

RESEARCH ARTICLE

# Narratives of Structural and Cultural Violence in the Context of the Stateless Hill Tribes Living with HIV/AIDS in Chiang Rai, Thailand

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**Abstract:** Stateless hill tribes living with HIV/AIDS are the most vulnerable population in Thailand. This article adopts the issue of the structural and cultural violence of Johan Galtung as a conceptual framework and analytical tool to narrate their experiences. Data encompassing the experiences of structural and cultural violence were collected from the 53 eligible stateless hill tribes living with HIV/AIDS recruited from 10 district hospitals and 15 communities in Chiang Rai, Thailand, using a combination of the snowball technique and purposive sampling. The present authors argue that the stateless hill tribes living with HIV/AIDS mainly experienced the following two dimensions of violence: 1) statelessness as a structural violence practice and 2) stigma as a cultural violence practice. This study revealed the subjective experiences of stateless hill tribes living with HIV/AIDS in Chiang Rai, Thailand, while engaging with the violence sphere.

**Keywords:** structural and cultural violence, stateless hill tribes, HIV/AIDS, stigma, access to healthcare

## Introduction

The largest stateless population in the world is settled in Thailand (Herberholz, 2020). The indigenous hill tribes are one of the biggest stateless groups in this country (Rijken et al., 2015). These hill tribes are minority ethnic groups that live in villages, particularly in the mountains of the border areas of Northern Thailand (Apidechkul, 2016), and around 400,000–600,000 are stateless (Kemasingki, 2017).

In Thailand, nine “non-Thai” ethnic groups have been officially identified as the “hill tribes”

(Chao Khao) since the National Committee for Hill Tribes was set up in the year 1959. Listed in order of importance, these tribes are the Karen (Kariang), the Hmong (Meo), the Lahu (Museu), the Akha (Ikho), the Mien (Yaw), the H’tin (Thin), the Lisu (Liso), the Lua (Lüa), and the Khamu (Khamu) (Clement, 2011).

The Karen migrated from Burma to Thailand in the 14th century between the Burmese–Siamese War of 1547–1549 (Chua-Maharwan, 1998). The Akha moved from the Shan State in Burma to Northern Thailand due to the disturbance of the Yunnan armed force in

the 1950s (Sinchaiworawong, 2003), and the Lahu and Tai Yai tribes arrived as a result of the Burmese political conflicts in the 1960s (Phatthanakaya, 1991). Another group, Khmu, moved from Laos in the 1950s to Northern Thailand for economic and agricultural opportunities (Khamkam, 2014). Hmong and Mien moved to Thailand through the northern part of Laos due to the Indo-China War that took place between 1955 and 1975 (Inter Mountain Peoples Education and Culture in Thailand Association, 2002; Matisilp, 1993). Finally, the tribes settled in the Mae Fah Laung, Mae Sai, Mae Suai, Mae Chan, Chiang Khong, Chiang Saen, Doi Luang, Phaya Mengrai, Wiang Kaen, and Mueang districts of Chiang Rai Province. Nowadays, most of them are third generation (some more than that) and get married across ethnicities (Thutsanti et al., 2019). Most of the hill tribe people qualified for Thai citizenship, as their ancestors had settled in the country more than 200 years ago, while some of those born in Thailand and who have one or both parents who were also born in the country remained stateless (Park et al., 2009).

It is widely accepted that Thailand has one of the highest HIV prevalence rates in Asia and the Pacific, accounting for 9% of the region's total population of people living with HIV. An estimated 470,000 people were living with HIV and 14,000 people died of AIDS-related illnesses in 2019 (Avert, 2020). In 1990, the first case of HIV/AIDS in the hill tribe people was a 25-year-old Lisu, reported at Mae Suai District Hospital, Chiang Rai Province. The peak period of HIV/AIDS infection among the hill tribes occurred between 2001 and 2010, in which 76.1% of the hill tribe HIV/AIDS patients did not receive any treatment, 90.5% did not have a measured CD4 level, 33.3% were still alive, and 30.7% had tuberculosis disease after the HIV/AIDS infection was diagnosed (Apidechkul, 2016). Stateless hill tribes in Northern Thailand are vulnerable to HIV/AIDS infection, as they live in HIV/AIDS epidemic areas. Chiang Rai Province has the highest prevalence rate at 21.29 per 100,000 population in that peak period, and HIV/AIDS survival time among the hill tribe population was lower than among the native people (Apidechkul, 2011).

In 2020, UNAIDS (2020) estimated that around 80% of Thai people living with HIV were on

antiretroviral therapy (ART) and 78% had suppressed viral loads but more than half of hill tribes living with HIV/AIDS in Chiang Rai Province, Thailand, have a history of opportunistic infections of one to two times (Wongnuch et al., 2019). The question here is although all the medical resources in Thailand have high-potential affordability in the present day, with Thailand claiming that they are the first country to have adopted a policy of free ART for all Thai people who live with HIV/AIDS (National AIDS Management Center, 2017), then why is the hill tribe population more vulnerable than the others, why is it harder for them to access medical care and treatment, and why are they more likely to develop final-stage HIV? Is it rooted in the enduring effect of being stateless and being denied access to basic rights and services or being stigmatized, which drives inequality and discrimination further, threatening peace and security? This research aimed to reveal the voices of the stateless hill tribes living with HIV/AIDS regarding their structural and cultural violence experiences through a narrative approach.

## Structural and Cultural Violence

According to Johan Galtung (1969, 1990), structural violence is an avoidable impairment of fundamental human needs. It is indirect/visible violence that can produce the same consequences as direct violence. In structural violence, it is difficult to identify the agent of chaos or the nature of the threat, but institutions that create the condition for the violence on social groups can be identified. This form of violence includes racism, sexism, ageism, marginalization, fragmentation, etc. Farmer et al. (2006) expanded the term to make it applicable to political, economic, and social inequalities that prevent people from reaching their full potential.

The other form is cultural violence. It is a type of violence where the source originates from cultural domains such as religion and ideology (internalization), language and art, and empirical and formal science (logic, mathematics), among others. As Galtung (1990) disputed, culture can be used to legitimize or justify whether direct or structural violence looks and even feels right, or at least not wrong.

## Methods

### *Study Site and Design*

Chiang Rai Province was selected as the study site primarily because it has been one of the top-ranking provinces with major HIV/AIDS-affected populations in Thailand (Chiang Rai Public Health Provincial Office, 2018), and the province has 652 villages, which are inhabited by 180,214 hill tribe people.

A narrative approach was used to collect in-depth information from the hidden populations, stateless hill tribes living with HIV/AIDS in this region. This approach facilitated the research subjects with the freedom to express their experiences and allowed the researcher to attain a deeper knowledge of the life stories of the research subjects and understand those stories' sociohistorical contexts. Attention and respect were duly given to the participants' subjective experiences to empower them (Elliott, 2005; Jovchelovitch & Bauer, 2000).

### *Participants and Data Collection*

In the 10 months between August 2017 and May 2018, using a narrative approach that combined the snowball technique and purposive sampling, we collected data from our sample comprising the stateless hill tribes living with HIV/AIDS in the Chiang Rai Province in Northern Thailand. All of the research participants were discovered from 10 district hospitals and 15 communities. The ones who fulfilled the following inclusion criteria were invited to participate in the study: 1) living with HIV/AIDS for at least one year, 2) living as a stateless hill tribe person, and 3) have been living in Thailand since before 1999 (as the population survey of the hill tribes by the Thai government was in 1999) or born in Thailand. After considering the inclusion criteria, 53 participants were deemed eligible, out of which 39 were female and 14 were male. The sample consisted of nine hill tribes (such as the Akha, the Lahu, the Lisu, the Karen, the Mhong, the Mien, the Tai Yai, the Lua, and the Khamu), with individuals aged 16 to 68 and living with HIV/AIDS for 1 to 18 years. Most of the participants could understand Thai when they hear it (we say "hear" because most of them could not read and write).

Trust and rapport were built with the participants before the commencement of the interviews. The narrative interview guideline was developed from the literature and approved by experts in HIV/AIDS and

hill tribes. This guideline was revised after being piloted with five hill tribe persons living with HIV/AIDS in the Mae Suai and Mae Chan districts of Chiang Rai Province. The guideline allows the questions to inquire about demographic data (such as gender, age, ethnic, marital status, socioeconomic status, etc.), followed by the participants' personal life and family history, experiences in acquiring Thai citizenship, getting access to healthcare, experiences with illness (route of transmission, opportunistic infections, social stigma, and discrimination, among others), their life after their HIV/AIDS diagnosis, social network, and health status (current CD4 cell count, CD4 cell count before treatment, quality of life, etc.). The narrative interviews with some of the research participants were conducted in their homes, while with others, they were carried out in the district hospital's counseling room.

### *Data Analysis*

Interviews were transcribed in Thai and entered into the NVivo program (NVivo, qualitative data analysis software; QSR International Pty Ltd. Version 11, 2015) to carry out thematic analysis (Vaismoradi et al., 2016). This process required the involvement of two research teams (one with a medical anthropology background and the other with a counseling psychology background) and also an external auditor (with a social epidemiology background) for reading transcripts and highlighting meaning units, coding-recoding, and looking for abstractions in the participants' accounts and for organizing, comparing, contrasting, and defining the key themes. This procedure was conducted by an interdisciplinary research team. Moreover, researchers collaborated and shaped patterns of structural and cultural violence that affect the stateless hill tribes living with HIV/AIDS and access to care by creating a dialogue with the research participants for insightful discussions. Then, we highlighted and reported the multivoicedness of the narratives of the participants regarding their experiences with violence.

## Results

### *Structural Violence against the Stateless Hill Tribes Living with HIV/AIDS*

The various manifestations of structural violence were observed during the data gathering process.

Many people from hill tribes were not given ART, and some who had shown poor HIV/AIDS treatment outcomes succumbed to opportunistic infections such as tuberculosis. This phenomenon came as a surprise to the research team because the Thai government claims a high rate of people with HIV in Thailand are on treatment and virally suppressed that no one should die from opportunistic infections today. It asks why AIDS patients' health outcomes are likely poor. Researchers have found that many participants with poor health outcomes from the Akha, Lahu, Lisu, Karen, Mhong, Mien, Tai Yai, Lua, and the Khamu were commonly stateless people who did not have any official documents to indicate them as Thai citizens. They are denied basic rights; they face difficulties in accessing education and are unable to register their marriage, travel independently, hold property, and work. Further, they are denied a funeral and death certificate, are unable to access healthcare, and live under the fear of being arrested as they are stateless. Therefore, it is unfortunate that these topics concerning HIV/AIDS have been neglected in academic literature and policy concern.

In the 2010s, many nongovernmental organizations raised the issues of stateless hill tribes, although the Thailand government has never been concerned about the basic facts involved in the matter. The activist groups led by the Hill Area and Community Development Foundation in Chiang Rai called upon the citizens to campaign for the stateless hill tribes, including elderly groups who were people born between the 1900s and the 1960s. Although the law states that all Thai citizens are entitled to medical care, this law interprets Thai citizens as people of Thai nationality having a 13-digit identification number. Meanwhile, the process for registering persons to acquire Thai citizenship is extremely complicated and necessitates going through many approval steps, which may take more than three to five years. Due to their lack of citizenship or legal status, hill tribes are considered "illegal migrants" in their own country. Researchers found many hill tribe people were not included in a highland population survey conducted by the Thai government in 1999.

A 37-year-old hill tribe female with HIV said the following:

At that time, I was not surveyed because I went to work in another village. I was not

counted, but my sister got a Thai ID card. I must get approved through DNA test with my sister to establish relation, which cost around \$300, but the difficult part is my birth certificate because I have no official documents. I started an administrative process to certify my birth, but the district officers told me that I must bring the person who saw me get born, such as a traditional midwife. Therefore, I took a traditional midwife to the district office, but the deputy district chief was absent that day, therefore he could not sign my petition for approval. I tried to contact the district office many times. It is very hard for me because I did not have a private car... I paid too much in this process. Finally, I am still a stateless person... I am so stressed... How do I get the medicine? I do not have any official documents. I do not have enough money to buy the medicine. I just pray for myself.

Nowadays, many people from the hill tribes with HIV are still without Thai citizenship even though they were born in Thailand. Under these conditions, they receive disparate access to healthcare and education resources as a 27-year-old hill tribe female with HIV remarked the following:

I don't have any cards to get my status approved. I was born and raised in this area, but my parents are not able to process my birth registration because they are stateless person. Accordingly, I didn't have the opportunity to go to school and avail health insurance. The healthcare staff advised me to register for migrant worker's health insurance.

The participant expressed that their health and financial crisis are due to the lack of health insurance because of being stateless. It impacts them at every step of the process, ranging from diagnosis to effective care. Being stateless has limited their opportunities to avail adequate quality care and meet healthcare needs. It manifests the power of social forces beyond the control of patients. A participant who is a 46-year-old hill tribe female with HIV said the following:

When we come to the hospital, there is a cost of medicine, which causes me trouble. I have

to pay for the medicines and patient card fees. I don't go to the hospital because purchasing medicine is very expensive until I got sick with tuberculosis and was bed-bound for three months.

During the period of antiretroviral drugs limitation of 1990–2000, stateless hill tribes living with HIV/AIDS were not the priority group and, as such, did not receive treatment on time. The government had set the priority criteria regarding medicine allocation, as described by a 43-year-old hill tribe male with HIV: “They have a quota to accept drugs. We were the first criteria of exclusion.” We found that many participants have a history of opportunistic infections as they did not receive treatment till they develop into the third stage of HIV infection (AIDS). This was conveyed as a hill tribe female living with HIV and vision loss as a result of ocular cytomegalovirus infection saying, “At that time, I did not have the chance to take medicine until I lost my vision. I tried hard to go to the hospital, but the doctor said that it was too late. He said that because of this disease I lost one of my eyes.”

Some participants were advised by the healthcare staff to register for migrant workers' health insurance that would cover their treatment expenses. However, that would cause a major problem later in their Thai citizenship getting approved. It has been discovered that clinicians are not trained to understand social determinants. It has long been clear that many medical and public health staff are unable to understand the social and political force that cause patients harm. They are exclusively focused on the biological phenomena in everyday clinical practice that they neglect the negative consequence on their patients, as was asserted by a 42-year-old hill tribe male with HIV:

I cannot approve my Thai citizenship because I registered for the migrant worker's health insurance, therefore, the government officers imply that I am a migrant worker, not a permanent resident. When I registered, I was not aware of this negative consequence. I just wanted access to the ARV treatment.

As a result of not possessing any Thai government-issued citizenship cards, many HIV hill tribe people are not able to receive free education and, as such,

are exploited due to their vulnerability. We were not surprised that language was an obstacle for communication between a healthcare provider and our participants, which led to the misunderstanding of medication. Most of the participants did not know the names of their medicines and were also unaware of their current CD4 cell count; researchers found that a participant stopped taking medicine because they believed that they had recovered from the HIV disease. As a result, drug resistances were developed; this case was reviewed by a 52-year-old hill tribe female with HIV:

I don't understand Thai because I did not study. The doctor tried to explain to me, but I don't understand. I don't know what to say... At that time, I stopped taking medicine because I thought I had recovered, and my condition had improved. I didn't understand until my body collapsed again. So, I returned to take medicine, but the doctor said I had developed drug resistance. Nowadays, I got the new-line regimen of antiretroviral therapy, but the pill is very large and hard to swallow.

Meanwhile, medical staff were constructed as the representatives of hill tribes who are illiterate and cannot understand Thai. Hence, it is not necessary to clarify the details of disease and treatment process to the patients. This was supported by a 66-year-old stateless hill tribe woman with HIV, who went to the hospital alone. She could not understand Thai, which compromised her body autonomy and liberty in medical decision-making:

At that time, I had a very unbearable stomach ache, and therefore, I went to the hospital alone. I didn't understand what the doctor said... I just nod my head. Finally, the doctor took me to the operating room. I don't know what organ that the doctor cut away. When I came back home, I could not explain to my daughter what illness did I have and what did the doctor do to my body.

Without citizenship, the stateless hill tribes were not able to work outside their district without a special permit from the Thai government; their career opportunities were generally restricted to labor, domestic works, or unemployment due to the stigma of their HIV diagnosis. These people had a low



socioeconomic status, and half of them had an average income below \$50 per month or \$1.6 per day, which puts them below the international poverty line.

Therefore, the government restriction of this population's mobility from their home district acts as a great barrier to their access to healthcare, as confirmed by a 45-year-old hill tribe male with HIV:

It's very difficult to travel... to get the medicine... to see the doctor. That is quite difficult. I am stateless. I have not any cards approving my status. I can not go outside this village because I will be arrested by the police. I will become a fugitive.

With no Thai government-issued citizenship cards and no career opportunities, we found that a hill tribe female with HIV fell victim to sex trafficking. She was forced to be in an uncertain situation and always move to another city and could not adhere to an ARV treatment regime, as a 35-year-old hill tribe female with HIV said the following:

I do not have an ID card and have not received any education opportunities, can not own any piece of land. We have 11 family members, and I am the main source of my family income. I started to work in the Ayutthaya province and then moved to other areas steadily, working mostly in karaoke bars. I go to work for about 1–2 months at a time with uncertainty; after that, I came back to rest in my hometown when the money ran out. I'll go back to work again.

The impact of structural violence is even more obvious among the marginalized population such as the stateless hill tribes living with HIV/AIDS who are the most vulnerable group in Thailand. It exposes a person to many risky situations and prevents the patients from receiving standard care. The creation and maintenance of such disparities and structural violence are embedded in the long-standing pervasive social structures, normalized by institution and manifest in the stateless hill tribes' experience.

### ***Stigma Due to Cultural Violence among the Stateless Hill Tribes Living with HIV/AIDS***

The cultural violence toward the stateless hill tribes living with HIV/AIDS has been deep-rooted

since 1990; the representation of people with HIV/AIDS in Thailand was generally sex workers, drug users, and people with multiple sexual partners produced by the educational and prevention messages from the government. Healthcare staff picked up the belief about HIV/AIDS that it is sexually transmitted disease and introduced it in education material to show pictures of its severe symptoms. However, these pictures developed aversion and fear among most people who saw them. Through such messages, the fear and the notion of this infection doing a bad thing was internalized in the population's consciousness, including that of the hill tribe people.

Several stateless hill tribes living with HIV/AIDS told researchers that when they were young, they were taught by their parents not to go near a person with HIV/AIDS, fearing they would contract the disease. Some parents even seriously threatened their family members, saying that HIV is highly transmissible as well as incurable and that children should avoid AIDS patients as much as possible. Thus, parental socialization induced a fear in children regarding HIV/AIDS. Ideologically, HIV/AIDS is one of the most stigmatized disease found in this study. HIV/AIDS carries a reality expressed in cultural images and metaphors that are associated with specific sexual behavior and morality. Stigma toward HIV/AIDS is constructed not only by individual perceptions and interpretations from microlevel interactions but also by larger cultural forces.

Now, ART is available, and the outcome of HIV/AIDS does not always cause death. The link between HIV/AIDS and "immoral" sexual behavior leads to patients being denied for testing, treatment. Therefore, disclosure is still a concern for hill tribes, including the stateless, because of shame and the fear of being discriminated. Many patients often used the words "the disease of social aversion" to refer to HIV/AIDS. It is the disease that was named the disease of social ostracism. The term was introduced by the HIV/AIDS healthcare staff, and it has become the dominant term and concept. The ideology of HIV/AIDS constructed by the use of language surrounding HIV/AIDS is based on the notion of contagion, incurability, trouble, ostracism, and punishment. What results is a cultural construct that is representative of HIV/AIDS, couched in a language that maintains the stigma attached to it. Thus, the notion of stigma to HIV/AIDS is perpetuated in the society through the use of language.

### ***External Stigma***

Many stateless hill tribes affected by HIV/AIDS have actually experienced discrimination on different levels, which is acted out externally; the behavior of gossiping and avoiding a community member, unnecessary isolation measures, expulsion, abandonment and distancing, and the disempowered and control of the stigmatized.

### ***Gossiping and the Avoidant Behavior of Community Members***

Gossiping behind the patient's back is an indirect interactional process. All of our participants were aware of the discrimination and have known social ostracism by communities existed. Gossips about HIV/AIDS patients often came back to them. The stateless hill tribes living with HIV/AIDS learned how much aversion the community felt toward them through community gossips and their being avoided. These processes are the mechanisms for social control and sanction for excluding AIDS patients from social activities. A 62-year-old hill tribe female with HIV said the following:

If we look skinny, the villagers said that we have AIDS. If we look weak, they gossiped. If we look upset, they looked down on us, asking questions such as, "Did you get infected by your husband? Did you spread AIDS to your children?" They discussed us, so we did not talk to anyone. The village reacted badly... Our neighborhoods also... Someone knew, but they did not say anything. When we have a village ceremony, we do not have any meals with others. Other people in the village with AIDS infection also covered their statuses like me.

As reflected by the accounts of many hill tribe stateless people, the disclosure of their HIV/AIDS status resulted in them being denied treatment in a public hospital because of the associated stigma, as a 39-year-old hill tribe female with HIV said the following:

I am so worried about my secret. I trust private clinic service because if I received service in a private clinic I feel like a normal person... no different treatment... no discrimination. If I went to an ARV clinic at a public hospital, I feel

that everyone will know my status because this is a special place for people living with HIV/AIDS.

A 44-year-old hill tribe male living with HIV said,

They will discuss and label me and my wife as troubled persons. I have never told anyone because my wife has many relatives in the village. My wife hides our HIV status from her parents. We never said anything. If anyone were to know my status, I am scared that my wife will face a difficult situation.

A 49-year-old hill tribe female with HIV said the following:

I come to take the medicine for me and my son. He has taken the medicine since childhood. Now, he is 18 years old. He has never been to the hospital because he is afraid others will be known his HIV status.

### ***Unnecessary Isolation Measures***

In Thai society, sharing a meal or drinking with neighbors signifies the culturally mandated code of polite behavior and the expression of hospitality to visitors. The northern Thai family offers a water jar and a glass or small bowl placed in front of their house that serves visitors or strangers drinking water. However, no stateless hill tribe neighbor ever ate or shared the same meal or glass with a person with HIV/AIDS. In fact, they were never invited to join in for a meal or drink. A 53-year-old hill tribe male with HIV said the following:

As I was too thirsty. I forgot to drink water in another person water container. He immediately changed and poured the water container. I saw it with my own eyes. At that time I had a lot of regret. I shouldn't have drunk their water because some people still discussed.

### ***Expulsion and Abandonment***

HIV/AIDS carries an especially heavy stigma because in the past, in the public sphere, patients' bodies were viewed as deteriorating over time, eventually ending in death as effective treatment was

not available; HIV/AIDS progressed and became more debilitating over a short time. The most seriously affected patients represented in the media had swollen lymph nodes and scars on the body due to fungal infection, and they were dark and skinny. Moreover, the senior hill tribes permanently perceived HIV/AIDS as the disease with no cure as people died from the disease. Therefore, the family members of some of the participants were discriminated against, as claimed by a 45-year-old hill tribe female who lives with her mother who has HIV/AIDS:

My mother was expelled from her family because of her HIV infection. They fired her; my grandpa and grandma feel that they are being discussed. I had to quit my job and went home to live with my mother. People in the village said I got infected with HIV because I took care of my mother. We tried to explain that the doctors and nurses said that HIV is not easy to transmit, but it's not working. At one time, me and my husband visited some of our neighbors' homes, and they did not allow us to use the restroom. They were afraid of HIV transmission.

A 19-year-old hill tribe male with HIV said the following:

I got an HIV infection from my girlfriend. She was HIV infected with mother-to-child transmission. I don't know before that she is HIV infected. My friend came and told me... I couldn't believe it until I tried a blood test and the result was HIV positive. Now, I am adhering to drug treatment, but my girlfriend stop to take medicine for a couple years. She had very painful experiences. Finally, she decided to stop taking medicine. My parents very against her, especially my father. She was not allowed to visit my family. At present, we separate from own family to live together. Devalued, Disempowered, and Controlled

The outcome for the stigmatized person such as the stateless hill tribe living with HIV/AIDS is that they are devalued, disempowered, and controlled by the "stigmatizer." In this process, stigmatization becomes a part of a preservative reassertion of power

and relationship among the stigmatizer, stigmatized, and HIV/AIDS's symbolic associations with danger or pollution.

A 38-year-old hill tribe female with HIV said the following:

In my case, I live in the Thai people village. At a community meeting, they voted that I was toxic. If I am dead, I have to be burned not bury. It violates my rights. I am Christian... our tradition is buried. My daughter asked, If the mother dies, why do I have to be burned? Why not buried? I asked the village headman could we have another solution. He told me that they had already voted in the community forum. We can't do anything.... burned the body and buried the bones. He said that, the Thai people do agriculture and some toxins from my body will seep out into the ground. I feel very terrible. Many participants described their experiences of being discriminated and devalued, both verbally and nonverbally. It is clear that the stereotypes and the ideology of stigma regarding HIV/AIDS are still embedded in people's individual notion and experiences even though at present it has an effective treatment.

### *Internalized Stigma*

The stateless hill tribes living with HIV/AIDS held the same ideology toward their disease as that of the other community members. Therefore, internalized stigma exists around HIV/AIDS. Internalized stigma causes a certain degree of psychological distress, low self-esteem, low self-efficacy, and social withdrawal. The people with HIV/AIDS will internalize stigmatizing ideas with self-blame, self-isolation, and self-loathing and believe that they are less valued because of their disease.

Some participants demonstrated their internalized stigma and exhibited self-blame for risky behaviors due to their HIV/AIDS status. They viewed themselves as being mindless, as a 41-year-old hill tribe male with HIV said the following:

When I came to know of my blood results, I blamed myself in spite of the public media warning. They sing a song to warn us on television, but why are we still not being careful and let ourselves become infected?



Etiologic beliefs about HIV/AIDS reflect the concept of immorality embedded in the notion of HIV/AIDS. The belief that HIV/AIDS is the transformation of a sexual behavioral disease reflects the notion that HIV/AIDS is a punishing disease. As such, stateless hill tribes considered themselves unclean, impure, and polluted. Therefore, most denied intimate relationship or self-isolated themselves because they did not want to harm other people.

A 26-year-old hill tribe female with HIV said the following:

I am afraid and do not want others to come close to me because I have HIV/AIDS. Even though some try to flirt with me, I just tell them... "In another life, I would be your love... In this life, it would not be possible."

Some stateless hill tribes expressed feelings of shame, guilt, self-loathing. HIV/AIDS was viewed as a contamination of the body, which led to low self-esteem and therefore the concealment of the HIV infection status from everyone including close family members.

A 43-year-old hill-tribe female with HIV said:

If I think about it, I hate myself. Why?... I faced this situation. I am named as person were infected with AIDS.

A 38-year-old hill tribe female with HIV said the following:

I cannot accept that I have this disease. So, I didn't come to get the drug. I'm embarrassed. The others think that I did a bad thing. No matter what, I will not let my parents know because most old people are afraid of people who get this disease. They are afraid of getting infected by HIV/AIDS.

Society is accepting this stigma as normal because HIV/AIDS high-risk group discourse had been for a long time constructed and reproduced in the public sphere and people's notion. The social stigma in stateless hill tribe people living with HIV/AIDS was neglected, which forced them to turn the violence against themselves.

## Discussion

### *Statelessness as a Structural Violence Practice*

Structural violence can be seen in the content of people facing different aspects of inequality in political, social, or economic structures or systems (Galtung, 1969). Among the most marginalized groups living with HIV/AIDS in Thailand, we found several forms of structural violence persisting among stateless hill tribes living with HIV/AIDS. Without citizenship, stateless hill tribes have to face the turmoil of having their basic human rights violated and are confronted with the denial of identity licenses, mobility restrictions, refusal of driver's licenses, vulnerability to trafficking, and the absence of land ownership rights (Rijken et al., 2015), including inadequate education and habitation as well as high degrees of unemployment (Apidechkul, 2016), susceptibility to the use of illegal substances (Chomchoei et al., 2019), and obstacles in accessing healthcare services (Apidechkul et al., 2016).

Moreover, stateless hill tribes living with HIV/AIDS were excluded from the Universal Coverage Scheme. While out-of-pocket health expenditures increase this population's financial vulnerability, a lack of health insurance also contributes to their perceived poor quality of care and healthcare needs not being met (Herberholz, 2020). The participants describe their experiences of dealing with late HIV/AIDS diagnosis, late treatment, high rate of opportunistic infections, various obstacles related to accessing care such as inability to attain necessary health information as a result of illiteracy, difficulty in transportation as they live in very remote areas, unaffordability of healthcare, stigmatized experience in accessing healthcare, and the fear of the disclosure of status (Wongnuch et al., 2019).

As individuals with a lesser level of education and fewer economic opportunities, stateless hill tribes living with HIV/AIDS are clearly more vulnerable to structural violence. As shown in the research led by Clement (2011), it could be seen that lack of citizenship is the greatest risk factor for highland minority girls and women in Thailand being trafficked or otherwise exploited. While highland girls constitute a small percentage of the total number of sex workers in Thailand, they are disproportionately positioned at the worst-paid and most-abused end of the sex industry.

### ***Stigma as a Cultural Violence Practice***

As Galtung (1969) argued, cultural violence, originating from cultural domains such as ideologies or religions, is the type of violence that makes direct violence and structural violence seem acceptable in a given society through the society's value system. Messages of distinction are an HIV/AIDS media campaign in Thailand. In predominantly rural Thailand, television is the primary knowledge source of HIV/AIDS. Since 1990, HIV/AIDS warning messages have been aired regularly and repeatedly on television as a part of the national strategy to minimize the transmission of HIV. The education and prevention messages chose to do more than merely suggest measures to avoid infection. These messages defined the characteristics of people who are signified as threatening agents of infection. In Thailand, prostitutes and drug users are portrayed as the feared other. As commercial sex is so widespread, prostitutes are demarcated as a high-risk group, which signals that the diffusion of threat cannot be easily managed by conceptual distancing. It is the pervasive and often fear-based associations resulting from media material that, in large part, establish the basis of emergent practices when thoughts or actions are triggered by the consideration of HIV/AIDS status (Lyttleton, 1994).

The experiences of stigma to HIV/AIDS faced by the stateless hill tribes were produced and reproduced by the messages communicated by some healthcare staff, the socialization process taught by adults to their children in the family, the use of language, and the use of HIV/AIDS metaphor. The stigma towards HIV/AIDS was formed not only through direct interactional processes (unnecessary isolation measures, expulsion and abandonment, and devaluing, disempowerment, and controlling) but also through indirect processes such as ongoing social contacts (gossiping and the avoidant behavior of community members). Therefore, the intensity of internalized stigma increases as an individual internalizes dominant cultural beliefs about HIV/AIDS and the external stigma in their everyday life that identify them as members of a deviant group, doing immoral acts and having polluted bodies.

### **Conclusion**

Stateless hill tribes living with HIV/AIDS in Chiang Rai, Thailand, are targeted by structural and cultural

violence, while society is accepting this practice as normal. Those are the major sources of vulnerability of this population and act against their basic human rights. The results of this study are useful for establishing policies to safeguard this population from being victimized in the violence sphere.

### **Declaration of Ownership**

This report is our original work.

### **Conflict of Interest**

None.

### **Ethical Clearance**

This study was approved by the Ethics Research Committee of Chiang Rai Provincial Health Office, Thailand (Certificate of Approval No. REH 53/2560).

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