A CULTURAL APPROACH TO

HIV/AIDS PREVENTION AND CARE

UNESCO/UNAIDS RESEARCH PROJECT

THAILAND'S EXPERIENCE

COUNTRY REPORT

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Since the mid-eighties, the fight against HIV/AIDS has gradually mobilized governments, international agencies and non-governmental organizations. However, it became evident that despite massive action to inform the public about the risks, behavioural changes were not occurring as expected. The infection continued to expand rapidly and serious questions began to emerge as to the efficiency of the efforts undertaken in combating the illness. Experience has demonstrated that the HIV/AIDS epidemic is a complex, multifaceted issue that requires close cooperation and therefore multidimensional strategies.

The establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1994 initiated a new approach to the prevention and care of this disease. The first requirement stressed was the need for increased coordination between institutions. An emphasis was also made on the need to work on both prevention and treatment while considering the significant social factors involved. As a result UNAIDS was involved in several studies focusing on developing new methodological strategies with which to tackle the issue.

Following a proposal made by UNESCO's Culture Sector to the UNAIDS Programme, on taking a cultural approach to HIV/AIDS prevention and treatment for sustainable development, a joint project "A Cultural Approach to HIV/AIDS: Prevention and Care" was launched in May 1998. The goals were to stimulate thinking and discussion and reconsider existing tools with a cultural approach.

Taking a cultural approach means considering a population's characteristics - including lifestyles and beliefs - as essential references to the creation of action plans. This is indispensable if behaviour patterns are to be changed on a long-term basis, a vital condition for slowing down or for stopping the expansion of the epidemic.

In the first phase, of the project (1998-1999) nine country assessments were carried out in three regions: Sub-Saharan Africa (Angola, Malawi, South Africa, Uganda, Zimbabwe), Asia and the Pacific (Thailand and bordering countries) and the Caribbean (Cuba, Dominican Republic, Jamaica). The findings of these studies were discussed in three subregional workshops held in Cuba, Zimbabwe and Thailand, between April and June 1999. All country assessments as well as the proceedings of the workshops are published within the present Special Series of Studies and Reports of the Cultural Policies for Development Unit.

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PART I

I. THE CULTURAL CONSTRUCTION OF HIV/AIDS IN THAILAND

A. Socio-economic and Cultural Context

The HIV/AIDS epidemic in Thailand began during the late 1980s when the Thai economy was growing at a remarkably high rate. The rapid economic growth brought about social and cultural changes which constitute the context for this epidemic.

Thailand's development policy for the last three decades largely emphasized export-oriented industrialization, tourism promotion and development of major cities with the aim of inducing trickle-down effects into the outlying areas. Such a policy has led to more investment in the industrial and service sectors and the expansion of urban centers. In Northern Thailand, an industrial estate was rapidly developed during this period. It was filled with factories developed with Taiwanese, Japanese and Thai capital. These factories used imported materials and local labor to produce garments, food, beverages and electronic parts for export.

During the same period a large amount of fertile agricultural land in Northern provinces, particularly along the highways linking cities to other cities or along roads to outlying districts, was bought by price speculators as well as those building factories and developing large housing projects and resorts. In urban centers, Western style, luxurious condominiums and housing projects were built and developed to sell to the emerging middle class and to rich Bangkokians. It should be pointed out that the real estate business boom during this period was due to the speculation rather than to real market demand.

Among other things, the change which occurred during this period led to different forms of rural-urban migration. A number of rural dwellers went to Bangkok and other major cities for better job opportunities. Some chose to live in their rural communities while commuting daily to work in the city. Some farmers brought their produce to sell in the market in Chiang Mai very early in the morning and returned to their home in the afternoon. Some split their household labor to work on their farm as well as to seek off-farm employment, i.e., working as wage laborer in urban areas or becoming a vendor in the city. Those who sold their agricultural land had no choice except to work in urban areas. Most of them became construction workers, small factory workers, company employees, waiters, garage hands, mini-bus drivers, etc.

In Chiang Mai, a large number of hill tribe people also came to urban areas to work as wage laborers or gas station attendants or to sell their tribal crafts in the night market. They stayed together with relatives and friends in slum areas, which expanded as the urban center grew rapidly.

The expansion of urban centers and tourist-related activities in Northern Thailand also induced many young rural Thai women -- as well as hill women -- to work in private homes, restaurants, factories, etc. Some of these women started their own small businesses selling vegetables, foods, drinks, snacks, etc., but others ended up working in bars and brothels.

Another type of rural-urban migration has been caused by the expansion of educational opportunities in Northern Thailand since the early 1980s. In major cities like Chiang Mai, Chiang Rai and Lampang, public and private vocational training and higher education expanded tremendously in response to the demand for human resources. Parents placed high value on vocational education in the hope that their children would not have to work on their farms any more. These students came by motorcycle or minibus to study in urban schools during the day and returned to their villages in the evening. Many also chose to stay in low-priced dormitories or to rent a house together in urban areas. The more time these students spent in schools and urban areas, the more they became socially distant from their parents.

The economic growth and expansion of educational opportunities which were largely concentrated in urban areas did not only bring about different forms of rural-urban migration in Northern Thailand. They also gave rise to new lifestyle and cultural values, and changed consumption behavior among Northern Thai people. More importantly, these changes created more geographical and social spaces which became meaningful for the people who experienced these changes.

First, cities in Northern Thailand became the center of economic transactions. In each province, the city is essentially a market center. Goods and products from rural areas are transported to the central market and distributed back to rural areas. During the period of economic growth, the cities in Northern Thailand, such as Chiang Mai, Chiang Rai, Lampang, Lamphun, became more than a market center. They became centers of administration, education, finance, transportation and tourism, and provided services to urban dwellers, bureaucrats, businessmen, vendors, wage laborers, tourists, etc. Modern shops, stores, hotels and night bazaars as well as bars, pubs and restaurants mushroomed. Food centers and street hawkers operated until late at night for tourists and local people.

Although the day market was still essential mainly for food supplies, shopping centers became a new type of market where one could find factory-made clothes, foods and vegetables, electrical appliances, sport goods, toys, video games, etc. in one place. The shopping centered offered a new lifestyle for urban people in which they could shop in an air-conditioned complex, buying different goods while taking their family to eat lunch. In a shopping center, people can buy various products and commodities that are ordered, categorized, fix-priced and clean. This is contrary to the day market where buyers go to different shops to bargain with vendors for better prices. Products in the market are neither ordered nor categorized.

Second, the expansion of urban centers in Northern Thailand has created new geographical and social spaces for people who came to visit, live and work or study in urban areas. Tourists and rural migrants are the primary categories of people in this context. The former bring money and the latter supply labor and skills, but both are strangers and do not know local culture. They congregate in certain spaces of the urban area, excluded from the urban people. In Chiang Mai City, for example, the southeastern part of the city from the Tapae Gate to the Mae Ping River bank — which was the old commercial and residential area — gradually changed into a tourist area. In this area, guest houses, shops, bars, restaurants, night bazaars and tourist-related business can be found.

As the urban Chiang Mai grew, more than thirty slum areas, (such as Santitham, Klong Ngeun, Ra Kaeng, etc.) were developed and occupied by the rural migrants. These slum

areas are located out of the inner city. Some slums are located along a small stream which run through the city; some are in an area south of the city near a large slaughter house.

Cheap dormitories can be found in small lanes both in the inner city or around the four corners of the city. Certain areas of the Chiang Mai City, such as the well-known Kampaeng Din and Santitham, became place where brothels, bar and karaokes could be found. (In Santitham, brothels are located right in front of a Muslim cemetery and the Tai Lue cremation site.) Shopping centers, the Botanical Garden, and parks became new spaces for young people to hang around and meet each other. During the late evening, the Tapae Gate plaza was a place where loitering "Krathoey" found customers and a group of street children hung out. Along the highways leading to outlying districts, low-priced bars and restaurants were available for commuting workers to stop for a drink before going home in the evening. In fact, it can be said that certain spaces in the urban center have been designated for rural migrants and outsiders. In a way, they are seen as the others who are placed in a certain geographical and social space.

For the rural migrants, the city is a new social space distant from their families and relatives--a social space with no community control as in their local communities. Dormitories are their new home where they live among strangers who pay no attention to what they will do. The rural migrants are in an ambiguous position. They live in the urban area, but they are not urban people. At the same time, they are not rural people, because they do not live like rural people. With new friends and new social networks, they define their new culture, allowing them to enjoy more freedom and adopt new social behavior and social values. After working hours, they can go dancing in discotheques — a new social space — where they can drink whisky and beers until very late hours and meet potential sexual partners.

Living in urban areas can become expensive for them. Sharing a room with a boy friend or a girl friend is therefore a common practice to reduce some expenses. Some girls can also find extra financial support by establishing a sexual relationship with wealthy men. Despite the fact that prostitution is illegal in Thailand, it exists in various forms. Instead of prohibiting it, the law is meant to discourage it. The police often raid brothels and arrest a few from each place in order to contain prostitution. As the law enforcer, they can benefit from their interpretation of the law. At the same time, prostitution exists because of the demand by many Thai men, who are culturally allowed to have sexual relations with women other than their wives. However, prostitutes are not openly accepted. They are socially excluded and belong to an ambiguous category in Thai society. Some young women who work as singers, waitresses, masseuses, etc., may also serve as part-time commercial sex workers.

Different forms of commercial sex have proliferated in Northern Thailand since the early 1980s. Besides the direct commercial sex workers who could be found in brothels in cities and towns, the new purveyors of indirect commercial sexual transaction could also be observed in karaokes, bars, coffee shops, pubs and restaurants. Discotheques, bars and karaokes became a new form of entertainment attracting adults and teenagers and a part of the popular culture of urban life. Customers were mostly the salaried class and college students. Some were also domestic or international tourists. In these places, negotiation could be done between the girls and the patrons. In some urban centers, (e.g., Chiang Mai, Chiang Rai, Pitsanoloke) male commercial sex workers were also available to meet the increasing demand of Thai and non-Thai male customers. Small restaurants with flashing

red and green lights were numerous alongside major roads. In the evening, one often found that truck drivers, middlemen and construction workers would stop to eat and drink and go off with waitresses.

Among men with high economic status, having multiple sexual partners is common. It is not unusual for local businessmen, government officials and influential headmen to have minor wives or be involved in temporary sexual affairs with good looking young girls. This kind of unequal social and sexual relation seems to be widely expected in Thai society, especially when income disparity between the rich and the poor is large.

Homosexuality has become much more tolerated and visible in Thai society than before. Gay or "Kathoey" asserted another sexual identity in Thai urban society. At least two subcategories of Thai gays have been observed: commercial "Kathoey" who behaved and dressed up like women and non-commercial "Kathoey" who dressed up normally like men. "Kathoey" seemed to occupy a certain role in urban Thai society. They often worked as dress makers, hair-dressers, vendors, florists, etc. Since they tended to behave like women and had no sexual interest in women, they were seen as no threat to women. They mixed well with women. They usually had their own network. Some served as brokers introducing well-to-do men to indirect commercial sex workers.

It can be said that the economic growth during the late1980s and early 1990s brought about migration from rural areas to urban centers. The new social and sexual space was expanded, allowing the testing of new cultural values on sexual relations and sexuality. Premarital sex was no longer seen as an offense to the ancestral spirit cult as before. In fact, temporary sexual relationships became largely accepted among young people. Living together became a common practice among college students, particularly for those away from their families. Commercial sex became a means of producing income for those without the skills or connections to participate in the expanded economy.

B. The Initial Response to HIV/AIDS Epidemic

The outbreak of HIV/AIDS in Thailand during the early 1990s caused alarm among many Thai people. Most of them then did not have a clear understanding of the disease. HIV/AIDS was associated with sexuality. Initially the disease was seen as spreading among the intravenous drug users who later transmitted it to commercial sex workers. Sexually active, heterosexual men then contracted the disease from commercial sex workers or from homosexual men. Thus, HIV/AIDS was regarded as polluted.

Most people did not seem to take the problem seriously, because they thought that the problem was exclusively the others' problem. Because they were not promiscuous, many women did not imagine that they could become infected. They did not realize that their husbands might have unsafe sex with other women or commercial sex workers. Many people did not even believe that it was such a lethal disease and real. Some did not believe in AIDS because they had never seen a person with HIV+. They hardly understood its etiology and the mechanism of its transmission and infection. Many did not care to change their sexual behavior.

Government Response

The initial response by the government was undertaken mainly by the Ministry of Public Health, which stressed the changing of attitude and social behavior among the risk

groups, particularly commercial sex workers and adult males. This was done through nationwide educational campaigning. The emphasis then was on the bio-medical aspect of the disease and how the disease could be transmitted via sexual relations, blood transmission, and needle-sharing. HIV/AIDS, as it was explained, was caused by a virus which can adapt itself to blood cell system. The virus then destroyed the immune system of the body, which made the body vulnerable and susceptible to any disease. It was said then that there was no medicine to kill this virus or to cure this disease. Such a campaign largely emphasized the fear-based approach to the problem.

Although the campaign was carried out widely by several government agencies, it was not that effective. This is due, in part, to the limitations of the campaign, which failed to create understanding and awareness about HIV/AIDS among a variety of groups. It was also due, in part, to the lack of cooperation among different government agencies at the district level. HIV/AIDS was seen as a health problem; therefore it was perceived as falling under the domain and responsibility of Public Health. Even though there were committees on AIDS prevention at the provincial and district levels, the committees' effectiveness entirely depended on how each individual committee reacted to the problem. In some districts, the committees hardly met and carried out few activities on HIV/AIDS prevention.

In addition, HIV/AIDS was seen as a bio-medical problem, not a social problem. This view led to a series of educational campaigns and training workshops aiming at raising awareness among the people. Although such an approach enabled people to better understand the medical problem, it did not change their behavior. Attitudinal change is an individual effort, whereas behavior change is more complicated. It involves social and cultural dimensions. In the Thai context, conformity to group's norms and values is still important. To change people's pattern of sexual behavior, it is necessary to involve one's peers and community. In several cases, it was difficult to engage villagers in discussions about changing sexual behavior when the local authorities themselves did not set good example for them to follow.

Responses to the Condom Use Initiative

During 1993-94, the Ministry of Public Health launched a campaign to increase condom use. Although it could be said that this campaign was relatively successful, there were cultural problems associated with the use of condom. Condom use was not part of sexual culture in Thai society. Northern Thai people became more familiar with the use of contraceptives than condoms in family planning campaigns during 1960-1980. Condom use was not introduced by family planners during the successful family planning campaign in Northern Thailand during the 1970s.

Many Thai young men tended to believe that condom use inhibits natural sexual intercourse. There are also many ways in which they use condoms. For example, some people prefer to break the tip of a condom before use. Some men do not use a condom throughout intercourse, but rather wait to put it on until just before they reach orgasm.

Condom use was, and is, also a matter of social interaction between commercial sex workers and their customers. A commercial sex worker may not insist that a customer use a condom if he looks nice and clean, or if he is a regular customer. Many commercial sex workers did not know how to negotiate with customers who were drunk or who took them out from the brothel overnight. More importantly, they had less bargaining power with

customers, and particularly with brothel owners, to whom they owed money. "Being more afraid of hunger than AIDS" was a common phrase one often heard from these commercial sex workers. Some male commercial sex workers, on the other hand, would also have sex with their girl friends after having sexual relations with men customers.

Within a marriage, suspicion and misunderstandings can occur and sexual relations between husband and wife can be problematic if either of them suggest using a condom. If a husband wants to use condom with his wife, she may believe that her husband is indicating that he has visited commercial sex workers before. If a woman wants her husband to use a condom, he may perceive that request as an admittance that she has had extra-marital sexual relations.

Individual and Community Responses

During early 1990s, HIV/AIDS started to infect people from the outlying areas of Chiang Mai City such as San Sai, Mae Rim, Hang Dong, San Patong, Doi Saket Districts, and Fang. People who were infected hid their problem; they did not want to disclose to their family or other villagers that they were infected with HIV/AIDS. Many went to one hospital after another in order to find medication to cure the disease. They sought information on how to cure the disease through relatives and close friends and consulted with the anonymous clinic set up by the Communicable Disease Control Region 10 (hereafter CDC 10) in 1992 and the Euang Phueng Anonymous Clinic.

The initial reaction from villagers toward PWA was rather negative, fearful and discriminating. When they saw people exhibiting certain symptoms such as weight loss, darkening complexions, skin rashes, etc., villagers would start gossiping. The reactions varied according to the PWA's own background and situation, however. Some PWAs were not allowed to use plates and water glasses in the noodle shops. In the case of Umpan (see details in the case study below), who was infected by her husband, her neighbors still visited and talked to her. However, she reported that once her customers knew that she was infected with HIV/AIDS they stopped buying foods from her. In her case, her family accepted the problem and helped her face it calmly. In the case of Somya, her neighbors did not express an outright negative feeling toward her, but tried to limit social interaction with her by not asking her to participate in the village labor exchange in agricultural work. But Somya was able to convince her community members that she should continue to be accepted by proving to them that she could contribute to the community even though she was a PWA (see details below).

In some communities, there were fears that HIV/AIDS could spread when a PWA died. The corpse was wrapped with plastic sheet as a mark of a corpse of a PWA. The community members did not even attend funeral ceremony or eat any food served at the ceremony. At the beginning, most Buddhist monks refrained from being involved with AIDS issue. HIV/AIDS was related to sexuality and promiscuity, so it was considered polluted and sinful. Monks enjoyed high status in Thai social order; they are supposed to deal with purity and sacred.[1]

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[1] *See* Akin Rabibhadana, *Buddhist Monks and Aids Prevention and Care In Three Buddhist Settings,* attached.

The Northern Thai communities did not understand about the AIDS epidemic and kept their distance from the PWAs. In most cases, close relatives looked after the PWAs. Fear of contacting the disease, which came from the earlier campaign made by the government, and the lack of understanding about the etiology were the major factors leading to this social distance and stigmatization.

II. CULTURAL DECONSTRUCTION OF AIDS BY PWAS: THEIR GROUPS AND NETWORKS

A. Negative Cultural Constructions

Since AIDS appeared in Thailand in 1984, it has been constructed in three negative cultural images. These cultural images have serious negative impacts on PWAs and their families.

1. AIDS: A Moral Laxity

The images and interpretations of AIDS which have been developed and transmitted to the general public are highly negative. In these images and interpretations, it is homosexual men who are first infected and then pass the virus on to intravenous drug users and then to commercial sex workers. Heterosexually active men then receive the virus and pass it on to their pregnant wives. Then their children are born HIV+.

It should be noted that in this explanation of the stages of HIV transmission the initial victims of this disease are already marginalized groups in Thai society. They are the ones who have already been stigmatized. Once they are infected with HIV/AIDS, they are considered to be the "reservoir" which breeds and passes the virus to other groups. They are even more stigmatized as "sexually promiscuous", groups whose behavior is sinful according to Buddhist norms. They are seen as the cause of the misery for innocent victims, i.e., women and infants. Such a perception toward PWAs prevails in the society and has led to view that they deserve to be punished by their own "karma".

2. PWAs as The 'Dangerous Others'

The bio-medical significance of AIDS has led to a general belief that AIDS is a lethal disease which cannot be cured by any available medicine. AIDS is an infectious disease which can be transmitted through blood from an infected person, needle sharing or by sexual intercourse with an infected person. However, there is no clear explanation for the mechanism of AIDS infection. Therefore the PWAs are signified as "persons with a disease which is ready to cause other people's lives." Such a perception indeed makes PWAs become "the others" (see Clarks and Mutchler 1989) in society. The media spreads this perception throughout society and compares PWAs to murderers or to an enemy which should be repressed entirely. A cartoon depicting a figure with bloody fangs and a sword and a statement describing AIDS as a "disaster" or "silent danger" are both commonly used in the government's campaign against AIDS. This further depicts PWAs as "the other", excluding them from the social and moral space of Thai society.

Creating such images about PWAs exacerbated the prejudice and social stigmatization against them. Newspapers that ran an article about a PWA who needled other people in a shopping center became best -selling editions and created more misunderstanding about PWAs. Although there were other sides to the story about the PWAs and their families — such as being laid off work before exhibiting any symptoms, the ostracization of members of a PWA's family, or suicides among PWAs and their families — the society's attitude and prejudice remained unchanged.

3. AIDS: An Individual's Problem or the Risk Group which Deviates from the Society's Norm

The common social explanation about AIDS seemed to indicate that PWAs are persons who share needles, are sexually promiscuous or are infected by a virus through blood transfusion. This led to two interpretations: a) AIDS is merely an individual problem, and b) AIDS is a problem endemic to certain risk groups. It also means that AIDS was seen neither as a community problem nor as a public issue. As a consequence, society, community and family are excluded from the AIDS problem.

More than that, because the then analysis of the AIDS problem was based on an epidemiological model, social factors related to the AIDS problem were left out. Those who may be infected are commercial sex workers, farmers, wage laborer, small vendors, etc. They are from a low socio-economic background and lead a life which provides conditions conducive for HIV/AIDS infection. They are people who work long hours and often use alcohol and drug, or are involved in activities which are high risk behaviors. Therefore, the convenient conclusions about HIV/AIDS infection have concealed the complexity of the process of becoming HIV+/AIDS, which is caused by multiple socio-cultural factors. In addition, social differentiation as caused by the development model which emphasizes material growth, the changing of social values and the unbalanced gender relations, etc., has been left out from the analysis.

B. Cultural Deconstruction of AIDS by PWAs.

Under the prevailing construction of the negative image of AIDS, PWAs are excluded from the social and moral space. In response to this exclusion, PWAs have tried to struggle in order to cope with such a problem. The process of contesting for social and moral space is very important and complex. It involves transforming PWAs from passive to active individuals and forming themselves into active groups and networks.

The prevailing social attitude against PWAs — that they were sexually "promiscuous", that they committed a sin, and that they are dangerous to others — has often made PWAs feel that they have no human dignity and value. Before PWAs can reveal their HIV+ status to the public, they have to go through a process to construct their own identity. Therefore, it is important to describe two stages leading to the formation of PWA groups:

1) Process of Self Disclosure: Significancing and the New Identity Construction

2) Process of Group Formation and Networking: Significance and Role of Group in Social Spatial Contestation and Response to the Needs of PWAs.

1 Process of Self Disclosure: Significancing and the New Identity Construction

The process of self disclosure by PWAs provides two bases for interaction among PWAs and within the larger society. First, it is a means of mobilizing supports from various groups within society, and second, it is a means of providing another set of information to Thai society in order to allow more social and moral space.

1.1 Self Disclosure for Social Support, New Meaning and New Identity

During the initial period when a person confronts the fact that he or she is HIV+, an emotional and psychological crisis emerges. This crisis is experienced as trauma about their own life and their own death, a fear of social stigmatization, the loss of dignity and confidence, as well as the feeling that they are losing the control of their own future. It has been observed that many PWAs resort to a search for a new meaning of the incident and a new meaning for their life.

The New Significance and Resource (Authority)

a) New Significance of Etiology of HIV+/AIDS.

One of the explanations given to PWAs on the etiology of HIV+/AIDS is that they have become HIV+ because of their own "karma." This explanation is derived from a popular Buddhist belief — which in turn is based on Buddhist philosophy, Brahminism and animism — that relates to fortune, bad luck and birth-death cycle. This view also relates to the Buddhist concept of the impermanence of the physical body and the Buddhist belief that death is common to all human beings. Such an explanation also allows PWAs to see the incident as misfortune or bad luck that is out of their control. This explanation corresponds with their behavior. They "remake" merit or good deeds by offering foods to Buddhist monks, studying Dharma, practicing meditation and observing ritual ceremonies which are believed to cancel bad luck and extend one's life.

b) Creating Positive Meaning from Being PWAs

While AIDS has been given a negative meaning by the rest of society, PWAs have also tried to develop a positive meaning of HIV/AIDS. Being a PWA allows them to rethink themselves and their meaning of life, to change to a new life and to become a new person who leads a life meaningful to the others. It also gives them a chance to become a good Buddhist, to observe Buddhist teachings and to attend the temple.

c) The New Meaning of the HIV/AIDS Disease

The scientific explanation of AIDS states that HIV virus invades the body and immune system, causing a person to become vulnerable to many opportunistic diseases and to eventually die. Some PWAs have defined another explanation of HIV/AIDS that creates hope and psychological support for themselves. They state that HIV/AIDS does not invade nor destroy the body. They believe it can coexist within the body. In addition, they also incorporate some of the explanations given by practitioners of alternative medicine, such as "HIV/AIDS occurs because of imbalance of the body system or the body has received the

certain ray which radiates from the sun." Such explanations lead to certain observable practices such as strict self-caring, the use of herbal medicine to re-adjust the balance of the body system, abstention from taking certain kinds of food as well as doing "spinning meditation" in order to discharge the ray from the sun.

The explanations and practices also come from the practical experiences of the PWAs themselves who learn from each other on how to live with AIDS. This is the major initial step for group formation. These new meanings for HIV/AIDS and the corresponding practices are individualistic efforts which are more effective and meaningful if other PWAs or members of society understand and share the same interpretations, particularly the members of their families.

1.2 Self-Disclosure as A Means to Provide Alternative Information or A Claim for Social and Moral Space.

In general, self-disclosure of PWAs will fall into a common pattern: that is, they disclose themselves to those who would be sympathetic. This is because the PWAs tend to be from the low socio-economic class. Their life depends on the other, i.e., they are wage labour, farmers who also work as wage labors, or small vendors. However, disclosure to the general public will often have negative effects, particularly on their work, and may lead to prejudice from society against their families.

Amidst the flows of information which create negative images of AIDS, it is important for PWAs to construct their own social facts and realities so the society will have other images and meanings of AIDS. There has been an attempt to present to society with alternative information on AIDS since 1991. For example, a mini-series on PWAs was presented on television and several forums were organized for the PWAs to "tell their own life experiences" to the public. Such self-disclosure involves two patterns:

a) NGOs-initiated Disclosure and NGO-PWA Collaboration

During the initial period when the society was still panicing about AIDS epidemic, there were attempts by NGOs and PWAs to work together on self-disclosure practices by PWAs. These practices are:

1) Dismantling the existing negative social images of PWAs and creating a new and positive image.

The prevailing view of society toward PWAs was that they were breaching moral codes, being sexually promiscuous. In addition they were seen to have the possibility to take revenge on society by intentionally spreading the disease through sexual transmission or by attacking with tainted needles, as was often reported by newspapers. PWAs counter this by saying that they share the same sexual norms and practices as other Thai men. If they are infected it is because they knew nothing about AIDS before, they were not careful enough in having sex, or they were drunk and did not use a condom. The PWAs contend that they feel guilty and sorry for what happened to them. They want their own mistakes to be lesson for the others by agreeing to tell their own personal stories so that others would change their behavior and avoid risk behavior. This kind of narrative is often made together with a question and answer session conducted by medical personnel.

This approach is obviously an epidemiological process which presents concrete evidence by 'using the narrative about risk behavior of the PWAs to campaign for the public to change their behavior.'

2) Raising Moral Concern toward PWAs and their Families

PWA stories of how they have been mistreated have raised moral concern and sympathy among the public. These narratives often involve relating ways in which PWAs are discriminated against and dehumanized, such as being denied access to medical care at the hospital, being laid off their job, not being allowed to use the dishes and bowls in restaurant, or seeing their children barred from school.

It has been found that when self disclosure was first used by PWA's, it was unclear what the response would be by the rest of society. Both NGO's and PWAs' chose to initiate disclosure away from the PWA's own community, and to make such disclosures at venues such as The Population and Community Development Association located in Bangkok. There PWA's from Chiang Mai could reveal their life experiences anonymously. Provided with free accommodation, the Chiang Mai PWA's helped launch the Association's campaign. Due to the isolated life style in Bangkok, negative effects from self disclosure was rare.

In the Northern part of Thailand, The Church of Christ in Thailand-AIDS Ministry (hereafter CCT-AIDS Ministry) had applied the same strategies in 1994 by transporting PWA's from their own community in Chiang Mai to tell their stories to the public in the city of Chiang Rai Province.

b) PWA's Self-Disclosure and PWA's Own Course
(Self-Disclosure as a strategy for Community Outreach)

The use of self-disclosure to the public began in 1994 in the upper part of Northern Thailand, where there were many HIV+ persons and PWAs. Initially, self-disclosure began in a rather restrained way, but later PWAs changed their approach to a more aggressive community outreach program to gain social and moral space. A two-pronged approach was used to take into account the different needs of rural and urban communities.

Rural communities

These are characterized by their intact close relationships between individuals. Self-disclosure in this situation consisted of revealing the typical physical symptoms of HIV+ such as thin build, darkening complexion, dark spots on skin, etc. In some cases, when the husband showed symptoms of AIDS his wife was registered as a PWA by the community. It was inevitable that self-disclosure of a PWA's condition would bring to the surface the community's fear of AIDS. Consequently PWAs were looked down upon, insulted and discriminated against by their community members. However, some PWA's were able to change their situation into a claim for social and moral space, using strategies based on religion and traditional patterns of being patient and non-violent in their reaction. They also told others how they were mistreated in order to elicit moral concern and sympathy from community members. This allowed them to improve their dignity in the community by using their knowledge about AIDS to face their suffering and to support their neighbours

with HIV+. Self-disclosure extended further than relatives, as PWA's formed networks with more distant communities.

Urban communities (where self disclosing PWA's came from different districts)

Self-disclosure was used in Chiang Mai City and had an impact upon people all over Thailand. It had a great effect in spreading information about their suffering and on government policy toward PWA's. This self-disclosure attracted attention and had wide-ranging effects on society because this self-disclosure was caused by tension within the society. It began when a traditional healer who provided traditional treatment for PWA's was arrested by police. PWA's felt they were mistreated because at that time most state hospitals had refused to treat patients with AIDS. They set up a group and revealed their plight to the mass media, such as newspapers and television. In addition, they handed the Prime Minister a letter asking for their rights. This act of claiming their rights from the Thai Government was rare in the realm of public health. A working group later developed in Chiang Mai City to help and support PWA's. From this emerged several leaders, one of whom is a committee member of Friends for New Life. (See below.)

These two types of self disclosure revealed some important concerns:
1) PWA's who were pioneers in claming social and moral space were women who received HIV infection from their husbands. Some of these women had children who were HIV+ (so called "innocent victims"). Examples of this are the pioneering work of Umpan, who initiated self disclosure in her village, and Lamai, who contacted HIV infection from her husband and had a child with HIV+. Lamai joined the "Friends for New Life" and pioneered contacting the media to claim their rights from the government and various organizations.

2) The claim for social and moral space needed support from people and organizations outside the community. Such support varied depending upon the strategy used, for example Umpan aimed for acceptance and a life within her community. The process of her return to the community was based on her personal power and relationship with health agencies. It was not related to powerful structures and organizations but to how good her relationship was with people in the community. However, Umpan could not fight on her own because people in her community were afraid of HIV contamination. Organizations outside the village played two major roles in their support of Umpan's self disclosure. They provided Umpan with a consistent base of support and used their knowledge knowledge about AIDS to show that PWAs could live with their families in their community without discrimination (by having meals together, bathing and providing physical support to PWAs).

Friends for New Life began with the main purpose of negotiating with government structures. However, members of this group were poorly educated and from a low socioeconomic group. The process of self disclosure was challenging and they needed support from various social groups including the mass media, academics and NGOs. Later, they decided to retain their group and to use a location in Chiang Mai City from which to continue their activities. As the group grew into an organization, it gained a budget and more knowledge.

Both these strategies used non-violent reactions, the relating of stories of mistreatment, and the improvement of PWA self esteem to elicit sympathy and moral support from society. It can be concluded that initially when there was discrimination against PWA's they fought their demoralization by asking others for moral support, and with devaluation by showing their self-worth. In addition, they provided positive information about PWA's to the public both in words and practice.

Initially, self disclosure by PWA's assisted in the development of a support group. The pattern of self disclosure then extended out toward the public by relating their painful experiences. This later became an important strategy used by the government, organizations and NGOs to eliminate social discrimination.

Case Study: "Umpan"

Umpan is a food seller in a small community marketplace 30 kms from Chiang Mai City. After her husband became ill with AIDS and developed dark spots from a fungal infection all over his body, his parents began to fear AIDS contamination. In addition, the neighbors gossiped about Umpan and her husband. Umpan continued with her business, which was the major source of income for her family. However, she found that the income from her business was not as good as before. She sold very little, and only to the whole-sale merchants or people who did not know her story. When Umpan's neighbors asked her about the disease, she re-stated that the doctor had told her that AIDS could not be transmitted through food. Umpan told her neighbors that the decision to buy the food she cooked was up to them: if they feared contamination they could buy food from other sellers. She wondered "If I quit my job and begged for money, would they give it to me?"

Umpan struggled in this situation with patience. Her greatest encouragement to continue with daily life came from the practices of "spinning meditation" and Bhuddism, which gave her more patience and understanding. "If somebody blamed me and I got angry I would never be able to sell my food. If they understood me, they would buy my food. If I did not get angry, my accusers would return and be good with me." Umpan continued going to the market and persisted with selling her food. Later her neighbors (including relatives of sellers in the market) also became ill from AIDS, just as her husband had. Umpan visited them and supported them. She gave them suggestions on how to deal with social discrimination and how to take care of themselves and she accompanied them to the hospital where she took her husband until they got better. Umpan was familiar with the hospital system and had developed a good relationship with the hospital staff.

Umpan persuaded some PWA's in the community to join an HIV+ group in Chaing Mai City. Information about Umpan had been distributed to neighboring villages. More and more PWA's and relatives came to Umpan for suggestions. Sales became better, and later her husband helped her do the food packaging. Umpan took time from her business to join the Community Health Team and to became a speaker, sharing her experiences with people in different community.

Case Study: "Friends for New Life"

During 1993 to 1994 there was a general fear of HIV contamination all over Thailand. PWA's were discriminated against by Thai society, including the health professionals who

had full responsibility for their medical treatment. Therefore, PWA's had to seek alternative health-care treatments which gave them hope and whose proponents treated them as "human beings". In this way PWA's had an opportunity to exchange their experiences with others who had the same problems. They thus developed friendships and set up a club for PWA's. In the beginning, this club ("Friends For New Life"), was known only among PWA's and not by the general public. Members of Friends For New Life used a liquid extracted from herbs as an alternative medicine. CCT-AIDS Ministry wanted some PWA's to be spokespersons and to share their experiences with other PWA's. These PWA's chose to go into villages where they were unknown. Later, the herbalist who had prepared the herbal remedy for PWA's was arrested for "mischieving". PWA's from Friends for New Life asked the police to release him. Moreover, with the support of the mass media, academics and NGOs, Friends for New Life continued reporting cases of mistreatment of PWHIVs and PWAs by government officials. This type of campaign required PWA's to disclose themselves to the mass media and it was inevitable that people in their villages became aware of their HIV+ status.

There were three people who were happy to reveal their stories to the media. Lamai, a woman who had been infected with HIV from her husband, had a daughter who was also HIV+. Lamai took the role of group leader by handing the letter to the Prime Minister and by speaking to the media about the PWAs' plight. Another was Chumlong, who was chosen for his intelligence and bravery in his negotiations with government officers. At last the group was allowed to continue the herbal treatment, and they set up the group named "Friends for New Life". The group was supported by the Thai-Australia Northern AIDS Prevention and Care Programme (hereafter NAPAC). Group activities consisted of seeking alternative treatments, especially herbal remedies, providing suggestions for PWA's, contacting government offices for medical and pharmaceutical rebates, and providing a free supply of infant formula powdered milk and job training. Later this group had support from The Northern AIDS Coordination Center (hereafter NACC), which is a specific project of the Government to solve the widespread AIDS problem in the upper part of Northern Thailand.

Even though there was an attempt to provide information about the mechanism of AIDS transmission in the community, and to stimulate empathy and social conscience, there were some situations in which it was not possible to reduce the fear of contamination from PWA's, for example when having meals with them or eating food prepared by them, especially when PWA's showed obvious physical symptoms. Therefore PWA's who had already revealed their HIV+ status avoided joining in village activities; for instance, they would not have meals in restaurants but eat take-away food instead. In holy ceremonies, they avoid helping others prepare food, but might wash dishes or prepare articles for monks. However there were some unavoidable conflictive situations in public life, such as when one community prevented the child care center from receiving pre-school children of PWA's.

2. From Self-Disclosure to Group Process and Network Development amongst PWAs

The role of the group was to network PWA's to be able to claim social space and to respond to group needs. The first PWA's group was developed in 1993; later many PWA groups evolved. Networks developed at several levels (tumbon, umphur, province, region and national level), and had a great influence upon, and support from, The Northern Thai NGO Coalition on AIDS (NTNCA).

The following research investigates the process of group and network development in two periods: prior to and after the support from *NTNCA*.

a) Process of group and network development prior to the support from the Northern Thai NGO Coalition on AIDS.

As mentioned earlier, self-disclosure by PWA's for the purposes of community outreach had been supported by people and organizations outside their community. The research found that prior to support from *NTNCA* there had already been a PWA group. This group had formed for the purposes of mutual self help and support. This group's development could be seen from two perspectives: as an organisation outside the community running the group's activities and as PWA's running the group's activities themselves with support from an organization outside the community.

1 An organization outside the community running the group's activities

Group activities were held in Chiang Mai City as a “forum” where PWA's could meet each other confidentially. This pattern was initiated by the Public Health Office, which sometimes collaborated with other organizations and later became the model for PWA group activities in community hospitals.

In the initial phase of group formation, group activities served the HIV investigation process by encouraging people to volunteer for blood testing. When an HIV+ test result was obtained, counseling from the "Anonymous Clinic" was provided. Here, PWA's were introduced to each other and gradually a support group that was then run by the Health Service (like a diabetes group). The group provided an initial health screening, counseling, and updated information about PWA's, opportunistic disease reduction, meals, job training and tuberculosis medication.

The forum was also a crucial activity of the group. Here members could share their experiences and attitudes towards this new life. Many PWA's set up a similar group in their villages. The Forum provided them with a model for group development.

Since the formation of this type of group was initiated from an epidemiological perspective by public health personnel, they did not suspect that they could not negotiation with the government or performing duties which would confront with government. An example of forum activity was the Thursday Friend Club, which was organized by the Chiang Mai Provincial Public Health Office, incorporated with World Vision Thailand and Thai Red Cross-Chiang Mai, or the *Euang Phueng Anonymous Clinic* organized by the Communicable Disease Control Department of Ministry of Pubic Health.

2 PWA's ran their group activities with support from organizations outside the local community

This type of group and network development was a continuing process of self disclosure for community outreach. The focus of such a group's activities related to that of the supporting NGOs. For example, PWA groups which were supported by CCT-AIDS Ministry — such as Umpan's group, Hang Nok Yoong's group and Nam Baw Laung's group — would work at the micro level of the village and use community tradition as their

main way of fighting discrimination and providing support. However, PWA groups supported by NAPAC focused on the macro level. The initiatives of these groups therefore included reporting to the national and international mass media on their activities, joining in the work of other NGO's, and negotiating with the government. Examples of these groups were Friends for New Life, Doi Saket Widow's Group, Clear Sky Group, and Pimjai's Group.

Group activities run by the PWA's were different from the Forum (initiated by Public Health personnel) in two respects:

i) They had a clear process by which to gain more social and moral space in society.

ii) They created a sociable and friendly environment. Members had more opportunities to set up group activities and use of alternative medicine was stressed.

The Process of PWAs-initiated Group Development and Group Disclosure to the Public

Groups which were initiated by PWAs became the means for creating the movement towards social and moral space because they revealed the existence of the group. In this way, the group had more meaning and power than individual disclosure. However there was discrimination and fear of PWAs in general. It was not easy to run group activities openly in the public arena. Group activities required a complex process that began with the investigation of social acceptance. This involved setting up a way to disclose to the public without social resistance and running group activities related to community needs.

Group development and self disclosure which occurred in the villages had some similarities. Prior to the setting up of the group, at least some form of social relationship between PWAs already existed. This relationship usually began when they joined the forum, which was arranged by an organization outside the community such as Umpan's group and Pimjai's group. The relationship could also have started when they came for alternative treatment such as that offered at Friends for New Life. Later they revealed their HIV status to their neighbours in the village and visited other PWA's who needed help, inviting them to join the forum or to receive alternative medicine. Groups gradually grew in this way.

The leader of the group had traced back her relationship to the community in a pattern that helped group development, including self empowerment for setting up a group. Some PWA's who did not disclose themselves in the special situation like Friends for New Life wanted to set up their own group. They presented themselves to the public with their own potential and joined a higher potential organization. They were concerned with communities near their home. These communities had some significance both for evaluating social acceptance of PWA's group and for forming a group. PWA's had learned from their working experiences with government, NGO's or existing PWA groups. Umpan had learned the importance of Home-Visiting PWA's from the staff of CCT-AIDS Ministry, and had been a speaker for District Public Health Office. She was a member of Euang Pheung Anonymous Clinic which was located in Chiang Mai, and a member of Doisaket Widow's Group. Pimjai was a co-speaker with The Chiang Mai Red Cross' staff, a

speaker on AIDS for the AIDS Education for Youth Project. She also had studied the working process of the Doisaket Widow's Group and Umpan's Group before setting up her own group.

PWA's who planned to set up a group in their village had placed a high value upon information distribution and investigation of social response to the group. The information distribution at this time was indirect in order to observe the villager's reactions. They began their activities by integrating themselves into community life during various traditional social events or by getting support for the group from inside and outside the village. For example Umpan invited PWA's to join her in two important events in her own life. The first event was to invite PWA friends to join a traditional merit-making ceremony at her home in the village. The second event occurred when she celebrated her birthday and invited her PWA friends to a party at home. She also invited CCT-AIDS Ministry to help in recreational activities. She found from these two events that neighbors did not insult her or her group. She and her PWA friends later set up group activities quite openly. The Tung Yow Romjai Group used the *tod pabha* activity (a Buddhist fund-raising ceremony) to present its group to the community. PWA's invited their neighbors in the village and other neigboring villagers to attend this activity. A famous monk was also invited to give a Buddhist sermon to them, and he later donated money to help set up a budget for group formation. Pimjai's group initiated her group activity by presenting a group project proposal, which she meant to submit to NAPAC, to key people in the village such as village health volunteeers (VHV), village headman, the abbot of a famous temple in her district and Chiang Mai Provincial Public Health officials. She used these key persons as advisors to the project, and invited them to the official opening ceremony. The Clear Sky Project used the same method as Pimjai's group, that is they had key persons, NGO's and community hospital staff join in the opening ceremony.

Friends for New Life differed from the previously mentioned groups. Members began by joining the group for the purpose of claiming their right to health-care services from the government. They did not plan ahead for a group setting as other mentioned groups did. The group could survive social resistance and lack of acceptance and could continue their group activities for two reasons. The group was located in Chiang Mai City where the urban life-style was more insular than in villages. Moreover, the group had support from powerful organizations such as NAPAC, CDC 10, NTNCA and academics from Chiang Mai University.

There was a special feature in the process of this group's opening to the public and in the presentation of group identity and the group activities which met community and PWA's needs. The formation of the group's identity signified acceptance from powerful persons and organizations in the community. This was demonstrated by the office arrangement which displayed photographs of visitors and the staff of organizations who donated to the group, and by a wall-mounted Honour Roll, prominently listing names of committees and consultants to the group. A sign was erected in front of the office stating: "The Herbal Research for Health Promotion Project, the Faculty of Medicine, CMU". Other differences included the use of the group's symbol on stationary letterheads, and the uniform pockets on committee-members, who were now able to introduce themselves as “Friends for New Life", not PWA's as they previously had.

The presentation of the Friends for New Life image was a continuous process which had support from organizations such as CDC 10, NAPAC, NAM Cheewit Project and CMU

Social Research Institute. This enhanced image of PWA's had thus been created via a cultural process and the mass media.

This group of PWAs combined a group activity with the cultural process in order to set up the PWAs' funds. That *Todpabha* activity was held on December 1st 1995 with the help of a famous monk, academics, the Director of CDC 10, and the Chiang Mai Provincial Public Health Officer. Other group activities were herbal remedy distribution, counseling, coordination with the government and provision of information to members. Friends for New Life presented their group activities via regional and national forums and mass media. It should be noted that NAPAC played an important role in supporting this new image of PWA's, which continues to this day.

PWAs Networking Prior to NTNCA Formation

The research found that there were some networks prior to the support of NGOs. Some PWAs branched out from the original group and created a new group in their own village with help from the original group. This characteristic was found in groups which had good linkage to CCT-AIDS Ministry such as Umpan's group network, which links with Hang Nokyoong, and Nam Baw Luang groups.

The network had been formed with encouragement from NAPAC such as the Friends for New Life group, the Doisaket Widow's group and the Tumbon Ta group.

It was found that the network of PWAs in this period developed only loosely. Members would join a big group only on some special occasions. The network provided an opportunity for PWAs to exchange the group working experiences. The relationship among members of the group was horizontal, not vertical.

b) Group and Network Development After Support from the NTNCA

Prior to the formation of *NTNCA's* policy of setting up PWAs groups, PWA groups were spread out in a loose, horizontal network. The image of PWAs' power and the negotiation with the government for their rights were not clear.

With the revision of NTNCA policy a formal network was established. The hierarchical structure of the group included many levels (e.g, sub-district, district, province, regional and national levels). As a result, PWAs could change their situation and were empowered enough to be able to negotiate with the government agencies.

Important conditions that helped to create a formal network were:

1) The leaders of *NTNCA* had experience in community development and supporting community organizations

2) Since 1994, government policy emphasized collaboration between all agencies, including NGOs and community organizations to help solve AIDS problems. This encouraged community professionals, NGO staff and representatives of PWAs groups to join together and form strategy plans. An organization called Northern AIDS

Coordination Center (NACC) was established which had some degree of autonomy, and the government backed a budget of 60 million baht for the initial operation.

3) The Third Conference on AIDS in Asia and the Pacific was held in Chiang Mai in 1995. This gave *NTNCA* an opportunity to set up a round table forum where they presented the claim for PWAs right to government organizations. This was relayed to the public via the mass media. Some PWAs became spokespersons and gave information to government at the national level.

The positive approach to dealing with PWAs' problems lead to the formation of PWAs' networks. However, it should be noted that these PWA networks were vertically formed, especailly during July - September 1995. This was a period when policy on AIDS was formulated with the aim to submit options to the government. PWAs, recognizing the possibility of funding and other support, then divided themselves into several new groups and prepared to disclose themselves to outside organizations. The number of PWAs groups reached 52 groups, 48 more than the initial 8 one which was formed during 1993-1995. In Chiang Mai alone, there were 34 groups. After that, these PWAs groups were organized into The Northern PWAs Network (hereafter NTPWAs), consisting of PWAs provincial networks from Chaing Mai, Chiang Rai and Phayao. Attempts were also made to establish linkages with PWAs networks from other regions in order to develop a national PWAs network.

The recommendations from the forum organized by NTNCA and PWAs focus on two basic issues: a) PWAs' rights to medical service, access to information, equal employment opportunity, pregnancy, etc.; and b) government policies on setting up funds to support PWAs, supporting traditional medicine, and developing social welfare system for PWAs.

It should be noted that the government acceded to only two of the recommendations on PWAs' rights: medical service for PWAs and support for the formation of PWA groups. Of the recommendations on social policies only two were accepted. NACC approved 4 million baht to support PWA group activities through the NTPWAs network and the Ministry of the Interior approved the tuition fee for PWAs children and unemployment welfare. 500 baht was to be given per month to each PWA, if there was a medical recommendation indicating HIV+ status. With this new development, and with the decrease of social stigmatization, the self disclose of the PWAs and the establishment of their PWA groups thus increased dramatically, from 52 groups in 1995 to 108, 152, 192 groups in 1996, 1997, 1998, respectively.

Changing PWAs Group's Patterns of Expanding or Creating for More Social and Moral Space:

1) Adjustment into patron-client relationship. This often occurred after a PWAs network formed, especially in groups that are based in the hospitals (for example, Jai Prasan Jai group (under supervisor of San Patong hospital), Malison group (under supervisor of Prao hospital) and Lamp for Life group (under supervisor of Sunsai hospital)). Generally, these PWAs groups has a limited degree of power to negotiate with hospital staff.

2) Restoration of social relationship in village community based on cultural norm. This strategy was used by some groups that had revealed their HIV+ status to neighbors

prior to the availability of NTNCA support. They had continuously resorted to the norm of "community sharing" to enable their return to the community with self dignity and self reliance. An example of this was Prasan Jai Tung Satok group which evolved from Umpan's group. The members of this group disclosed themselves through participating in a sewing-training course for housewives which was organised and attended by PWAs in their village. Later the group contacted the local Abbot (a relative of a PWAs group leader) to act as an advisor to the group, and was allowed to use a space in the temple as a place for training and other group's activities.

3) Development of new social relationships within the village so PWA groups could negotiate further financial support and welfare. This was a new strategy which was encouraged by NTNCA. It occurred according to the funding policy of the government. The government allocated a budget to community organizations through the Commune Local Government (CLG), so the PWAs group was required to present an organizational project to CLG.

3) Development of good social relationships with the wider community outside their own village. This strategy of social adaptation occurred in groups which were formed in the early period and in which their leaders were well recognized by people outside the village. An example of this was the Clear Sky Group. The group was well known for its holistic health focus and gradually formed a working relationship with the community outside its group by representing itself at various levels of meetings, and by speaking for various organizations.

Some groups' strategies for social adaptation became quite dynamic. They integrated the four patterns of strategies into their activities. For example, most members of Prasan Jai Tung Satok (a community-based group) were not exclusively separated from the members of the Jai Prasan Jai group (a hospital-based group). The New Hope group used the rebuilding of the social relationship in the village community by mediating with the key persons in the village in order to cope with the problems faced by orphans with HIV+, as well as working with CLG and community health officials.

3. Some Interesting Aspects from the Networking of PWAs at The Present Time

Structural arrangements within the network provided two important advantages to PWAs. They had more opportunities to negotiate with the government and other organizations and they gained benefits from resource-allocation (budget, information, etc.). Therefore, the unity of the PWA's network was a key to the process of gaining their social space and acceptance in Thai society. However, from the researcher's observation, there were some limitations which should be pointed out.

1) Overall, PWA groups and networks had high dependency characteristics and tended to rely on the patron-client relationship that prevails in Thai society. In the early years of group formation, they questioned the Thai public and its government about the rights of PWAs and the mistreatment that they received. Consequently, the PWA groups promoted their activities independently in order to solve their problems. Once the social discrimination had decreased and more support from the government and other organizations was rendered, PWA groups found themselves gradually entering into the patron-client relationship. This is partially because getting outside help is easier than trying to solve complex problems by themselves.

The tendency of group dependency, however, needs to be considered in specific characteristics of the group.

- Most PWAs who disclosed themselves to the public were poorly educated and came from a low socio-economic background. Most of them were wage labourers. When their physical symptoms became obvious, they could not continue working. However, they faced more economic hardship as their illness became severe and they therefore needed to seek help.
- With the definition of HIV+ being a "fatal (lethal) disease" from the Western medical point of view, most PWAs then had no other alternative care except relying on expensive Western medicine. This was quite common in the beginning when there was strong social discrimination. In the later period PWAs gained some hope from alternative medicine. But when medical treatment from state hospitals became available, most of PWAs accepted the Western medicine as a major treatment and used alternative medicine in their self-treatment. Therefore, the dependency on hospitals and government increased.

2) It is observed that most PWA group activities served individual PWA needs rather than the group needs, which are mainly assisting the PWAs who have less access to information, searching for alternative health care, and identifying the ways in which PWAs can live with their local community. Even though in the later period PWAs created linkages with some powerful outside organisations, such relationships have not been used effectively to solve problems at the grass-root level. For example, the AIDS problem was still viewed as an isolated health problem without connection to other community problems. In addition, PWAs gained some health knowledge but did not develop it further in order to counter the dominant Western medical knowledge. Furthermore, PWA groups, organizations and academics did not use this knowledge to shift from a curative paradigm to a health promotion paradigm. They did not restore the concept of self-help or traditional medicine so as to develop an alternative paradigm based on the local knowledge and beliefs in the community and their real practical experience.

3) Even though government organizations, NGOs and PWAs have developed a collaborative working relationship, some elements of a patron-client relationship still exist. Such a contradiction meant that some problems faced by PWAs, such as mistreatment by government organizations, could not be dealt with effectively. The problems were often discussed in the forum, but serious attempts to follow them up were not pursued.

4) One of the major problems facing PWA groups and networks was the lack of continuity in their organization's work. This is mainly due to death of a group's leader. Due to social discrimination, PWAs were largely forced to form a group and network. This, therefore, led to a lack of leadership development. lt was found that a capable leader developed his/her leadership through his/her working experience. Often by the time he or she became a capable leader, the physical symptoms of AIDS and finally death had come to his/her life. New leaders often meant the group started work over again or changed direction. Therefore, the group did not develop continuously.

5) From the above-mentioned conditions, the NGOs which play a role as "supervisor" need to recognize the nature and needs of PWAs and give a high priority to the following issues:

5.1 Their capacity to support PWAs to work together with other PWA groups and community organizations focusing on the endemic problems in local community which relate to he AIDS problem rather than to the PWA group's interests.

5.2 Their capacity to assist PWA groups in advocating policy on AIDS, PWAs' rights, etc. as well as translating these policies into practice.

5.3 Strategies which place the PWA groups in a position so that the groups can resolve internal and network conflicts, and become more self-reliant.

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PART II - ANNEXES

1 GENERAL SITUATION IN THE NORTHEAST REGION

The spread of HIV in the Northeast, as well as the reaction to it, appears to have occurred much later than in the North. At a workshop organized by the Social Research Institute of Chiang Mai University in January 1994 entitled "Socio-cultural Dimensions of HIV/AIDS Control and Care in Thailand," representatives from Khon Kaen University[1] stated in their paper that the Northeast had received considerably less attention than the North and Central Region from both government and NGOs AIDS prevention efforts. [2]

The AIDS virus may have been introduced into Thailand before 1980, but a sudden outburst of the epidemic occurred in 1988. It was concentrated in the North, "Nearly 50 percent of all AIDS/ARC cases are from five provinces in the upper North, while these five provinces account for only 4.7 % of the Thai population. It has been suggested that apart from cofactors such as STDs, the spread in the North is also related to a specific pattern of sexual behavior and culture which differs from other regions."[3]

No definite explanation was given for the concentration of HIV infection in the North of Thailand, As a consequence of such high concentration and due to limited resources, the Ministry of Public Health had to focus most of its activities there. NGOs also threw their efforts and resources into the North, leaving little for other regions.[4] In this paper, we try to explain the delay in the spread of HIV into the Northeast and the late reaction to it in socio-culture term. We shall also try to investigate the corresponding activities in prevention and care, including the involvement of communities and cultural institutions.

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[1] They were medical anthropologist from the Deparment of Community Medicine and a professor in the Departmint of Psychiatric Nursing.

[2] Kanato,..., *Cultural Factors in Sexual Behavior Sexuality and Socioculture Contexts of the spread of HIV in the Northeast, Thailand*, (paper presented to the Conference on Cultural Dimensions of AIDS Control in Thailand, January 19-21, 1994, Chiangmai, Thailand, mimeographed).

[3] Brummelhuis, Han Ten. *Between Action and Understanding.* Paper presented at the Workshop on Sociocultural Dimensions of HIV/AIDS Control and Care in Thailand, Chiang Mai, Thailand, January 1994.

[4] (Kanato 1994, op. cit.).

2 SOCIO-CULTURAL FACTORS IN THE SPREAD OF AIDS IN THE NORTHEAST

It is interesting to find out that the earliest reported death through AIDS was in 1984 in the Central Region. The first case was reported in the Northeast in 1988. However, the most rapid increase of death rate has been reported in the North since 1990. In 1994 it was found that the rate of death through AIDS in the North was double that of the Central Region, about four times that of the South, and about eight times that of the Northeast.[5] This could partly explain the concentration of research as well as prevention and care in the North and the neglect of the Northeast.

No sufficient reasons have yet been given to explain the slow growth of the rate of death through AIDS in the Northeast. This may, perhaps, be explained through socio-culture factors, as we shall attempt to do here.

Traditionally, there appears to have been much similarity in the kinship organization of the North and the Northeast. The essence of kin relations lies in *katanyu* or the corresponding term *bun-khun*. "A person was said to have made *bun-kuhn* to another when he has given something to the latter or has done something of benefit to him. The recipient of the favor is obligated to do something in return."[6] The most important obligation is that of the children towards their parents. They have to repay the debt of gratitude (*bun-khun*) which has arisen from the fact of giving them birth. In this respect, there is an important difference between the roles of sons and daughters. Daughters are expected to support their parents' families, while sons are not expected to do so. While boys can repay the *bun-khun* by being ordained as monks, the daughters must repay it by working in support of their parents.[7] Thai daughters are trained to be responsible for the welfare of their families.

Traditionally, daughters were obligated to support their parents. They worked in the rice fields, as well as growing fruit trees and vegetables. They would sell the produce in nearly markets and give their earnings to their parents. It was a part of the household income to which the daughters contributed. Such obligation and responsibilities exist both in the North and the Northeast.

Migration has always been a way to relieve poverty in the poor Northeast and the upper North. In the 1960s, the road networks in the Northeast were constructed and were linked to Bangkok. The condition of roads in the North improved later. Influxes of migrants from both regions to Bangkok began. The early migrants were men. A major change in migration occurred in the later part of the 1960s. It was found that

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[5] Akua Unnalekka and Wilawan Senarat, The Development of AIDS Epidemic and AIDS Situation in Thailand (Wittayakarn Rabat Khong Rok AIDS Lae Sathanakarn Rok AIDS Nai Prated Thai), in Wichit Srisupan, et.al. (eds), *Treatment for People with HIV and AIDS* (*Karn Payaban Puthitchua HIV Lae Pupuey AIDS*). Chiang Mai: The Nursing Faculty, Chiang Mai University, 1997. (In Thai).

[6] Akin Rabibhadana. *The Organisation of Thai Society in the Early bangkok Period 1782-1873*. Bangkok: Amarin Printing and Publishing, 1996.

[7] *See* Akin Rabibhadana. "Kinship, Marriage, and the Thai Social System" in Aphichat Chamratrithirong ed. *Perspective on the Thai Marriage.* Bangkok: Mahidol and Hawaii Universities, 1984.

during the period 1965-1970, women exceeded men in a ratio of roughly 4:3 in movement from the Northeast to Bangkok, and in movement from the North by 5:4.[8]

Migrants were concentrated mostly in the age range from 15 to 24. Within this range women greatly exceeded men. This change in the sex-ratio must be related to the demand for female workers in Bangkok. The growth of textile industry, for example, demanded female workers. It might also be related to the presence of foreign military personnel in Thailand during the Indochinese wars, and later to influxes of tourists.[9]
During the 30 years period from 1960 to 1991 Gross Domestic Product (GDP) increased from Baht 64.4 billion to Baht 2,509 billion. The average annual income of Thai population at current market prices increased from Baht 4,420 in 1972, to Baht 36,032 in 1990.[10] Such growth involved a change in the economic structure. The government's policy was export oriented, and promoted rapid growth in manufacturing and tourism. The country's production structure became increasingly based on industry and services.

The difference between the North and the Northeast emerged during this period. Chiang Mai, which was the capital of the Northern Kingdom and has been renowned for the beauty and elegance of her women, became one of the most important tourist centers in Thailand. The Northeast Region, on the other hand, despite a few important prehistoric sites and ancient Khmer temples scattered about in the vastness of its arid plateau, could never become a tourist center. Furthermore, while large industrial plants grew up in the North, the Government never succeeded in inducing investors to set similar plants in the Northeast, despite the availability of a huge labor force.

Thus, while there are large numbers of commuting labors and workers in the North, those of the Northeast go down to Bangkok and other distant places, coming home only once or twice a year on special occasions like Songkran (the Thai New Year).

From a Report of AIDS situation of the Ministry of Public Health, the cumulative records of AIDS patients from September 1984 to January 1994 show the following figures:

PWA, categorized by sexed: 61,119 males, and 13,629 females (4.5:1)PWA, categorized by occupation: laborers 31,927 cases (45.60%) farmers 15,325 cased (21.89%) pre-school children 3,712 cases (5.30%) traders 3,056 cases (4.37%) and Government officials 2,733 cases (3.90%).[11] Distribution of PWA up to the end of August 1998 is as follows : (1) Chiang Mai 10,048 cases. (2) Bangkok 9,514 cases (3) Chiang Rai 8,630 cases (4) Phayao 5,380 cases (5) Lampang 4,273 cases (6)

[8] Pasuk Phongpaichit. *From Peasant Girls to Bangkok Masseuses***.** Geneva: International Labor Office, 1982 p. 35.
[9] *See* Akin Rabibhadana . "Thai Society in Transition" in Anand Panyarachun ed. *Thailand, King Bhumibol Adulayadej, The Golden Jubilee 1946-1996*. Singapore: Archipelage Press, 1996.
[10] Ibid.
[11] Sarup Rai-ngan Sathanakan Rok AIDS nai Prathet Thai, tang tae kanyatyon 2527 chonghung 31 Mokkrakom 2541.

Rayong 3,033 cases (7) Lamphoon 2,263 cases (8) Khon Kaen 2,171 cases (9) Chonburi 1,863, and (10) Kanjanaburi 1,590 cases.[12]

It may be noted that the concentration of AIDS cases is often connected to large industrial areas, gig market places, and tourist centers. Chiang Mai, Bangkok and Chonburi reflect all of these three aspects. The only place in the Northeast which has a large number of PWA is Khon Kaen. Khon Kaen is the administrative center of the Region, an industrial area, a communication center, and a place where people from other urban centers and even from abroad visit on business, Aside from Khon Kaen, in comparison with the Northern Region and the Central Region, the Northeast Region has no areas which possess the factors likely to generate the spread of HIV.

Migrants are, perhaps, the most effective carriers of HIV, but there are important differences between the Northern migrants and the Northeastern migrants. As the Northern cities continue to expand at a much faster rate than Northeastern cities in industrial as well as tourism development, large numbers of Northern rural-to-urban migrants turn into commuters or temporary migrants. These Northern commuters or temporary migrants still maintain close ties with their rural homes. The Northeastern migrants, on the other hand, go to work far away, outside their own region. Their absence affects the family structure and the village communities in the Northeast Region.

In many villages in the Northeast a visitor finds only old people and children. People of working age have gone to work far away in Bangkok and other places in Thailand, or even abroad. These workers send remittances to their parents at home. Many working daughters elsewhere send their children home for the grandparents to look after them. We have learned from our interviews with a number of NGOs working the Northeast region that these migrants, when infected with AIDS, do not want to return to their home for fear that their children and their parents would be discriminated against by the villagers. In part because of this fear and the reluctance of workers with AIDS to return home, the number of PWAs in the Northeast is much lower than the number of PWAs in the North. In the future, however, there may be an increasing number of female PWA in the Northeast who are infected when their husbands who work outside the region, and who do not know that they carry the HIV virus, visit home.

There is an important exception to the general statement, made above. While the Director of AID Division in the Ministry of Public Health, Dr. Wiput informed us that in the Southern part of the Northeast (e.g. Surin, Buriram and Sisaket provinces) there are many male PWA who have returned home. These men have been working in the fishing boats in the Eastern and the Southern part of Thailand.[13] Culturally, the Northeast Region can be divided into three parts. The people of the northern part of the Northeast Region are called Thai-Laos. They speak a dialect of Thai language which is very similar to Lao. The people of the Southern part of the Northeast speak

[12] Division of Epidemiology, Ministry of Public Health.

[13] See also a statement from a newspaper, quoted in Suriya Samuttakupta and Patna Kitimasa, *HIV/AIDS in Rural Northeast Thailand: A Global Disease and an Anthropological Challenge*, Khorat: Suranari Technical College, 1997.

the Khmer language, and the people of Khorat, which geographically is the largest province and closest to the Central Region, speak a dialect close to the Central Thai. Culturally, it would appear that the northern part of the Northeast is closest to the North, but migration patterns and different land fertilities have somewhat changed the structure of the families and communities in the northern part of the Northeast which results in their different reactions to PWA as compared to families and communities in the North.

3. FAMILY AND COMMUNITY ATTITUDES TOWARD PWAS

From a number of sources, it appears that most families of PWA's accept him or her.[14] Recently some PWAs have been willing to reveal themselves, but discrimination against people with HIV and AIDS in the communities is still widespread and serious, particularly among older people.[15]

We have mentioned before that the Northeastern migrants (mostly women) often do not return home for fear of inciting discrimination within the community against their parents and their children. The parents, on the other hand, are found to be worried about their sons and daughters who are PWAs. We have learnt from NGOs in the region of a few cases in which the parents went down to Bangkok to bring their son or daughter back home. Usually the condition of the son or daughter is so serious that the PWA has to go straight into the hospital.

We interviewed a PWA who lives in a village north of Khon Kaen. She resides with her parents and is the only PWA in the village. When she first learned that she was infected with HIV she was living in Bangkok with her husband, a migrant from Pitsanuloke. When her husband fell ill with AIDS they both returned to his home in the North, where her husband died. The woman and her daughter then returned to her village in the Northeast and lived in her parents' house. Her parents knew that she was infected with HIV. She also informed the village headman. There were no repercussions and nobody else in the village knew.

According to the PWA, later a faculty member at Khon Kaen University, who was working on a project focused on the prevention of HIV transmission and the care of PWAs, invited her to go on the radio. She was to discuss her part in the project's process for establishing an association of PWAs. From the radio discussion the people in her village learned that she was a PWA. She then had to leave the village and live in a temporary shelter in the rice field. However, after a certain length of time -- she did not say how long -- she was allowed to come back to live in her parents' house. She laughed as she said that when the village people saw that she did not die, they began to feel that she had not been infected with HIV after all.

On the other hand, although the PWA was allowed to remain in the village, she had to work like a normal person. When we interviewed her she had just been transplanting rice for her parents. She had suffered from severe diarrhea for 2-3 days, and was in a very bad shape.

We also visited a forest temple called Wat Pa Chulaphon in Udon. This wat provides treatment for drug addicts and PWA. We found 30 PWA living there: all were women who had been migrants. They informed us that they had to pay Baht 3,000 each but could stay at the wat until they are cured. The Baht 3,000 covered their costs for shelter, meals, and herbal medicines. It is important to note that, although they stayed

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[14] Interview with Phra Suthep of wat Manao Noi, Mukdahan Province.

[15] Ford Foundation, UNICEF, and Thai NGO Coalition on AIDS, Summary Report, *Kan Prochum Samucha phuthid Chua haeng Prathet Thai*. 8-10 October, 1997.

as patients in the wat, the PWA all went home to work in their parents' rice field during the planting season. It seemed as if they wished to look like they are seasonal migrants and are hiding the fact that they are infected with HIV.

One way to explain why Northeastern migrants do not return home when they are infected with HIV is that they fear that their parents and children -- particularly their children -- would be discriminated against by the people in their villages. Another reason is that they may fear that they will become burdens on their families. In general resources are far scarcer in the Northeast than in the North and the Northeastern families of farmers are much poorer than those in the North. The Northeastern families generally depend on remittances sent to them by their migrant offspring. Therefore when any of their offspring is ill with AIDS and cannot work the Northeastern family would be deprived of a part of their existing income. It would be extremely difficult for them to find new resources to feed and look after a PWA and the person who has been infected with HIV would be well aware of this fact. Both of these two factors would deter people with HIV from returning home to the Northeast.
With regard to the southern part of the Northeast, which is somewhat the exception to this, according to both Dr. Wiput and Phra Suthep Chinwaro most of those PWAs who came back home are sailors who have been working on fishing boats of international waters. The incomes of these people are relatively high and their lives are spent mostly on the high sea with little chance to spend their earnings; this would allow them to save up a lump sum of money. When they are ill with AIDS they would return home with a sum of money so that their presence at home would not be a burden on their poor parents. Since their working conditions and jobs are difficult, their physical condition would likely be bad already. Phra Suthep stated that while their families can accept these PWAs, the communities (the villages) often cannot. Phra Suthep said that the number of PWAs in the Northeast is small, but the number of migrants is very large. Phra Suthep suggested that some Northeastern PWAs may go to die elsewhere. It is rumored that the hospice run by Phra Alongkot in Lopburi, which helps thousands of PWAs, has many Northeastern PWAs.

4 BUDDHIST MONKS AND AIDS CRISIS

We have written elsewhere about Buddhist Monks and the AIDS Crisis.[16] That paper deals with the roles and activities of monks in the Northern Region in three settings: a rural setting in Amphoe Mae Chan in Chiang Rai, a semi rural setting in Phayao, and an urban setting in Chiang Mai.

Monks in Mae Chan District in Chiang Rai are often relatives of the villagers. Monks are villagers who have been ordained and live in village wat. The monks in this district have worked closely with the villagers in rural development activities. When the AIDS epidemic occurred, monks visited PWHIV/AIDS to comfort them and assist them with gifts of food and other necessary items. The monks of each wat did this separately and there was no overall organization of these activities. However, in 1991, the Director of Mae Chan hospital, aware of the severity of AIDS epidemic, asked for cooperation from monks in the area. A meeting of monks was organized where they were informed about HIV transmission prevention and the care of people with AIDS. Then monks began to preach about AIDS, teaching the villagers how to live with PWAs and how to protect themselves against the HIV virus. Later, the Thamma tan AIDS Project was organized. In this project the abbot of each village wat searched for "households without AIDS", and asked them to take and keep the following promises:

- I shall avoid risk behaviors
- I shall not discriminate against PWHIV/AIDS.
- I shall help PWHIV/AIDS.

After organizing group visits to see other monks' projects, e.g. Phra Alongkot's in Lopburi, the monks wanted to build hospices for PWHIV/AIDS but this project was stopped by two senior monks and by villagers. The monks also began to take turns working at the District hospital giving consultation and advice on AIDS prevention and care. At the same time, monks of every village wat visited households whose members were ill for any reason, not only those with PWHIV/AIDS. As the monks found their work was overlapping with those of government officials, they decided to cooperate with these officials and set up Sai Than Jai Foundation chaired by the District Chief and supported by the Population Development Association.

Another project we looked at is Jut Prakai Sai Than Tham of Phra Sumat at Phayao. He has set up a *samnak-song* (something like a small monastery: not a wat) He used to work with a well-known medical doctor, Phairote Harinsut, who started a center to take care of PWAs. He had to stop this activity because the neighboring villagers protested against the center. Pra Sumet started his *samnak-song* for the care and treatment of PWAs. He does not let it be known openly that there are PWAs living there: but it is known as the place where PWAs can be treated with herbal medicine. The medicine can be taken (orally) free of charge at the *samnak-song*, but those who wish to take the medicine home have to pay Baht 200 a bag. Phra Sumet coordinates his activities with public health officials of Phayao Province. In March 1995 a

[16] Akin Rabibhadana. *Buddhist Monks and AIDS prevention and Care in Three Buddhist Settings.* Paper Presented at the 6th International Conference on Thai Studies, Chiang Mai, October 14-17, 1996. Attached.

meeting was organized in which representatives of the Public Health Office of Phayao and three hospitals participated. It was agreed that the hospital would provide modern medical service to the *samnak-song*, and that those patients of *samnak-song* who were seriously ill could be transferred to the hospital. We are told that among those who regularly come to buy his herbal medicine are people of high position who could not reveal themselves.

The urban case is that of Phra Phongthep's Sun Phuen Chiwit in Chiang Mai. He is not a Northerner and he had a background in electronics. When he enlisted in the army he became a medical orderly. Before he was ordained as a monk he worked for an NGO. After ordination he eventually came to live in Wat Umong, which is associated with Buddhadhasa, a famous monk in the South of Thailand. Buddhadhasa is well known for his unorthodox interpretation of Buddhism and views on human society.

Phra Phongthep started his center about 1993. His original plan was to set it up a Dhamma studies where PWHIVs/PWAs could learn meditation. The abbot of Wat Umong adviced him to locate his activities outside the temple. He therefore set up a *samnak-song* not far away from Wat Umong, on the outskirts of Chiang Mai.

Few people came to the *samnak-song*. However, through talks Phra Phongthep had with people living with HIV/AIDS he realized that, more than anything, PWHIVs/PWAs need friends to help them deal with their problems and social isolation. When Phra Phongthep heard about new cases he made home visit. At this time, he came to be a close friend of a Protestant priest, *archarn* Sanan, and they made home visits together. During these home visit Phra Phongthep met PWHIV/AIDS who were in desperate need of medical and nursing care. They were from a poor background and had little knowledge about AIDS. Members of their families were afraid to go near them, or too busy making a living, or did not know what to do. When it turned out to be difficult or impossible to have these patients admitted to hospital, Phra Phongthep decided he would take care of them himself. He wanted to provide them at least with food, medicine, and a place to stay.

Thus Sun Phuan Chiwit (a hospice) came into being in 1994. Since the end of that year, the operation of the center has been assisted by Dr. Detsit Sukolpanish, a medical doctor, who visits the center rather regularly to examine patients and who tries to make improvements to the center.

Phra Phongthep's contacts with hospital doctors has not been smooth. He had a few clashes with regular health-care services when trying to get seriously-ill AIDS patients admitted to hospital.

Another conflict arose from the feeling of many health personnel that Phra Phongthep, a monk, was trespassing into the territory of the modern medical profession. Moreover, Phra Phongthep's argument in support of his activities was a strong criticism of the modern medical profession.

However, Phra Phongthep later established contacts with Nakhon Phing hospital and now even exchanges patients. The hospital admits patients who are seriously ill and

need hospital care, while Phra Phongthep's center takes patients who have recovered but still need nursing care. These are patients have no one to look after them.

In fact, all patients at the Sun Phuan Chiwit center are poor, and have no reatives or friends to care for them. None has come from nearly communities. Most of his AIDS patients are from urban areas, especially that of Chiang Mai.

By contrast, we must note that in the Northeast there is an absence of such institutions as that which the monks of Mae Chan District in the North have formed. There are no wats or *samnak-song* in the Northeast which work on HIV transmission prevention and the care of PWAs in village communities with the cooperation of the families of PWA. There are, however, *samnak-song* such as that of Pa Chulaphon and that at wat Ma Nao Noi in Mukdahan Province. They both provide hospices for PWA and use only herbal medicine for treatment. Moreover, the monks of both places came from other regions. He was a university undergraduate who had gone into the jungle to join communist insurgencies. He has had connection with wat Suan Moke, which belongs to Buddhadhasa (mentioned above).

The interesting fact is that the Northeast has famous schools of meditation or forest monks under the leadership of Phra Archan Man (who died number of years ago). A number of his disciples have been or are very famous monks with reputations for extreme purity as well as meditational power. Although a few of the most senior of this school would refrain from practicing any supernatural power, even such ritual blessing with holy waters, the younger ones are still doing so. However, none of the monks of this school would have anything to do with PWAs. Perhaps, this is because HIV and AIDS are connected with purity and danger, the sacred and the profane.[17]

Although in some documents, it is said that there are 11 PWAs groups in the Northeast, they do not seem to be operational. Phra Suthep stated that Government Public health personnel do not trust or support the organization of PWAs groups because they are afraid of protest and political actions. This statement was confirmed by an official at the Public Health Center in Khon Kaen who is worried that any kind of group organization in the Northeast Region would turn into a protesting political group.

The organization of PWAs groups and their effective operation in the Northeast appears to have been linked primarily with the work of NGOs, particularly Sanan of AIDS Ministry of the Church of Christ. Their organization has become an important strategy of the Government Public Health Agency in the North.

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17 *See*, Akin Rabibhadana, 1996, *Ibid*.