Thailand have been recipients of organized injunctions suggesting that by following instructions their lives will 'improve'. Primary Health Care policies adopted since the 1980s advocate local community participation but the entrenched bureaucracy hinders comprehensive involvement in the alleviation of social and economic factors aggravating morbidity. After 30 years of development programs, Isan villagers remain the poorest and least healthy in Thailand.³ There are in Thailand several hundred non-government organizations (NGOs) many of which have also attempted to shift the locus of control of 'quality of life' to individual communities. Many of these work in rural development with an operating premise more firmly embedded in notions of participatory politics than the top-down government programs. But from either perspective, Isan villagers are frequently the target subjects of planned change and they are thoroughly familiar with receiving guidelines for how to behave.

While small locally based organizations are playing an ever-increasing role in community awareness and support programs, the primary sources of HIV/AIDS knowledge in rural Thailand⁴ have been messages from the Ministry of Public Health and the Population and Development Association, a large NGO which uses the Ministry of Interior as the conduit of information. Much of the material sent through either the mass media or the government bureaucratic channels is in a medical framework. While a burgeoning discourse on morality, and HIV as a threat to the nuclear family, has informed more recent campaign material, for the large part HIV/AIDS has invariably been depicted as a health problem, a threat to life. Medical officials are presented as those who have the necessary knowledge to alert the Thai populace to the problem AIDS poses to society.

The influence of public health campaign material cannot be isolated from the continuing dynamic of village-state interaction and, to a large extent, the collective response to current

³A study in 1987 found a correlation between regional wealth disparity and disease rates: the regions with the highest wealth had the best health status, while the Northeast had the highest rates of death and disease (see Cohen 1989:170) See also Proceedings (1991) for many summary statistics that show the Northeast ranking persistently higher than national averages in certain endemic diseases such as pneumonia, dysentery, dengue fever and hepatitis.

⁴Thailand is rapidly urbanizing and has tremendous numbers of seasonal migrants (urban health issues are becoming an increasingly urgent problem), but the large majority of Thailand's 57 million maintain their primary residence in more than 60,000 rural villages.

campaign messages in rural Thailand is a product of previous experience with development projects in general and health programs in particular. Just as the HIV/AIDS campaigns adhere to certain patterns established by previous national development programs, so too, villagers accept new information in a preconditioned manner. At the same time, indigenous concepts of illness and health, and beliefs in the efficacy of institutionalized medical practice shape the reception of details of a new medical threat. Before focusing on health behaviour at the village level I will provide a brief overview of public health developments.

Medical systems in Thailand

The institution of traditional Thai medicine has a long and esteemed presence in Thailand's history. However, over the past 100 years, Western medical practice has become an integral part of systems of diagnosis and treatment in Thailand and over this time has predominated in terms of both government support and local patronage.⁵ Towards the end of the nineteenth century, the adoption of Western medicine was started by the royal family's interest in 'modernizing' indigenous medical practices at a time when cholera epidemics were widespread in Bangkok. The first hospital and medical school, Siriraj, was opened in 1888 and during the first 16 years of operation traditional medicine was phased out of the teaching curriculum to make way for Western methods (Chantana 1989:69). In 1916, Prince Mahidol, the son of King Rama V and father of the present-day monarch King Bhumipol, went to Harvard University to study Public Health and subsequently persuaded the Ford Foundation to assist Thailand to develop a modernized medical program (Muangman 1987:73). The Foundation's advice and funding centred on the advocacy or 'selling' of modern Western medicine rather than training of junior doctors to meet the health needs of the Thai populace (Donaldson 1982:113). Over the first half of this century, the association of Western medicine with scientific knowledge, modernity and royal patronage led to its domination of the traditional Thai medical practice. Cohen notes:

Thus, the history of the Thai medical profession closely parallels the development of medical professions in the West: elitist (in terms of class and status), capitalist, drug oriented, urban centred, and assertive of its dominance over other health practitioners by means of subordination or exclusion (Cohen 1989:165).

At the onset of the Five-Year Development Plans in the early 1960s, the emphasis in government health policy was firmly placed on curative rather than preventive measures (Tawatchai, Ora and Pisamai 1988:2). Epidemic diseases such as cholera and smallpox had virtually been eradicated and the crude death rate had dropped from around 30 per 1,000 before 1950 to 8.2 in 1983 (Apichat and Chintana 1986: 528). The development of a national health institution was primarily encouraged in the cities, particularly the primate centre of Bangkok that still has an overwhelming proportion of doctors and facilities. In the 1960s, health coverage reached only 30 per cent of Thailand's population (Tawatchai et al. 1988:17). Since then, the network of health facilities has been gradually extended across the country,⁶ but research has indicated that the government health service is not heavily patronized. A 1980 study showed that 60 per cent of villagers went to drugstores to treat themselves and

⁵Modern forms of institutionalized medical treatment in Thailand are almost always associated with 'Western medicine' (Riley and Santhart 1974:36).

⁶Despite the establishment of widespread medical facilities and a relatively high national health budget, 5.1% of the total budget (Gohlert 1990:111), the ratio of doctors to local residents still shows huge disparities. For example, in Isan in 1990 there was one doctor to nearly 12,000 people compared with a national average of 1 doctor to 5,000 people (Pichet 1991:141; Suwit 1991:153).

there was a preference for private clinics over government health stations (MOPH 1988:3). Tables 1 and 2 show the increased number of health facilities and summarize a national survey of the rates of patronage.

Table 1
Public health care facilities in 1989

Administrative Division	Health Care Facility	Number	No. of Beds
Bangkok	University hospitals	5	1000-2300
	Institutions	15	150-500
	General hospitals	10	300-1000
Four regions	University hospitals	3	600-1000
	General hospitals	17	500-1000
72 Provinces	General hospitals	72	150-500
735 Districts	Community hospitals	673	10-60
6,754 <i>Tambons</i>	Health centres	7,764	
61,411 Villages	Drug co-operatives	38,744	

Source: Health Planning Division (1990:28).

In conjunction with public hospitals there were, in 1989, 354 private hospitals, 13 traditional medicine hospitals and 5,763 (in 1987) private clinics. These clinics are largely run part-time by government-employed doctors. A Village Drug Co-operative will generally provide certain types of medicine such as paracetamol and oral rehydration salts. In 1989, 64 per cent of villages in Isan had a drug fund (Suwit 1991:157).

Table 2
Utilization of health services (%)

Types of health services	1970	1979	1985
Self-treatment (buy drugs) ^a	51.4	42.3	22.3
Health centres	4.4	16.8	13.3
Government hospitals	11.1	10.0	32.6
Private hospitals and clinics	22.7	20.4	20.8
Traditional healers ^b	7.7	6.2	2.4
VHVs, VHCs	-	-	2.1
None of the above	2.7	4.2	6.3

Source: Department of Family Health (1988:10).

^aSelf-medication has been reported at far higher rates in other studies. For example, a 1988 study of four Northeastern villages both close to and distant from district hospitals found that between 68% and 86% of illness episodes were self-treated by the villagers. In this study traditional healers treated between 0.5% and 3% of cases (Le Grand, Luechai and Stretland 1993:1029). It should be noted that these surveys do not discuss the categories of illness that are self-treated: in some instances, medical diagnoses would doubtless be unnecessary and the purchase of pharmaceuticals or traditional remedies is an appropriate strategy.

^bTraditional medicine in Thailand is multiplex and includes a diverse range of therapeutic practitioners in distinct modes of treatment (see Riley and Santhat 1974) historically linked to major traditions of Ayurvedic and Chinese medicine.

Gradually, as government health services have become more accessible they are becoming more popular. An important drawback is the pharmaceutical drugs dispensed with the consultation, although, despite government attempts to limit the sale of drugs without a prescription, self-medication also remains widespread. Many drugstores throughout Thailand readily sell most types of pharmaceuticals across the counter. Consequently, Thailand has one of the highest pharmaceutical drug consumption rates per capita in the world. This is abetted by persistent and successful advertising by the large drug companies. It is common in rural Thailand for travelling movie shows to screen free movies as hawkers sell a host of different medicines to the assembled audience. Data on drug use have shown that almost 50 per cent of health expenditure is used to buy drugs (Cohen 1989:164). These figures illustrate the extent to which medication is a fundamental component of medical practice and indicate a strongly embedded bias towards curative rather than preventive practice. This is not simply a product of the introduction of Western medicine but also stems from traditional forms of herbal treatment. As Riley and Santhat note, 'Medicines *per se* occupy a pre-eminent place within the Thai medical system (traditional and modern)' (1974:8). Thus, at the same time as attempting to limit self-medication, one of the major underpinnings of primary health care in Thailand has been the provision of essential drugs to all villagers (Office of Primary Health Care 1985).

Primary health care policy

Throughout the 1960s and 1970s, small pilot projects encouraged local participation in health schemes in order to widen the scope and efficiency of health promotion and use of government health services. During this period, the attempt to increase social and economic well-being was strongly influenced by international policy guidelines. In 1976, the Thai Government (RTG) established intense collaboration with the World Health Organization (WHO) through the operation of the RTG/WHO Co-ordinating Committee. Integrated planning was initially considered such a success that a secretariat was created in the early 1980s comprising middle-level Ministry of Public Health and WHO managers to oversee the effective use of WHO resources throughout Thailand.

Primary Health Care (PHC) emerged in the late 1970s as a development philosophy suggesting that health is linked to a range of social and economic factors and not simply an issue of specific morbidity levels (see Walt and Vaughan 1981; Rifkin and Walt 1986). When WHO advocated Primary Health Care as a global strategy, Thailand endorsed it with enthusiasm and the prime minister immediately signed it into policy (MOPH 1988:13). Thailand prides itself on being the first country to specifically organize a seminar on PHC only four weeks after WHO's inaugural Alma Ata charter in 1978. Some suggest that PHC was incorporated into national planning in response to the growing awareness that top-down development policies were, in fact, lowering the health status of the rural population by widening income gaps and increasing the dependence of the poor on central government support (Tawatchai et al. 1988:1). Cohen, however, argues that the Thai medical profession remains strongly tied to the capitalist sector and PHC policy was adopted as a result of pressure from both international agencies and prominent (albeit the minority) 'advocates of a rural oriented health policy' (Cohen 1989:159). And as Krasae notes, international direction is not always particularly helpful:

Likewise in many health development projects (both government and non-governmental) where international funding agencies must be given immediate proof of 'success', the aim is usually towards short-term gains (outputs), i.e., quick increases using one or several evaluation techniques to measure changes in health status or levels of social development. These though are often conducted at the expense of long-term growth, i.e., ensured

partnerships between the parties involved. Hence, while changes may be made their sustainability is in great doubt (Krasae 1990:100).

In the Fifth Five-Year Plan (1982-1986), bottom-up planning from the village and subdistrict level was encouraged in order to attack poverty more effectively. The National Rural Development Project and the Social Development Project were intended to do this through a process of intersectoral planning. Four key ministries, Interior, Education, Health and Agriculture were to co-operate in planning at various levels, national, provincial and district. Thailand's sprawling bureaucracy, however, has not been noted for its success in horizontal co-operation and planning. The Ministry of Public Health itself comments:

In a country which has a long history of centralised government with an administrative machinery empowered by the legalised role and function of civil servants like Thailand, there are always difficulties in pursuing the decentralisation of government participation and achieving the required community participation for development activities (MOPH 1988:39).

In recognition of the need for a clearly defined strategy, the Basic Minimum Needs approach, alternatively called the 'Quality of Life' program, was adopted to determine and guide multisectoral village-level programming. Hand-in-hand with a shift in global planning from WHO and UNICEF, the Thai government felt that the establishment of concrete criteria was the best way to achieve primary health care goals.⁷ Integrating health care with a wider level of rural development, the Thai government vigorously promoted essential elements of primary health care in the villages: health education, nutrition, Mother and Child Health (including Family Planning), safe water supply and sanitation, immunization, prevention and control of locally endemic diseases, and provision of essential drugs (Damrong 1987:27).

As a core aspect of primary health care philosophy, local self-management has been encouraged through the recruitment of Village Health Workers, called volunteers (VHV) and communicators (VHC), to supervise these projects (see Bender and Pitkin 1987). Not only are village health workers identified as key resource people, but, in conjunction with the Basic Minimum Needs strategy, the Ministry of Public Health-WHO collaboration linked the village community to the national PHC system through these volunteers. In 1982, the Office of the Primary Health Care was established as a division under the Office of Permanent Secretary, Ministry of Public Health. Subsequently regional centres were established in the four regions to undertake supervision and training of provincial, district and village health workers. By 1990, virtually all the villages in Thailand had some members trained to assume the liaison role between national public health initiatives and the village community. Various schemes of community-financing have also been organized in a large number of villages. Certain village co-operative organizations, such as drug co-operatives, rice banks, health card funds and fertilizer funds were founded with seeding money from various arms of the Government ministries.

Table 3 lists the recorded accomplishments of the National Primary Health Care program.

At the same time as village networks and co-operatives were being established, more health facilities were built. Since the 1980s, the *tambon* (subdistrict) health centre has become the nexus of government-village interaction (Chaichana 1990). At present, there is more than one health centre for every ten villages in Thailand. These health centres are

⁷There remains a continuing debate on whether the logistic strategies advocated within this development paradigm are an effective concentration of resources or a surrender to dominant biomedical perspectives (see *Social Science and Medicine* 1988).

usually staffed by at least two paraprofessionals, graduates of a Public Health College. It is from here that the various government health programs are initiated at the village level through both technical support and supervision.

Table 3
PHC project achievements

Activities	1982-1986	1977-1989
Training of VHCs	287,138	588,737
Training of VHVs	30,457	64,182
No. of village co-ops	23,216	38,744
No. of nutrition funds	24,450	24,450 ^a
No. of sanitation funds	11,950	11,950 ^a
No. of health card funds	15,961	15,961 ^a

Notes: ^afrom 1986 data. Source: Health Planning Division (1990:32)

Village-state interaction in public health

A key principle of primary health care is that government services are to provide learning opportunities to villagers (MOPH 1988:17) in the establishment of co-operative funds and the training of village health volunteers. As a health strategy this is, therefore, based fundamentally on effective communication between officials and villagers. Not all assessments of this approach are glowing, however, as Gohlert reviews the evolution of PHC as a development strategy:

The principal challenge was how to induce government officials, particularly at the provincial level, to adopt new attitudes and acquire new skills...The principal lesson regarding government development programs concerns the inevitable and pervasive influence of bureaucracy. Its unwillingness or inability to go along, in this case, is symptomatic of bureaucratic behaviour in general. At issue is the bureaucratic mindset, which resists change even if it might ultimately enhance the effectiveness and, thus, the power of government officials themselves. Unsurprisingly, the 'Quality of Life' campaign under government auspices has not been as successful as anticipated - or hoped for (Gohlert 1990:52-53).

It has been suggested that since the inception of the Five-Year development plans, the Thai State, that is, the government bureaucracy, perceived itself as the 'patron' of the Thai people (Chantana 1989: 124). In this view,

The relationship between state and society is seen as 'the state above the society' rather than 'the society above the state'. To elaborate, in general, according to the evolution of Thai social history, the state and its apparatus, be it military power or ideology, not the societal thrust, have dominated and determined social change (Chai-anan Samudavanij quoted in Chantana 1989:124).

Aside from providing basic and essential health services, rural development and the extension of public health facilities can also be considered from the perspective of a government apparatus expanding into the smallest units of society, the villages (cf. Chairat 1988). When coupled with attempts to elicit popular participation as espoused in the more

recent Five-Year Plans and evident in the PHC programs, the result is that 'people are bombarded by the number of group-activities belonging to different ministries' (Chantana 1989:146).

Furthermore, villagers' participation is controlled and monitored in these programs so that participation is, in reality, simply the nominal enlistment of villagers into development projects. Hirsch, writing of rural development in Central Thailand villages, notes:

Yet supposed vehicles of 'popular participation' - sub-district and village councils, village meetings, training programs, and 'development days' - serve to legitimate state intervention in village affairs rather than articulate community interests (quoted in Cohen 1989:172).

Despite the lack of any real village-level control of the nature and implementation of health projects, some government programs have, by all objective criteria, been noticeably successful. The first was the success of the family planning program. Thailand is often cited as a glowing case study of successful health promotion. In 1987, the population growth rate was 1.5 per cent per year compared with over three per cent in 1970. As the frontispiece of a USAID publication report on Thailand's Family Planning notes:

In just two decades, the total fertility rate in Thailand has dropped from over six children to just above two. The achievement is remarkable. That Thailand has achieved replacement fertility, and so rapidly, makes her unique among developing countries (Bennett et al. 1990:1).

While this report notes that it has been unable to establish why, in particular, the demand for family planning was so strong in Thailand 'at least a generation before modern contraception was available' (Bennett et al. 1990:67), it is certain that women's readiness to adopt methods for limiting family size was essential to the program's success. When the Ministry of Public Health began the National Family Planning Program in 1970 after nearly a decade of testing strategies, various factors contributed to its rapid acceptance by a huge percentage of Thai families. On the one hand, the Thai government readily acknowledged the World Bank's argument that economic development was tied to population control and, therefore, enthusiastically mobilized national programs through the Ministry. On the other hand, a ready supply of overseas funding was available to implement infrastructure development and personnel training. The growing Public Health infrastructure, assisted by the rapidly improving communications networks, especially the rural road coverage during the Vietnam War, made facilities and contraception available to the entire population by the early 1980s.

Coupled with this institutional expansion, the decision to allow paramedics, many of whom are women, to distribute pills, IUDs and injectables, significantly increased acceptance. Mass-media programs⁸ and several key individuals in government and private sectors further contributed to the successful implementation of this particular health program. Of these, Mechai Viravaidya, the head of the Population and Community Development Association, stands out as the charismatic spokesman associated nationally and internationally with his private-sector programs⁹ to raise awareness of family planning.

⁸Throughout the 1970s, music and drama programs were aired nationally. As with the HIV/AIDS campaigns that were to follow 15 years later, surveys have shown that radio and television were the predominant sources of contraceptive knowledge during this period (Bennett et al. 1990:53).

⁹The Population and Development Association established a network of centres throughout Thailand to complement the MOPH programs. Innovative incentive programs were tested in several target

A second example of a nominally successful program was that which addressed nutritional disorders prevalent amongst the rural children. As with many other health programs, policy was developed in conjunction with international assistance, in this case, with design and financial support provided by UNICEF. The nutrition program adopted within the Fifth Plan (1982-1986) was termed the 'Nutrition in PHC program'. The program espoused the goal of reducing malnutrition to a level of not more than two per cent of infants and preschool children, and proposed that by 1991, 92 per cent of all school children would receive necessary nutrients (Health Planning Division 1990:19). To this end, subdistrict-level health workers mobilize the village health workers to conduct tri-monthly weighing of the village children under five years of age. Between 1982 and 1990 children registering a normal weight for age steadily increased from 49 to 81 per cent. In 1990, Isan reported that 75 per cent of more than one million children weighed were within the normal range (Chaanchai and Suwat 1991:34-35). The program has encouraged giving nutritional supplements to underweight infants, that is, those classified as suffering second and third degree malnutrition. A nutrition fund has been established in many villages to work in collaboration with other village development projects to provide a source of high-protein food (ostensibly seed money for such crops as beans and sesame) and food supplements to all the malnourished children under five years old (MOPH 1988:64).¹⁰

In many instances, rather than promoting the cultivation of local high-protein crops the nutrition program has instead inculcated the idea that bought products can solve problems. So well, in fact, has milk formula been marketed that by 1992, the international year of the Mother and Child, local medical officers were attempting to re-instil the idea in new mothers that breastfeeding is of more benefit to the baby than canned milk. The reliance on formula infant food is further evidence of a well-entrenched appetite for pharmaceutical remedies.

NGOs and village development

Despite the Ministry of Public Health reports citing statistics of improvements in the key categories earmarked as basic criteria, critics point to prevailing inequities in distribution of goods and services:

Providing quality health care has thus far been mainly a matter of public policy pronouncements rather than policy implementation. ...Major responsibility for this inequity is placed on the government bureaucracy which is viewed as a conservative force monopolising authority and resources. The mentality of government officials is seen as that of rulers who are firmly in charge. Furthermore, presumably no serious efforts have been made to reform the system (Gohlert 1990:111).

The lip-service given to fundamental societal development fuelled by primary health care programs is sometimes no more than the manipulation of statistics that shroud the enduring factors that promote ill-health, as the poverty figures from rural Thailand attest: in 1989, with

provinces. See Weeden et al. (1986) for a review of one such program where community-level cash loan incentives from a village fund were tied to contraception acceptance.

¹⁰While the recorded data cited above show marked nutritional improvements it would be wrong to assume these programs work smoothly in every case. In some villages with which I am familiar, the extent to which there was efficient monitoring of birth weight depended largely on the enthusiasm of the local *tambon* health officer. Some village women avoided the weighing sessions because they felt they were too meddling and critical if their children were underweight. In Don Han and Baan Khem every few months there is an organized school lunch prepared by the health volunteers: given its infrequency, it is unlikely that it contributes substantially to the nutritional intake of the children.

over a third of the population, Isan contributed just 13 per cent to the Gross Domestic Product (Hewison and Thongyou 1993:7). For several decades, various non-government organizations throughout Thailand have made attempts to generate more fundamental changes to social and political systems. In Thailand, there are some 200-300 NGOs which have set up operations in the past 15 years and these range in size, philosophy and scope of action. While some more actively challenge the dominant ideology than others, frequently activities are undertaken as correctives to what is perceived as inappropriate government policy. Health is usually considered within the broad perspective of integrated community development and, at face value, this is very similar to the goals of the government PHC program. But, as Cohen suggests, while espousing similar 'health for all' goals, operations unfold differently. In essence, the bureaucratic functioning of government projects 'manifests itself in a paternalistic and anti-democratic interpretation of PHC which fundamentally contradicts that of the Thai NGOs' (Cohen 1989:160).

Non-government organizations frequently act as co-ordinating bodies and it is in this capacity that there is some uniformity to their functioning. Virtually all their operations rely on the constant of 'facilitation'; they organize village meetings and the transfer of material and ideological support. In the process of calling for alternative means of development, these organizations' staff do not always avoid inculcating their own set of organized imperatives. Hirsch describes the response of an NGO director, who has become aware of the difficulties in encouraging effective local participation and control over livelihood:

In the context of state-led rural development in Thailand, a key priority for increasing control in this sense is in clarifying the status and function of external developers *vis-a-vis* the local communities. The head of NKYFRD [Don Kha Yang Foundation for Rural Development] says that he would now prefer not to be known as a 'developer', for such a status has become ambiguous and tends to usurp moral responsibility that people have in deciding for themselves. He would rather be seen as an educator leaving it up to people to apply his teaching or otherwise Hirsch (1990:230).

Community organization, while obviously a potent tool for grass-roots change, in the hands of some non-government organizations becomes another hoop the villagers must jump through to receive donor assistance. I am not criticizing their philosophies—many NGOs perform a crucial role in fostering social mobilization—but, from the villager's point of view, the notion of assistance provided from outside, the arrival of 'help', usually involves the concept of planned change. Planned change, in turn, connotes the input of some facilitating contribution either material or structural. Jon Ungphakorn, who has spearheaded several NGO coalitions, comments:

Unlike some other countries, there are practically no development projects in Thailand which attempt to carry out social development alone at the community level, with no material inputs except for the development worker (or catalyst) (quoted in Cohen 1989:172).

Local response to these networks determines the outcome of the projects every bit as much as village reaction to government mandates shapes the results of national programs. Seri Phongpit remarks about the success of two locally developed initiatives:

In the 'champion' cases such as Srakoon and Kiriwong, the villagers are strong enough to make their own decisions. They dare to resist the proposals of the government and the NGOs, if those proposals do not fit with their situation. (Seri 1989:67).

Despite general opposition in philosophy, occasionally government and non-government organizations work together in specific areas. Such co-operation is increasing in response to specific government overtures. Hirsch notes that

while differences in approaches and suspicions remain, many NGOs work directly with state officials such as teachers and health workers. In a move that, at once, makes NGO activity less precarious but also raised the suspicions of many NGO developers, the Government indicated a desire for much closer co-operation between the State and NGO sectors in the Sixth Plan (1987-91) (Hirsch 1990:24).

Joint co-operation has been further formalized by an increased government allocation of funds for NGO projects in the Seventh Five-Year Plan (1992-1996). One case in point is the movement to regenerate interest in and use of traditional healing methods. In the 1970s, several NGOs had begun to rekindle local community-level interest in traditional health-care knowledge.¹¹ In 1983, UNICEF backed a national government program called 'Project for the Development of Traditional Medicine for Primary Health Care' to promote cultivation and use of traditional herbal plants. In contrast to the government focus on the practical availability of traditional medicine, the NGOs sought to reinstate traditional lore and custom involved in health diagnosis (see Seri 1989; Chattip 1991).

Local sources of HIV/AIDS knowledge

The Thai populace has for several years been bombarded with information about the presence of HIV/AIDS. The villages in rural Thailand have, to date, been recipients of blanket top-down information dissemination about HIV/AIDS. Most of this is spread through the mass-media networks but it has been complemented by a steady flow of official documentation through bureaucratic channels, in particular the Ministry of Public Health and to some extent the Ministry of the Interior and the Ministry of Education (see Lyttleton 1995a). Many NGOs are also implementing prevention and education programs but apart from the Population and Development Association their work is generally focused on small target groups primarily in Bangkok and the Northern region. Table 4 reflects the respective concentration of national campaign directives reaching rural villages that are not part of more localized operations. The data and those in subsequent tables were collected from anonymous questionnaires distributed in late 1991 (Don Han) and early 1992 (Baan Khem) to all villagers between the ages of 16 and 60. My intention here is simply to show responses at the village level; further breakdown into sex and age sets shows little variation with the pattern.

Table 4
Sources of HIV/AIDS information (%)

Villagers citing...	Don Han (n=435)	Baan Khem (n=540)
Television or radio	92	88
Doctor or health clinic staff	57	60
Village news broadcast	11	35

¹¹NGOs working with health-related and traditional medicine projects were active in my research area. One NGO, the Northeast Rural Development Program, organized, in 1991, the first meeting for traditional medicine practitioners specifically focusing on HIV/AIDS in the region. Villagers came from seven provinces to a two-day meeting and were addressed by both government and NGO health officials and educators.

Village health worker	16	25
Friends, family or neighbours	12	13

Villagers are increasingly both including AIDS in their personal vocabulary and using it as a metaphor for diseased bodies. During my stay, most described AIDS in abstract terms expressing general fear and dismay at its portrayed virulence but no sense of immediate threat. The metaphorical associations between AIDS and incidences of crop or animal disease are increasing, and the term's blanket application to situations of abnormality appears regularly in everyday village conversation. Informal discourse between family and friends must not be dismissed as a serious contributor of local ideas about HIV/AIDS despite the fact that it is not frequently cited by villagers as a source of information.

In Don Han there are ten health volunteers; in Baan Khem there are twelve. These teams are headed by one member, a Village Health Communicator who receives directives from the Ministry of Public Health chain of command. In keeping with the very strict bureaucratic hierarchy, there is a clear sequence of communication in both directions. Thus, the leader both receives and returns information to the subdistrict health clinic. From both villages, these volunteers said a large part of their time was taken up with fulfilling the seemingly endless appetite of the Ministry for statistics: for example, how many water containers were covered with mesh, and how many households have toilets.

Apart from the occasional district or subdistrict meeting some of these health workers attend, there are also periodic meetings in the village itself that encompass health and other development topics. At these sessions, government officials deliver ecumenical speeches designed to enthuse the villagers about this or that aspect of their lives that the bureaucracies feel needs amendment. At the meetings I attended, the tone was consistently akin to a school lesson. The villagers, who somewhat reluctantly attend, are exhorted to sing bawdy songs and listen to a series of admonitions about their daily lives as they fit into the government conception of Thai society as a whole. The meetings frequently have material relating to the general health of the population. Since 1991 AIDS has begun to appear as messages in these meetings.

The headmen in many Thai villages address the community through an amplifier and loudspeakers mounted on a centrally located tower. This address routinely begins just after dawn, both for personal use by the headman and for broadcasting radio news and cassette tapes. The Village Health Communicators are also able to broadcast details of health issues, but in both villages I was told AIDS was seldom mentioned. More commonly radio news broadcast through this system carries items about AIDS. The headman also receives tapes from the government that he is instructed to play. In the early 1990s, the Population and Development Association organized training sessions for virtually all District Officers and provided media materials intended to be distributed to villages throughout Thailand (PDA 1991). As a case in point, when we met in mid-1992, the District Officer had sent a cassette to 115 of the 123 villages in the district to which Don Han belongs. The headman had received this tape but only played it twice feeling it to be uninteresting to the villagers and only worthy of brief broadcast because of the technical nature of the language. Moreover, he considered broadcasting unnecessary, 'because the villagers already know all about AIDS'.

Dr Thin, at a local clinic, told us that she never tells villagers about AIDS because 'they all know about it, understand it and fear it enough already'. The head of the local hospital near Don Han felt that there was no point approaching the villagers directly because AIDS was not yet a serious threat in the local rural areas. In contrast, the doctor in charge near Baan

Khem felt the threat was indeed large¹² but had not yet organized for information to be taken to the village directly.

In place of locally devised village-level programs, documents, posters and ideas from Bangkok are employed. The few local programs target high schools, brothels and beauty parlours in nearby towns. Sometimes Village Health Volunteers, usually the elected leader and one or two other representatives, are invited to training sessions in the district town or Khon Kaen city; AIDS is discussed and condoms are demonstrated but this information is, according to Health Volunteers in Baan Khem and Don Han, not generally passed on within the village. It appeared that this breakdown occurs for several reasons: the incumbent Communicators or Volunteers are possibly not interested in the subject and assume others are not either (for example, one said she only wanted to hear about children's health, nothing else interested her); the Volunteers might have no communication skills or not be part of influential or dynamic village communication networks (cf. Voradej 1990).

Given the lack of any specific targeted programs, either government or non-government, many villagers explained that when they cited medical authorities as a source of knowledge on the questionnaire this meant having seen posters and stickers that are placed prominently at health clinics and local hospitals. The officer in charge of the AIDS division in Khon Kaen felt the posters were of little effect because of the minimal attention paid to them. But at the same time, there is no doubt that the posters serve to consolidate local village knowledge that there is a health threat newly included in medical discourse, and that there is obvious government desire that people know about it. They are placed alongside posters that have been well inculcated into village conceptions such as warnings of dietary risk. Liver cancer is widely found in Isan where the popular diet of raw fish introduces a liver fluke, that in high levels of infestation causes cancer (see Supraee et al. 1989; Doherty and Posanai 1990). For the past decade the government has mounted large-scale public health campaigns against this disease. In both Don Han and Baan Khem, villagers often compared recent HIV/AIDS campaigning with official attempts to alter local dietary habits. Over the past several years, villagers throughout Isan have been told that what they eat will kill them and evidence is on hand in many Northeast villages as people die slowly from liver cancer.¹³ They are now being told that incautious sex will kill them.

Local patronage of health practitioners

How villagers' health problems are solved by medical institutions, and with what degree of efficacy, will colour the trust with which they accept messages detailing a new threat. Some statistics give an indication of the overall health status of the villagers in the two districts in which I stayed. Tables 5 and 6 show the types of illness most commonly treated by the local district hospitals.

This list is not meant as an absolute summary of morbidity rates as there are various forms of treatment and diagnosis followed by the villagers that do not appear here. It does, however, indicate certain trends. With the exception of tuberculosis, the more debilitating illnesses, pneumonia, malaria, hepatitis and dysentery - are declining. Diarrhoea and undiagnosed fever remain prevalent and form a large proportion of the illnesses for which villagers seek assistance. In contrast to official records, liver fluke ranks highly in local

¹²This district was one of two in the province chosen to send health staff to special training sessions because of the high number of local brothels.

¹³Testing for liver fluke is carried out in both villages by both the MOPH and NGOs. The results are publicly announced and posted, reinforcing both the presence of the disease and the villagers' lack of privacy in the face of bureaucratic control.

conceptions of disease prevalence. In local perceptions, the most common illnesses in the villages were as shown in Table 6.

The villagers have several choices as to the form of treatment they may seek for illnesses. To some extent, such decisions depend on the severity of the ailment, but not always. A small proportion of the villagers will seek local practitioners, either herbalists or spirit healers, for serious sickness but this was typically used as a recourse only after official (government) medical systems have been ineffective. In both villages, most went to hospitals, either locally or in Khon Kaen, in the case of incapacitating illness. Similarly, for more minor ailments Western medicine is the first recourse for the majority of villagers, although many will combine treatments, taking herbal remedies (*yaa samunprai*) in conjunction with pharmaceutical drugs.

Table 5
Rates of illness (number of cases)

Illness	District 1 (Pop. 85,829)			District 2 ^a (Pop. 105,032)		
	1989	1990	1991	1989	1990	1991
Diarrhoea	726	926	747	1721	911	1143
Food poisoning	83	58	15	195	209	104
Dysentery	14	21	12	109	45	42
Fever (unknown)	131	476	526	418	545	600
Pneumonia	174	108	57	396	186	145
Tuberculosis	10	47	66	20	no info	61
Dengue fever	268	82	23	666	166	134
Malaria	11	10	4	19	-	-
Hepatitis	6	4	2	46	13	10
Chickenpox	10	10	9	27	4	10
Measles	4	11	3	46	51	24

Source: Registry, District Hospital in each of the two districts: Don Han is in District 1, Baan Khem in District 2.

^aThe higher figures from District 2 do not necessarily imply a population suffering more morbidity but rather indicate the higher profile the hospital plays in illness treatment and, therefore, the absolute numbers of patients treated.

Table 6
Illnesses considered the most common (questionnaire answers)

Sickness	Don Han	Baan Khem
Cold	166	296
Liver fluke/worms	174	271
Dengue fever	159	151
Diarrhoea	109	148

For a vast range of ailments not considered life-threatening, the first choice the villager makes is whether to simply buy a package of prescription drugs (*yaa chut*) from the village stores or to go for medical diagnosis. Despite government campaigns to eradicate illegal dispensation of drugs, they are freely available in the villages and in the town drugstores for a

few Baht. In Don Han, one shopkeeper would buy bulk quantities of variously coloured and shaped pills from the nearby drugstore and package them in several recommended combinations. I took a sample I collected in Don Han to the Khon Kaen School of Public Health to identify the different drugs. Table 7 shows the different combinations the villagers consume.

I am uncertain of the specific function of several of these drugs, such as eleapropene and prednisolone. Buprofen is an anti-inflammatory painkiller prescribed specifically for arthritis and back-pain, one of the most common afflictions during the planting season. Periacin is an antihistamine and appetite stimulant; Dramamine is an antinausea medication. Dexedrine is an amphetamine which suppresses the appetite and Librium is an anxiety-reducing sedative. These last two appear together in three of the five packages.

Table 7
Pharmaceutical drugs available in the village

Package 1	Package 2	Package 3	Package 4	Package 5
Librium	Librium	Ampicillin	Librium	Dexedrine (3)
Dexedrine	Dexedrine (2)	Decolgen	Dexedrine	Iron
Co-trimax	Buprofen	Periacin	Dramamine	Multi Vitamin
Buprofen	Vit B1	Dramamine	Paracetamol	Vit B1
	Iron	Apracur	Buprofen	Calcium
	Aluminium Gel			Eleapropene
	Prednisolone			

The combination of amphetamines (Dexedrine) and sedatives (Librium) in several of these packages is an addictive and dangerous mix. In package 5, Dexedrine is sold in three different-coloured pills. In Baan Khem, pressure from the local hospital to ban these drugs has made them harder to obtain but one local store still sells them discreetly. The inclusion of addictive substances, amphetamines and sedatives, has made them an immediate and regular aid for many villagers,¹⁴ particularly during the arduous rice-planting months when the number of people who take the time to visit either the government health facilities or the private clinics drops dramatically.

A second alternative is to consult a local village doctor (*mor pu'n baan*). As mentioned previously, these form a wide range of distinct practitioners: in the villages where I stayed there were local spirit or faith healers (*mor lam song*), masseuses (*mor nuat*), traditional herbalists (*mor yaa*), and injection doctors (*mor chiit yaa*). Neither the faith healers nor traditional doctors were frequently consulted and they usually formed an alternative source of aid when Western medicine proved unsuccessful. But 'injection doctors' are a popular alternative to visiting a clinic. In village society, injections are a highly valued means of taking pharmaceutical drugs because of their supposed efficacy in curing illness.

The local 'injection doctor' commonly performs both intravenous and intramuscular injections of medical drugs, vitamins and saline water for villagers. This 'doctor' is usually a villager, or sometimes retired government worker, who has acquired the skill by practice rather than any formal medical training. He (I am not aware of any female practitioners) offers the service to villagers who in many cases find it more convenient than having to go to a medical clinic. In most cases the 'doctor' will have a ready supply of drugs to inject on his diagnosis of the illness.

¹⁴During my stay, one man from Don Han was admitted to hospital suffering a severe ulcer of the stomach; he had been taking roughly eight packets of these pills a day for several months.

From Don Han it is only two kilometres to the nearest government health clinic (*sathaanii anamai*). However, when seeking an official diagnosis, from Don Han the majority of villagers will go to one of six private clinics on the main road eight kilometres away because of widespread dissatisfaction with both the frequent absence of the government 'doctors' (paramedics) and the inefficacy of the prescribed drugs. One private clinic is open all day and staffed by a nurse retired from the provincial hospital, the other five are only open in the evenings and weekends when the doctors that run them come from their work at hospitals in Khon Kaen. Doctors do not generally charge a consultation fee but make their money from selling medication. *Mor Thin* at one of these clinics says they are more popular than the government facilities because the drugs they sell are better although more expensive. Conversely, in Baan Khem, the district hospital five kilometres away exerts far more attraction. The majority of households go here for any medical assistance, primarily because so many have health cards encouraged as part of a hospital assistance scheme. The hospital also sends regular teams to conduct village health inspections.

Whether they go to the health station or private clinics, most villagers in Don Han constantly change whom they visit with no particular relationship developed between doctor and patient. The medical officials are considered simply an administering service and judged solely on the efficacy of their cures. Different doctors administer various brands of the same drugs but because of the different appearance villagers are not aware they are receiving the same medication. Many villagers told me that the doctors never provide any information about the illness or the type of medicine being prescribed and they are rebuked if they ask.

Dr Nonglak at the health station commented:

Villagers change clinics so much because of impatience. For example, if a child has a fever the parents will take it to one doctor one day and another the next if the fever has not abated, even though the first doctor has indicated that it will take several days. The doctor they go to on the last day is credited with being the successful practitioner.

Diviners and spirit healers

A notable difference between the more modernized Baan Khem¹⁵ and more traditional Don Han was the degree to which villagers used the services of faith healers. Amongst the older villagers in Don Han, many still believe that spirits (*phii*) are responsible for illness. These spirits are usually of someone known to the person suffering who has died in the recent past, although occasionally a more general spirit associated with specific locations may be regarded as responsible. Some of the villagers will ask a spirit healer (*mor lam song*) to perform divining rites so the spirit's dissatisfaction may be assuaged and the afflicting ailment thus removed. By contrast, in Baan Khem the villagers no longer seek treatment in this manner, for two reasons. On the one hand, modernization has lessened the extent to which spirits are considered a threat and Western medicine is felt to be the more appropriate strategy for curing illness.¹⁶ At the same time, in Baan Khem spirit healers are not considered appropriate recourse for traditionally ideological reasons. When the nearby factories were built 18 years ago there was great concern that they had been built on the site where the village dead had traditionally been cremated. In order to avoid any misfortune this might incur, the village as a whole was exorcized by a holy man from a nearby town. In this case, the practitioner (*mor tham*) was one who gained his power from the path of virtue, from the

¹⁵Baan Khem lies in the middle of a minor-industrial sector near the main highway north to Laos.

¹⁶Electricity, for instance, is regarded as having effectively banished the dreaded *phii porp*, a spirit or ghost that possesses its victims, devours their entrails and causes delirium.

Buddhist scriptures, from *dharma* or the path of righteousness, not from the ability to communicate with the animist spirits directly. While not a monk or strictly religious practitioner, this 'doctor' is considered to use the powers for 'good' (*pen phra pen tham*) associated with godhood, in direct contrast to those spirit healers (*mor lam song*) that effect cures by speaking with and for the many spirits that also influence people's lives. While he is occasionally sought to remedy specific illnesses, villagers consult him for more general advice as to how misfortune may be remedied. Thus, the villagers in Baan Khem say they now reside in the 'field of virtue' (*yu nai tham*) and to seek spirit healers would be to directly contravene the identification and belonging associated with this condition.¹⁷

During the time I stayed in Don Han, a spirit healer (*mor lam song*) was asked to come on various occasions from a distant district in Khon Kaen to oversee healing rites. A spirit healer's reputation in particular villages spreads by word of mouth and depends on previous success in the general neighbourhood. The ostensible illness varied from malaria and rheumatism to more general chronic fatigue, dizziness and malaise with no overt symptoms. In the majority of cases the spirit healer was invited because no improvement in health followed consultation with official doctors. In the case of the young man with malaria, the *mor lam song* was required by the man's mother to determine the cause of his affliction rather than make a specific diagnosis. Recognition that he had malaria required in this case a more specific personalized understanding of why he had been infected. While not all villagers believe illness is visited on the sufferer, many still hold that malevolent spirits are responsible for sickness. Some are clear in their minds what illnesses are best treated by which means. Villagers were generally unanimous that spirit healers were unable to cure advanced stages of fatal diseases such as the prevalent liver cancer or, as some surmised, AIDS. Phor Phan repeats a sentiment echoed by many villagers:

Usually villagers will only seek treatment from a *mor lam song* when the doctors cannot cure the illness. The old people know which symptoms don't require a trip to the clinic but are better treated by a *mor lam song*. For instance, lack of appetite, insomnia, edgy and nervous conditions can all be cured by the *mor lam song* but for appendicitis you have to go to the clinic.

The spirit healer was on occasion joined by a local village woman who, while not considered a diviner, was known to be possessed by a powerful holy spirit (*tehp*) whose presence could be used to coerce lesser malevolent spirits (*phii*). Mae Phim had for years been considered intermittently mad and she spent a period in a psychiatric hospital, during which time she was attributed with mythic powers by the villagers when, in her retelling, she was treated like royalty by both the other patients and the doctors. Only recently has she felt the possessing spirit willing to be harnessed for specific beneficial purposes. She was told by this spirit that she should not attempt any healing ceremonies until she was 40 years old. The *mor lam song* was asked to find out which spirit was causing the affliction and what it required to be placated; Mae Phim was credited with the power to cure: to actually exorcize the possessing spirit.

¹⁷The one case I was able to discover of a Baan Khem villager seeking a spirit doctor for treatment said that she was specifically directed to do so by the *mor tham* with his blessing saying this was how she would be cured of the repeated headaches she was suffering. When she went to a spirit healer she learned that her headaches were caused by the spirit of another very powerful healer of whom her mother had been a disciple. This spirit was angered at her switch to worshipping the path of righteousness, *dharma*, without due ceremony signalling the transfer. Once she made amends and offered four trays of sweets to the offended spirit she was cured of her headaches.

The sessions vary in length and complexity. The basic components of the healing session with the *mor lam song* begin with an initial offering and entreaty to the spirit as her assistant beats a drum in accompaniment.¹⁸ The diviner stands and rocks slowly back and forth, eyes closed and after five or six minutes makes contact with the spirit whom we hear replying in a different voice from that with which she questions. At this point, those attending, family and friends of the sick person and often neighbours who have come to watch, also converse with the *phii* to ascertain why it is tormenting the particular person and what it requires to leave. This exchange can sometimes contain both witty banter and confrontation. At various stages of the dialogue, the diviner reverts to a prolonged chanting to encourage the spirit to make more information available. Occasionally, the patient will get up and dance seemingly without volition. In some ceremonies the *mor lam song* recalled the *khwan*, or soul, that is considered to have departed the body of the person at times of ill fortune, in this context, accidents or sickness.

During the course of the dialogue and chanting it will be determined, first what was the inappropriate behaviour that caused the spirit to afflict the person, and then the particular recompense that must be made. In the case of the young man with malaria, it was learned that the inauspicious event was the day that he and his friends stopped near a shrine to ask the way to the sugar-cane plantation where they were to work. They went into the woods to shoot some birds on the way. The spirit of a widow, living nearby, immediately swooped on Boonmii as the most attractive of the young men to claim as her own. The required offerings can be quite elaborate. For example, to appease the spirit who had caused the malaria infection, the following collection was placed at the gate to the village (for most items models or fake examples were suitable): Chinese and Thai money: 300,000 baht and 20,000 baht; three pigs' heads, two kilograms of grapes, three grilled chickens, one house, two swords, a motorcycle, a ten-wheel truck, gold, elephants, horses, whisky, flowers, flags, candles, bananas, coconuts, Vietnamese hats, a comb, a mirror and silk cloth. If these offerings are not correct the exorcism will be unsuccessful and subsequent rites will be required.

Occasionally official doctors will recommend that the villagers see a *mor lam song* for a chronic illness that they feel is psychosomatic in origin. The prevailing perception is that such rites have a beneficial influence in psychological reassurance. In nearly all of the cases I observed the reason the *phii* had caused the suffering was deemed to be related to domestic dislocations. For example, Mae Phaap's son had taken her *khwan* when he had gone to live elsewhere: he needed to come back before it could return. Boonmii got malaria not only because he had encroached on the spirit's dwelling place but because his grandmother was of such consistently bad temper that until she went away the family would never live happily; this disharmony, it was determined, had been the underlying cause behind the young man's transgression in the woods. The woman with the insufferable rheumatism not only learned she had stolen the spirit's timber when she built her house but also was addressed by her dead husband who spoke through the medium expressing his concern that she might remarry.

When speaking with the voices of various spirits, both Mae Phim and the *mor lam song* also addressed social issues on a larger scale. In one exchange, the two advised the gathered audience:

We are selected by spirits to help mankind - everywhere things are getting worse with people becoming more and more sinful, neglecting the five precepts of the Buddha. Soon

¹⁸In her session Mae Phim was accompanied by a *kaen*, the local wind instrument. Mae Phim's rites required a more elaborate calling of her spirit and various ritual actions to assure the ceremony's success. In both cases, the incessant rhythmic accompaniment is conducive to trance-like states either for the diviner, or in the case of Mae Phim's healing ceremonies, the person who is ill.

there will be no more temples, monks and nuns. This is why there are frequent droughts but people refuse to listen. Nowadays, people are just concerned with making money, not with making merit. Just dressing up and putting on airs. We are gods and we are supposed to help them, that is the way it is supposed to be.

Explanations for illness

While the inroads made by public health and Western styles of treatment have reduced consultations with folk-practitioners of all types, a recent outbreak of unaccountable deaths has reaffirmed that Western knowledge has not the answer for everything. Since the late 1980s, Sudden Unexplained Nocturnal Death Syndrome (SUNDS) has claimed a substantial number of deaths. Kunstadter (1991:20) has suggested that SUNDS is one of the ten most serious diseases in Thailand, but notes that 'Epidemiological knowledge is still too limited to intervene'. Reports show that Isan has the highest number of deaths from SUNDS in Thailand: for men 20 - 59 years of age, death rates of 35 per 1000 per year have been calculated (Biyothat 1991:110). The villagers are aware of the high incidence. In 1989 and 1990, a number of people died in their sleep in neighbouring villages to Baan Khem and Don Han; throughout the area reasons and explanations for the unexplained deaths were circulated. It was widely believed the men died in their sleep at the hands of the spirits of widows who required male companionship. Thus, it became common to enter villages and see men wearing sarongs, with their fingernails painted, hoping to fool the spirits into believing they were women. Some men wore large phallic objects at their belts to scare the spirits away.

The village next to Don Han had a sudden spate of deaths: six men died in fairly rapid succession. It was said that the guardian spirit (*jao thii*) of the village was remiss in his duties because he was a flirt and a Casanova. He became entranced by the beauty of the seven widow spirits who approached the village in red skirts and white blouses, and he allowed them into the village. The guardian of Don Han is not thought to be so easily tempted and the widows can only sneak into the village occasionally at night. For a period of time different village men, dressed as women, took turns to sleep at intersections of the roads in the village to confuse the spirits as to which way to go to find the houses of the sleeping men. Some of the men claimed to have seen the spirits approaching. For three to four months the men wore sarongs and insisted on going to sleep before the women in the house as a means of avoiding being taken. Then it was felt the widows had given up and gone to another village. In both villages, some of the men still wore phallic objects and painted one fingernail.

There is little doubt that as AIDS deaths become more frequent, causality along these traditional lines will be invoked.¹⁹ Sharper profile can also usefully be added to a description of village reactions to illness by considering one further disease.

Leprosy is now virtually non-existent but in some respects it reflects important aspects of AIDS aetiology and is a possible indication of village reactions to the presence of people with AIDS. In Isan, leprosy is not officially considered an infectious disease any longer: the remaining cases are supposed to have been treated and to be under control; but people who have had leprosy are treated as though the disease is still contagious and interpersonal relations are inevitably governed by the villagers' avoidance of physical deformity. One

¹⁹The villages I am familiar with in Isan still have no local experience with people acknowledging HIV seropositivity or becoming ill as a result of infection. This is in marked contrast to many villages in North Thailand which, having been at the vanguard of HIV infection, are now commonly experiencing illness and death of community members.

villager explained that he disdained people with leprosy because it was a disease that 'society loathed' (*rok sangkhom rangiat*). Leprosy is often described with this catch-phrase depicting the social outcome of infection. I also heard this phrase used in both urban and rural contexts to describe AIDS.

In Don Han there are three cases of men who have had leprosy: all three live in varying degrees of isolation. One of these denies to this day he had leprosy; he attributes his loss of fingers and toes to untended and misdiagnosed venereal disease. Other villagers mock his dissembling and say they know it is leprosy. Social ostracism is aggravated by the custom of removing shoes to enter households or the temple. The men have lost toes and wear custom-made shoes to hide their leprosy; they do not go to social gatherings where they might have to remove their shoes.

One man in his sixties departed to live in a grove of trees near a large pond about a mile from the village. Here he built a house where his young nephews have also come to live. The atmosphere is one of great tranquillity and solitude; many animals graze freely around the house. Phor Sii said he contracted the disease 30 years ago and he was treated by both Western and Thai doctors. He felt he was not treated with any overt contempt by villagers but it soon evolved that the only people he saw were other men with leprosy, of whom there were many at that time. Even though he was invited to ceremonies and meals with other villagers he never attended and soon after he was diagnosed he decided to live alone. He never married and has lived in virtual isolation for many years. He has stopped taking medicine for more than ten years but his skin still gets very itchy; his back, he says, is the worst affected. Other villagers asked me if he was still infectious.

Phor Thonginn has had leprosy for ten years and continues to take medicine because he believes he is still infectious. He amputated his toe himself because it was causing him so much discomfort. Phor Thonginn said he is not disdained overtly by most villagers because they do not want to offend him, but he is aware that they pity him and stare at him as if he were a monster. Some actively avoid him. He commented that he is never invited to people's houses. More cynically he added: 'Development has brought material progress but not improvement in the human heart'.

Conclusion

Villagers are being incorporated into health schemes through the establishment of local networks that link village volunteers with bureaucratic or development agencies. Official programs are presented as being adequate and necessary to solve health problems, such as they are defined by the organizing agency, most commonly in health matters the Ministry of Public Health. But at the same time, local belief systems do not always credit the official doctors with exclusive understanding of the cause of illness: villagers also look for alternative explanations. Local reactions to the presence of Sudden Unexplained Nocturnal Death Syndrome and leprosy highlight important aspects of response to the perceived threat of physical illness. The issues of contagion and the extent to which forces outside the individual are at play are major components of the perceptions being established about the threat AIDS represents (see Fordham 1993). In this context, Buddhist ideology remains a powerful underpinning of attitudes to sickness and healing. Concepts of merit and karmic attribution to explain affliction are constant components of understanding illness. As Terweil notes in his discussion of historic responses to Thai cholera epidemics,

Precepts of virtuous behaviour have always formed an integral part of the Buddhist religion, and in Siam it may be regarded as axiomatic that proper moral action would inevitably lead to happiness, well-being and good health (Terweil 1987:152).

This attitude is still pervasive. The extent to which an individual feels personally able to control his or her well-being determines how much individual responsibility that person will take in health-promoting behaviour. Ford and Suporn have suggested that, in Thailand, risk behaviour is often associated with the concept of accepting one's fate into one's own hands (*siang duang*), taking one's chance with destiny (Ford and Suporn 1991:407). They cite this as the reason that the major cause of death in Thailand is road accidents. To my mind, such an explanation is over-simplistic; the number of road accidents is the product of numerous factors, not simply a putative national character trait. But the idea that fate or *karma* plays a role in attitudes to health or sickness cannot be dismissed.

It is more useful in this context to understand the extent to which *karma* is used as a prior rather than *post-facto* explanation, but it remains difficult to accurately assess the subjective sense of responsibility villagers feel about personal health. While Western medical knowledge and diagnoses are accorded prestige and potency because of their association with scientific knowledge and bureaucratic links to higher spirituality, villagers do not necessarily see such knowledge as excluding other coterminous explanations for illness. In particular, because doctors practising Western medicine never take the time to explain causes of sickness nor prognoses for improvement, a vacuum is created into which traditional practitioners provide crucial contextualization of the illness experience. Thus, while Western medicine and the germ theory of disease are widely understood and accepted as explanatory factors mitigating personal blame, there remain many avenues for additional contingencies.

On the distributed questionnaire, I asked about attitudes to personal health (Table 8).

Table 8
Local attitudes to personal health

Do you agree.... (%)	Baan Khem			Don Han		
	Yes	No	Unsure	Yes	No	Unsure
If you take care of your health, you won't get sick	89	4	7	86	4	10
Everyone has to die sometime so getting sick is something normal	76	17	7	87	8	5
When you get sick it is because you haven't taken care of your health	68	17	15	69	17	14
It is because of fate that you are healthy	24	54	22	29	45	26
Sometimes the doctor is wrong in his diagnosis	49	23	28	49	23	28
If someone contacts HIV/AIDS it is because of <i>karma</i>	13	73	14	12	77	11

These questionnaire responses depict general attitudes to individual control of sickness. We can see that the notion of personal responsibility ranks much higher than that accorded to fate in incidents of sickness (questions 1 and 4). However, there is also recognition that getting sick is not always under the control of individual behaviour. Most agreed that by taking care of health one can avoid sickness, but if one does get sick villagers are less sure that this is a result of individual behaviour (question 3). Very few villagers (before the fact) felt that AIDS was the direct result of *karma*. A sense of karmic causality appears to influence more powerfully the framework of understanding and subsequent interpretation rather than prediction.

What is remarkable about the responses to these questions is the extent to which both villages answered similarly. The virtually identical statistics lead me to believe that the sentiments tapped above are generalizable beyond just the particular village communities. Despite the much higher profile of medical doctors in Baan Khem than in Don Han, there is still the pervasive acknowledgement that clinical diagnosis is not always correct. This recognition provides the space for alternative explanations of sickness and for alternative therapies. Of particular relevance is the implication that the knowledge of HIV/AIDS forwarded under the guise of medical authority will not necessarily be accorded automatic acceptance. Against this background of structured programs and multiple health strategies which take place in a context of varied and fluid conceptions of cause and effect, villagers construct individual strategies to distance themselves from the threat of HIV infection.

The reproduction of knowledge is invariably related to local praxis (Bibeau 1988:414). While top-down education programs perform the valuable role of alerting the Thai populace of the present and potential threat HIV poses, history has shown that it is unreasonable to expect direct translation of this information into desired behaviour change. In any context of programmatic information transfer laden with regulatory intent, resistance to imposed ideologies is inevitable. Local participation in community-based projects is crucial to complement national initiatives both to personalize their relevance and to temper the inevitable although unintended counterproductive reactions.

References

- Apichat Chamrathirong and Chintana Pejarnonda. 1986. Levels, trends and differentials of mortality in Thailand. Pp. 527-541 in *New Developments in the Analysis of Mortality and Causes of Death*, ed. H. Hansluwka et al. Bangkok: Mahidol University.
- Bender, D. and K. Pitkin. 1987. Bridging the gap: the village health worker as the cornerstone of the primary health care model. *Social Science and Medicine* 24,6:515-528.
- Bennett, A., C. Frisen, Peerasit Kamnuansilpa and John McWilliam. 1990. *How Thailand's Family Planning Program Reached Replacement Fertility*. Occasional Paper No.4. Bangkok: USAID.
- Bibeau, G. 1988. A step toward thick thinking: from webs of significance to connections across dimensions. *Medical Anthropology Quarterly* 2,4:402-416.
- Biyothat Thasanaawiwat. 1991. Rok lai taai [Sudden nocturnal death syndrome]. Pp. 110-112 in *Sathanaakaan khong Isaan nai thasawat naa klum sukhaapaap [The Health Situation in Isaan]*, proceedings from Thamasaat and Mahidol Universities Second Conference *Khunaphaap chiwit khong chonabot [Quality of Rural Life]*. Bangkok: Mahidol University.
- Chaanchai Phaanthongwiriyaakun and Suwat Kutlertjariya. 1991. Panhaa phochanahaan khong Isaan [Nutrition problems in Isaan]. Pp. 34-42 in *Sathanaakaan khong Isaan nai thasawat naa klum sukhaapaap [The Health Situation in Isaan]*, proceedings from Thamasaat and Mahidol Universities Second Conference *Khunaphaap chiwit khong chonabot, [Quality of Rural Life]*. Bangkok: Mahidol University.
- Chaichana Ingavata. 1990. Community development and local-level democracy in Thailand: the role of *tambol* councils. *Sojourn* 5,1:113-143.
- Chairat Charoensin-o-larn. 1988. *Understanding Postwar Reformism in Thailand: A Reinterpretation of Rural Development*. Bangkok: Editions Duangkamol.
- Chantana Banpasiri. 1989. The indigenization of development process in Thailand: a case study of the traditional medical revivalist movement. PhD thesis, University of Waterloo, Ontario.
- Chattip Nartsupha. 1991. The community culture school of thought. Pp. 118-141 in *Thai Constructions of Knowledge*, ed. Manas Chitakasem and A. Turton. London: University of London.

- Cohen, P. 1989. The politics of primary health care in Thailand, with special reference to non-government organizations. Pp. 159-176 in *The Political Economy of Primary Health Care in Southeast Asia*, ed. P. Cohen and J. Purcal. Canberra: Australian Development Studies Network.
- Damrong Boonyoen. 1987. Thailand Case Study on Health Aspects of Development Planning at Village Level. Bangkok: Ministry of Public Health.
- Department of Family Health. 1988. Health Situation Analysis and Policy/Strategy. Bangkok: Ministry of Public Health.
- Doherty, E. G. and E. Posanai. 1990. Food consumption and parasite infection in Northeast Thailand. Master's Thesis, University of Queensland.
- Donaldson, P. J. 1982. Foreign intervention in medical education: a case study of the Rockefeller Foundation's involvement in a Thai medical school. Pp. 107-126 in *Imperialism, Health and Medicine*, ed. V. Navarro. London: Pluto Press.
- Escobar, A. 1988. Power and visibility: development and the invention and management of the Third World. *Cultural Anthropology* 3:428-443.
- Ford, N. and Suporn Koetsawang. 1991. The socio-cultural context of the transmission of HIV in Thailand. *Social Science and Medicine* 33,4:405-414.
- Fordham, G. 1993. The social and cultural context of the AIDS epidemic in Thailand. Paper presented at Fifth International Conference on Thai Studies, School of Oriental and African Studies, London, July.
- Foster, G. 1987. Bureaucratic aspects of international health agencies. *Social Science and Medicine* 25,9:1039-1048.
- Gohlert, E. W. 1990. *Power and Culture: The Struggle against Poverty in Thailand*. Bangkok: White Lotus.
- Health Planning Division. 1990. *Health In Thailand: 1990*. Bangkok: Ministry of Public Health.
- Hewison, K. and Maniemai Thongyou. 1993. The new generation of provincial business in Khon Kaen: economic and political roles. Paper presented at Fifth International Conference on Thai Studies, School of Oriental and Asian Studies, London.
- Hirsch, P. 1990. *Development Dilemmas in Rural Thailand*. Singapore:Oxford University Press.
- Krasae Chanawongse. 1990. *Understanding Primary Health Care Management: From Theory to Practical Reality*. Bangkok: Buraphasilp Press.
- Kunstadter, P. 1991. Interface of social and health sciences for high priority epidemiological research in Thailand. In *Health Social Sciences in Thailand*, ed. Santhat Sermsri. Nakornpathom: Mahidol University.
- Le Grand, A., Luechai Sri-Ngernyuan and P.H. Strefland. 1993. Enhancing appropriate drug use: the contribution of herbal medicine promotion. *Social Science and Medicine* 36,8:1023-1035.
- Lyttleton, C. 1994a. Knowledge and meaning: the HIV/AIDS campaign in Northeast Thailand. *Social Science and Medicine* 38,1:135-146.
- Lyttleton, C. 1994b. The Love-Your-Wife Disease: HIV/AIDS education and the construction of meaning in Northeast Thailand. PhD thesis, University of Sydney.
- Lyttleton, C. 1995a. Messages of distinction: the HIV/AIDS media campaign in Thailand. *Medical Anthropology* 16:363-389.
- Lyttleton, C. (ed.). 1995b. Thai Sexuality and the Age of AIDS: Essays in Memory of Robert Aris. *Australian Journal of Anthropology* 6,3.
- Ministry of Public Health (MOPH). 1988. *The Realization of Primary Health Care in Thailand*. Bangkok.

- Muangman, D. 1987. Prince Mahidol - father of Public Health and modern medicine in Thailand. *Asia Pacific Journal of Public Health* 1,4:72-75.
- Office of Primary Health Care. 1985. *Primary Health Care in Thailand*. Bangkok: Ministry of Public Health.
- Pichet Lilaphanmethaa. 1991. Saphayaakon saathanarasuk khornng phaak Isaan [Health resources in Isaan]. Pp. 138-141 in *Sathanakaan khornng Isaan nai thasawat naa klum sukhapaap [The Health Situation in Isaan]*, proceedings from Thamasaat and Mahidol Universities Second Conference *Khunaphaap chiwit khornng chonabot [Quality of Rural Life]*. Bangkok: Mahidol University.
- Population and Development Association (PDA). 1991. Rural AIDS prevention education through local government officers. Bangkok, unpublished manuscript.
- Proceedings. 1991. In *Sathanakaan khornng Isaan nai thasawat naa klum sukhapaap [The Health Situation in Isaan]*, proceedings from Thamasaat and Mahidol Universities Second Conference *Khunaphaap chiwit khornng chonabot [Quality of Rural Life]*. Bangkok: Mahidol University.
- Rifkin, S. B. and G. Walt.. 1986. Why health improves: defining the issues concerning 'comprehensive primary health care' and 'selective primary health care'. *Social Science and Medicine* 23,6:559-566.
- Riley, J. L. and Santhat Sermisri. 1974. *The Variegated Thai Medical System as a Context for Birth Control Services*. Working Paper No.6, Institute for Social and Population Research. Bangkok: Mahidol University.
- Seri Phongphit. 1989. Development paradigm: strategies, activities and reflection. *RUDOC News* 4,3-4: 1-78.
- Social Science and Medicine*. 1988. 26,9.
- Suntaree Komin. 1990. *Psychology of the Thai People: Values and Behaviour Patterns*. Bangkok: National Institute of Development Administration.
- Supraanee Changbumrung et al. 1989. Food patterns and habits of people in an endemic area for liver fluke infection. *Journal of the Nutrition Association of Thailand* 23,3:133-146.
- Suwit Wibunphonpraserit. 1991. Rabob borikaan saathanarasuk phaak Isaan [Public Health Systems in Isaan]. Pp. 143-157 in *Sathanakaan khornng Isaan nai thasawat naa klum sukhapaap [The Health Situation in Isaan]*, proceedings from Thamasaat and Mahidol Universities Second Conference *Khunaphaap chiwit khornng chonabot [Quality of Rural Life]*. Bangkok: Mahidol University.
- Tawatchai Yongkittikul, Ora Tansakul and Pisamai Chandavimol. 1988. *Health and Social Development in Thailand*. Bangkok: Royal Thai Government.
- Terweil, B.J. 1987. Asiatic cholera in Siam: its first occurrence and the 1820 epidemic. Pp. 142-161 in *Death and Disease in Southeast Asia: Explorations in Social, Medical and Demographic History*, ed. N.G. Owen. Singapore:Oxford University Press.
- Voradej Chandarasorn. 1990. Implementation of primary health care policy in Thailand: an analysis of strengths and weaknesses in the management system. *Thai Journal of Development Administration* 30,3:39-59.
- Walt, G. and P. Vaughan. 1981. *An Introduction to Primary Health Care in Developing Countries*. London: Ross Institute of Tropical Hygiene.
- Weeden, D., A. Bennett, D. Lauro and Mechai Viravaidya. 1986. An incentives program to increase contraceptive prevalence in rural Thailand. *International Family Planning Perspectives* 12,1:11-16.