

An Analysis of Non-Government Organisations (NGOs) and Women's Activism
in the Politics of Health Reform in Thailand

Montawadee Krutmechai*, Rashidah Shuib, Magdalene Ang Chooi Hwa
Centre for Research on Women and Gender (KANITA)
Universiti Sains Malaysia, Penang

*Corresponding Email: montawadee2009@gmail.com

Abstract

In the early 1990s, Thailand initiated a broad package of reforms in various sectors, including politics, education and health. The health reform brought about direct engagement of government agencies with NGOs and people's organisations in terms of policy formulation and programme implementation. One of the 'people's organisations' that has gained prominence in offering an alternative health model is the Buddhist Medicine Foundation Thailand (BMFT). Based on a bigger study of BMFT, this paper presents a preliminary analysis of the organisation, using both secondary and primary data; the former were gathered from relevant documents and literature review in a desk-review, while the latter were generated from in-depth interviews of the leader, volunteers and participants. The findings showed the importance of historical reform movements of civil societies, the pluralistic health care system as well as the people-centred ideology of the Tri-Power Model converging to form the socio-historical context of BMFT. Thematic data analysis of the in-depth interviews revealed deep spiritual belief that drives strong voluntarism, with about 80 percent of women involved. BMFT has also shown the capacity to be visible through holistic health activities nationwide, and the capability of being sustainable with its activities contributed mainly by women. BMFT as a people's organisation has shown to be an important stakeholder in the politics of health reform in Thailand.

Keywords: Buddhist Medicine Foundation of Thailand (BMFT), alternative health model (Buddhist Medicine model), civil society, engagement, health reform, non-government organisations, politic, people's organisation, women's participation.

1. Introduction

Thailand is one country in Southeast Asia known for its more than 18,000 civil society organisations which are varied in terms of size, type, characteristics and agenda (Asian Development Bank, 2011). Having its long history in charitable organisations, usually patronized by royal members or elitist groups, these organisations have now grown beyond charity work. The agenda are now linked to development issues such as economic, climate change and health, though there are civil society organisations that still provide charity and

services. An understanding of civil societies and their roles in Thailand, however, must be examined against Thailand's socio-political historical context.

Civil societies, in this paper, are defined generally as any organisations that are non-state in nature, non-profit, usually driven by volunteers though there are those with paid staff, and are externally funded by donors or contributions raised by volunteers. According to Castells (2008), "Civil society is a dimension of modern societies", and that engagement with the state takes place in the "public sphere", playing major roles as contributors in social development. The members of civil society organisations typically share a sense of obligation, common concerns in their voluntary participation in the various activities.

This paper, which is part of a bigger study, presents the preliminary analysis of the Buddhist Medicine Foundation Thailand (BMFT) or *Moolnithi Phate Vithi Dharma haeng Pradhes Thai* in Thai, a people's organisation in the health sector, providing an alternative health care model named "the Buddhist Medicine (BM) Model", framed in a holistic life-style, based on Buddha's principles in promotion of the "nine-pills". The BMFT is a grassroots initiative in developing an alternative health model. The BM model is different from others as reflected in its delivery systems, medical principles, philosophy and approaches in solving health problems. It applies specifically the Buddhist's beliefs and principles, and King Rama 9's Sufficient Economy theory while adhering to the mottos that "The best doctor is the people themselves" and "Zero baht curing every disease". A large number of people in the five regions of the country participated in BMFT's activities regularly. Women were the largest group and they participated actively playing various roles in the organisation.

The main aim of the paper is to highlight that the emergence and the development of BMFT into an organisation that could mobilize thousands of people is highly contextualized, shaped and supported by the "climate for reforms" and the "localism discourse", external to the organisation. Thus understanding the socio-historical context of BMFT is important. On the same note, the paper questions who the actors of BMFT were and whether women were involved, and if they were, what their roles were in the organisation. The In-depth interviews would illuminate the internal dimensions of BMFT such as the importance of leadership, the philosophy and beliefs of BMFT.

2. Research Methodology

In the bigger study, both quantitative and qualitative approaches were used. However for this paper only data from the in-depth interviews were analysed and presented. Sixty respondents (42 women and 18 men) from seven categories of respondents: BMFT participants, volunteers, coordinators, leader, consultant, Asoke community members (Asoke community is a Buddhist campus where there were Buddhist members holding a particular Buddhism beliefs and discipline based on a sufficient way of living, self reliance and being vegetarian.) and outsiders. Respondents were selected based on the following criteria: gender, year of engagement, health condition, residence (rural and urban), educational background, economic status, position in BMFT. The transcribed interviews were analysed using the thematic analysis with the help of the Atlati software.

For this paper, only the use of secondary data from the desk reviews and some primary data from the in-depth interviews were analysed and presented. Desk reviews were done with selected relevant documents of BMFT and literature on social movements, health sector reform and civil society engagement in Thailand.

3. Findings

The findings are presented in two parts. The first part presents the findings of the desk review of documents and literature on social movements and civil societies in Thailand that were read and analysed to tease out the socio-historical factors that shaped the development of BMFT. The second part is the relevant findings that emerged from the thematic analysis of the in-depth interviews.

3.1 Desk Review Findings

Socio-Historical Context

In understanding the emergence of BMFT, the socio-historical context is important. The long historical culture of the Thais in doing charity work, the emergence of democratic spaces which facilitated the involvement of civil societies in public policy reforms, the pluralistic health care system and the state-civil society partnership through the Tri-Power Strategy are factors that served as a critical context in the development of BMFT.

The Culture of Faith Based Charity Work

The long culture of charity work, strongly infused by strong Buddhist's belief can be traced as far back as the early 1890s. Usually receiving strong support from members of the royal family, monks and temples served the community as centres of healthcare, education and essential social services, driven by deep rooted Buddhist philosophy of 'merit-making'; doing good in this world to collect rewards for the next world (Pongsapich & Kataleradabhan, 1994). By the 1950s social welfare NGOs began to evolve into more of a "development NGO" in nature rather than just providing charity work. Nevertheless the culture of 'serving' the people has long been embedded in the Thai community and Buddhism is seen as the driving force that has influenced the emergence and the growth of BMFT.

The Emergence of Democratic Spaces: the Climate of Reforms

For seven centuries Thailand was ruled under absolute monarchy but this was replaced by constitutional monarchy through a coup by middle ranking military officers on June 24, 1932. Subsequently, Thailand experienced repressive, authoritarian regimes and witnessed periodic political instability, frequent changes of government, coups and counter coups and a shift back and forth between representative government and authoritarian rule (Bunbongkarn, 2014). The seeds for democracy emerged from political and social reforms in Thailand initiated by the rising of civil society in Thailand; most notable being the Democracy movement during 1960-70s (KEPA, 2011). But the emergence of Thailand as a growing economy during the 1980s-1990s brought a climate of reforms; political, education and health sector reform.

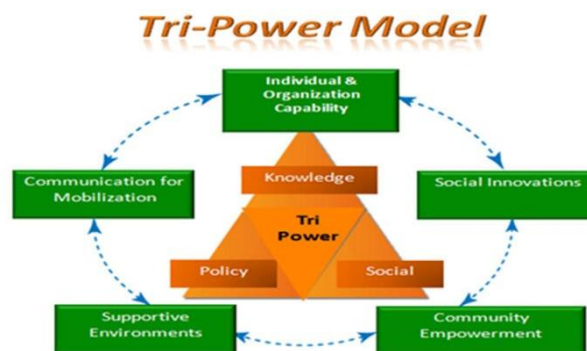
Political reformation took place after 1980s resulting in a more opened space for civil society's engagement and elected ruling politicians. At the same time Thailand's economic growth was impressive with its open market, industrialization and neoliberal ideology bringing in foreign investors. However, when the 1997 economic recession hit the world, Thailand suffered from a severe impact. This was particularly felt in the rural areas where family members were dependent on remittances from those in the urban areas where many factories and businesses closed down. To make matters worse, the International Monetary Fund's (IMF's) strategy for structural reform in the name of efficiency, leading to severe cuts in services and social support, created a counter move from NGOs and social movement-based oppositions who actively called for finding alternative means to development as a reaction to IMF and foreign investors who were seen as "buying" what belonged to the Thais. Pasuk (1999) called this the "localism discourse", "...the significance of the rural community as an

opposition to economic growth, urban and industrialization” (Hewison 1999). There were strong calls for “self-sufficiency” and “self-reliance” particularly in meeting basic needs such as food, health care, housing and clothing (Hewison 1999). The same language was used by the King and this strengthened the local discourse.

The cooperation between government and NGOs began in 1980s. NGOs became the key actor of Thai civil society by playing active roles in the 5th National Economic and Social Development Plan (NESDP) to 8th NESDP. Learning from the failure of the first NESDP, the ‘community culture movement’ concept and approach was promoted by the activists, and it became a guiding principle for many NGOs (Phongpaichit, 2004; Southard, 2016).

The Tri-Power Strategy: The State and Civil Society Partnership

There were professionals-activists who contribute to several initiatives to the health sector reform. A notable one was the “Triangle that Moves the Mountain” proposed by Dr. Prawes Wasri that utilizes a three-pronged strategy of knowledge creation through research, social movement or social learning and political movement (Chuengsatiansup, 2005 and Wasri, 2000). This idea was adopted and adapted by the government into the well-known “Tri-Power Model” as illustrated in Figure 1 below. The assumption here is that effective change is the result of bringing the synergy of the “top-down” and “bottom-up, thus improving health and health equity (Rasanathan, Posayanonda, Birmingham, & Tangcharoensathien, 2011), while tapping into the potentials of civil societies and local knowledge.



Source: www.ThaiHealth Promotion Fund, 2013

The Tri-Power Model not only shows the state-civil society partnership but a formal structure in policy making that welcomes the civil society as partners and this included local folk doctors who work for people individually, people’s organisations, Non-Government

Organisations (NGOs), and academic activists who analyse public health problems and policies and offer solutions. Many NGOs working in health care promote a holistic health and bottom up approach with strong people's participation in policy making(Ondam et al., 2002).

The Pluralistic Health Care System

An interesting feature of the Thai health sector is the Pluralistic Health Care System that exists to help meet the health care needs of the ordinary Thais. Traditional medicine healers exist side by side with modern medicine (Petraakas , 2013). Local wisdom in health care remains the methods that people seek especially in the rural community. In short, the Pluralistic Health Care System is the integration or interaction among these three systems of health care methods used by the Thais; the Folk sector, Professional sector, and Popular sector (Department for Development of Thai Traditional and Alternative Medicine, 2011). BMFT is one of the actors in the Pluralistic Health Care System of Thailand that offers spiritually Buddhist based medicine as well as an alternative approach to health care that fits in well with the Tri-Power Model because it focuses on local knowledge building, social mobilization through its health camps and strong community engagement.

3.2 In-depth Interview Findings

More than 80 per cent of BMFT members were women. This striking feature will be analysed further in the discussion section. The thematic analysis of the in-depth interviews revealed several findings that reflect the internal strength of BMFT. The majority of those interviewed pointed to the strong leadership of BMFT, the strong fit of what BMFT offers and Buddhism, and a strong volunteer culture.

Institutional Leadership of BMFT

The respondents reported that the leader of BMFT is knowledgeable in both modern and traditional medicine. Almost all of them expressed that, he has capability of mobilizing people, humble yet charismatic, and he is also with a leader by example who does not only talk the talk, but also walk the talk. Therefore, people trust him and have good faith in him. In addition, this study also found his leadership style is driven by strong Buddhism belief, as shown in these statements:

Very clear ...we can have deeper understanding. Mor(Dr.Keaw) is skillful. He explained about hot and cold elements in our body and how to cope with these. If we get too hot, we can use cold elements to balance hot condition. If we get too cold, we can

3rd KANITA POSTGRADUATE INTERNATIONAL CONFERENCE ON
GENDER STUDIES

16 – 17 November 2016

Universiti Sains Malaysia, Penang

get hot elements to mix. I think I can do, if I pay attention, to take care of myself, not ignore self-care. As I listen to Mor Keaw, I definitely cannot ignore. I understand how to apply these. (Puttan, female, 70 years, old participant, north)

The thing that makes me have confidence of him is...he does not take anything for his own...believe in him...he holds dharma discipline..The other is he has potentials to deliver knowledge to us. (Puangsaed, female, 53 years old, volunteer, west)

A strong fit between BMFT's activities and Buddhism

The BMFT is a Buddhist faith organisation that applies Buddha's principles and practices such as Karma belief and spiritual development through giving, sharing, and merit making. The strong belief in Buddhism is commonly accepted by Buddhists. There seems to be a good fit between what people want and what the organisation offers. Chaba (50 years old) had this to say:

We would like volunteers to join BMFT community. In any case, anyone can make a sacrifice to do zero baht working, and use this to get rid of defilements as a goal. Mor Keaw has given the policy that we must have time to work, however we should have more time to get rid of defilements more than working. (Chaba, female, 50 years old, volunteer, south)

Strong voluntary culture

The BMFT cultivates strong voluntary culture among its members. Since more than 80 percent of the members, both volunteers and participants, were women, it would be safe to assume that one of the strengths of BMFT has got to do with the fact that BMFT could rely on women to be volunteers. When religious beliefs and values are brought in, the fundamental in Buddhism which is the belief in *karma* (results of a person's actions and behavior), and ways to make *merit*, most of the people (and in this case women) who joined BMFT were willing to practice to be self-reliant and to help others voluntarily such as doing “self care, livelihood development, and harmoniously living together” and help those who were sick and suffering, and directly or indirectly create changes in the society.

If we have the opportunity to make changes, it is no wonder, like Khun Mor (Mor Keaw) said, in his words, that we can create vibrations in the country by the people in our group who are sincere...being sincere with themselves, sincere with Buddhism, and making sacrifices with the believe that it is merit making. (Phikul, female, 56 years old, coordinator, central)

*I can and do everything including work in panel, cooking, cleaning latrine (laughing).
I have done almost every kind of work. (Anchan, female, 41years old, volunteer, central)*

4. Discussion

This paper has shown that the emergence and development of BMFT is not just a result of an individual's leadership, the founder, but a complex working of factors, both external and internal to the organization. It is important to understand the socio-historical context, which in this case, has shown how the creation and emergence of BMFT was spurred on by an opening of 'public space' within a more democratic political climate as well as a climate of reforms and "localism discourse" in Thailand in the 1990s. Hence, BMFT experienced fewer barriers in the attempt to facilitate change for the community and society when compared to those struggles of previous civil societies.. The discussion and issues are already understood and served as good foundation for the further growth of BMFT. Importantly, the strategy of bringing in local partners (via Tri Power Strategy) of which the idea came from professional doctors who were also activists themselves, created spaces for the development of formal/institutional structure that welcomed non-government organisations. The symbiotic relationship of knowledge creation, social mobilization and using local knowledge for community development fits very neatly with BMFT's philosophy and strategies.

BMFT appears to have adopted a volunteer approach in carrying out its activities which in turn has helped shape the strong culture of charity work at BMFT. This strong volunteer culture is of the key characteristics of the organisation. From the interview data, BMFT encouraged the participants and volunteers to be aware of their health and social problems by promoting new ways of living for people to take care of themselves and others. Interestingly, these religious and cultural dimensions are vital to encourage voluntarism which fits nicely in with Thai socio-cultural and religious values.

As BMFT has more than 80 percent female participants of all ages and socio-economic class, the study found that the BMFT's approach contributed more at the individual empowerment level in terms of their physical and spiritual development. At the community level, traditional culture, religious beliefs and conservative interpretations among many members in BMFT remained traditional. Therefore, the women played more significant roles as implementers and supporters, whereas their leadership roles were rather constrained.

5. Conclusion

BMFT is an important stakeholder in the health reform in Thailand. It is a unique alternative healthcare model which emphasises a holistic approach of spiritual development based on a strong belief in Buddhism and also the King Bhumibol (Rama 9)'s theory of Sufficient Economy which is consistent and fitting neatly in with Thai social culture and religious values. Its emergence was timely given the climate of local discourse as well as the health needs of the Thais. Given its internal strength of a strong and committed leadership, and a pool of dedicated volunteers, facilitated by an institutionalised state-civil society's partnership, BMFT provides a great avenue for a more sustainable way of working for the health of the people of Thailand. Women are highly participative in BMFT and they are also essential contributors in all activities of the organisation. However, they play more of the implementation roles rather than leadership roles.

6. Acknowledgement

The authors would like to express their gratitude to The Institute of Postgraduate Studies (IPS), Universiti Sains Malaysia for providing the fellowship (2010-2013), the Right Livelihood College, and the BMFT that provided support to the study.

7. References

- Asian Development Bank. (2011). Civil Society Briefs Thailand [Press release]
- Bunbongkarn, S. (2014). Democracy and Monarchy in Thailand. *Thailandtoday*, 1-5.
- Castells, M. (2008). The New Public Sphere: Global Civil Society, Communication Networks, and Global Governance *The ANNALS of the American Academy of Political and Social Science*, 616(78), 78-93. doi: 10.1177/0002716207311877
- Chuengsatiansup, K. (2005). *Deliberative Action: Civil Society and Health Systems Reform in Thailand*. Nonthaburi: National Health Commission Office.
- Department for Development of Thai Traditional and Alternative Medicine. (2011). *Healthcare Manual by Thai Traditional Medicine and Alternative Medicine* Thailand: Department for Development of Thai Traditional and Alternative Medicine, Ministry of Public Health

**3rd KANITA POSTGRADUATE INTERNATIONAL CONFERENCE ON
GENDER STUDIES**

16 – 17 November 2016

Universiti Sains Malaysia, Penang

- Dipendra, K. (2016). Determinants of Internal Organizational Governance Practices: Evidence from Civil Society Organizations in Thailand. *International NGO Journal*, 11(1), 1-11.
- Hewison, K. (1999). *Localism in Thailand: A Study of Globalization and its Discontents*. Paper presented at the Working Paper No 39/99, Center for the Study of Globalisation and Regionalisation (CSGR), University of Warwick, United Kingdom.
- KEPA. (2011). Reflections on Thai Civil Society (pp. 1-6): KEPA: Service Centre for Development Cooperation
- Ondam, B., Chumchan, Y., Leethongein, P., Hassarangsri, R., Krutmechai, M., & Voharn, C. (2002). The Role of Non Government Organization in Health Care system Reform (pp. 45). Nonthaburi: National Health systems Reform Office(HSRO), Ministry of Public Health.
- Petrakas, P. (2013). Thai Traditional Medicine and Folk Medicine Service System (pp. 49-86). Thailand.
- Phongpaichit, P. (2004). Developing social alternatives. In P. Warr (Ed.), *Thailand beyond the crisis* (pp. 161-182). USA and Canada: RoutledgeCurzon.
- Phongpaichit, P., & Baker, C. (1999). Theories of social movements and their relevance for Thailand. *Position paper for project of Social Movements in Thailand, a project supported under the Thailand Research Fund's methi wichai awuso program*.
- Pondej, C. (2010). *Participatory Planning in Municipal Development in Thailand*. (Ph.D.), Universität Berlin.
- Pongsapich, A., & Kataleeradabhan, N. (1994). *Philanthropy, NGO Activities, and Corporate Funding in Thailand*: Chulalongkorn University Social Research Institute.
- Rasanathan, K., Posayanonda, T., Birmingham, M., & Tangcharoensathien, V. (2011). Innovation and participation for healthy public policy: The first national health assembly in Thailand. *Blackwell Publishing Ltd Health Expectations*, 15(1), 87-96. doi: 10.1111/j.1369-7625.2010.00656.x
- Southard, D. (2016). Collaboration or Appropriation? Development Monks and State Localism in Northeast Thailand. Singapore: National Institute of Singapore.
- Tejapira, K. (2004). The Emergence of NGO Movement in Thailand and the Sarit Regime. In S. Shegetomi, K. Tejapira & A. Thongyou (Eds.), *The NGO Way: Perspectives and Experiences from Thailand*. Japan: Institute of Developing Economies Japan External Trade Organisation
- Thabchumpon, N. (2011). An ASEAN Community for All: Exploring the Scope for Civil Society Engagement. In T. Chong & S. Elies (Eds.), *An Asean Community for All: Exploring the Scope for Civil Society Engagement* (pp. 127-137). Singapore: Friedrich-Ebert-Stiftung Office for Regional Cooperation in Asia.
- Thai Health Promotion Fund. (2013). Thai Health Promotion Fund. Retrieved from <http://www.thaihealth.or.th/Books/369>
- Wasi, P. (2000). Triangle that moves the mountain and health systems reform movement in Thailand. *Human Resources Health Development Journal*, 4(2), 106-110.