

Aging and Dying in a Rural Lowland Area of Laos : A Consideration of the Process of Creating a “Good Death” Together

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Aging and Dying in a Rural Lowland Area of Laos: A Consideration of the Process of Creating a “Good Death” Together

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In developing as well as developed regions, the phenomenon of aging populations cannot be ignored. Endeavors to maintain quality of life in old age and at the end of life are more important than ever before. However, aging and dying in developing regions have never been studied sufficiently. This chapter describes the social processes of aging and dying in Laos, the poorest and most resource-poor country in Asia. Descriptive data on aging and dying in a rural lowland area of Laos are presented, with a particular focus on the relationships between caregivers and the elderly and dying. Section 1 introduces the problem addressed in this chapter. Research context and methodology are outlined in section 2. Section 3 describes the process and experience of aging and caring for the elderly, while section 4 discusses the spaces and places of dying and end-of-life care, and especially the living arrangements and social relationship. Section 5 interprets local understandings of aging and dying. Finally, given these accounts and analyses, the discussion of aging and dying in developed regions is revisited briefly.

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1. Introduction

Developed regions such as Western Europe and North America have experienced an accelerated aging of their populations, attributed to the epidemiological transformation from infectious to chronic diseases, demographic transitions such as reductions in infant mortality and early childhood deaths, and medical and technological advances that can prolong life (*cf.* Riley 2001; Robine and Michel 2003). Consequently, “the proportion of elderly people in populations rises and the experience of dying is increasingly a feature of old age” (Seale 2000: 918); that is, death in developed regions has been “gerontologised” (van der Geest 2004: 902).

These transitions have inspired a search for meaning in aging and dying. “Questions such as what it means to age successfully and what is required to do so, and what it means to die well and how that might be accomplished, occupy an increasingly prominent place in both private conversations and those about health policy and medical care” (Schenck and Roscoe 2009: 61–62). It is therefore necessary to consider the process of dying from old age when we think about the well-being of the elderly (Callahan 1987, Diehr *et al.* 2002, O’Connor and Pearson 2003).

Developing regions are different: death is always around and a high percentage of deaths occur early in life, generally due to the prevalence of infectious and parasitic diseases and the limited resources of health care (*cf.* Seale 2000). For example, maternal and infant mortality have been seen as serious problems, with national and international programs dedicated to their mitigation. In such circumstances, the processes of aging and dying receive much less attention than they do in developed regions.

However, Seale (2000: 918) has pointed out “the overall trend worldwide toward longer life and the aging of populations. This has particular consequences for the experience of dying, since this becomes increasingly merged with the general problems of old age.” In developing as well as developed regions, the phenomenon of aging populations should not be ignored, for maintaining quality of life in old age and at the end of life are endeavors more important than ever before (Lloyd-Sherlock 2000).

Nevertheless, the processes of aging and dying in developing regions have never been studied sufficiently. Of the thousands of published books and papers on these subjects, most were written about developed regions, and only a few discuss the developing world. Though anthropologists already conducting fieldwork in developing regions can contribute to these discussions, ethnographic studies specifically focused on elder and end-of-life care in developing regions are few (*e.g.*, van der Geest 2002; 2004).

The purpose of this chapter is to describe the aging and dying processes in Lao People’s Democratic Republic, commonly known as Laos. Most studies represent Laos as the poorest and most resource-poor country in Asia (*cf.* Rehbein 2007; Rigg 2005). According to the United Nations, for example, Laos is one of the “Least Developed Countries” (LDC), which exhibit the lowest indicators of socioeconomic development and the lowest Human Development Index ratings in the world (UNDP 2010). On the other hand, in its *Human Development Report 2010*, UNDP listed Laos as one of the “top movers” in the world in terms of progress with human development in the past 20 years (UNDP 2010: 27). Health conditions have also been changing. The population is young, but there are signs of demographic transition. The WHO reported:



Figure 1 Map of Lao P.D.R.

the crude death rate declined from 15.1 to 9.1 deaths per 1,000 inhabitants between 1995 and 2007, while the total fertility rate (average number of children per woman) fell from 5.6 to 4.2 and the crude birth rate (number of births per 1,000 inhabitants) from 41.3 to 33.2. At the same time, life expectancy at birth rose by 10 years in a decade, from 51 years in 1995 to 62.5 in 2007. (WHO Western Pacific Region 2010: 174)

Still, Laos remains relatively weak in its national system for collecting health information, like other developing countries. It has also been largely inaccessible to foreign researchers, especially those conducting in-depth research of the sort that anthropologists preferred

until the late 1980s, and thus its society and culture have been little studied (*cf.* Evans 1999). Both quantitative and qualitative data as a whole are still scarce, and it goes without saying that few qualitative studies account for aging and dying. What I would like to provide here are descriptive data on aging and dying in a rural lowland area of Laos, focusing in particular on the relationships between caregivers and the elderly and dying.

The research's context and methodology are outlined in section 2. Section 3 describes the process and experience of aging and caring for the elderly, while section 4 discusses the spaces and places of dying and end-of-life care, especially living arrangements and social relations in the area studied. Section 5 interprets local understandings of aging and dying. Finally, given these accounts and analyses, the discussion of aging and dying in developed regions is revisited briefly.

2. Research Setting and Methodology

Fieldwork was conducted mainly in the LHN area (*khet*), a rural lowland area of SK district, Savannakhet province, in southern Laos. The area of LHN lies approximately 9 km from the center of the district, in turn about 70 km from the center of Savannakhet province. The population at the time was approximately 4000 people in about 700 households. The ethnic majority was the 'Phu thai' of the Tai-Kadai language group (Schlesinger 2003: 97–103)¹). Religious systems in the area were syncretic: most villagers were followers of Theravada Buddhism (*sasana phut*) and two Buddhist temples (*wat*) existed there, but meanwhile residents believed in 'spirits' (*phi*) and maintained three houses for the 'village guardian spirit' (*phi pu ta*) on the outskirts of the area.

Fieldwork was conducted mainly in the village of DB, the southernmost and smallest of 6 villages in LHN. Its population was around 200, and the number of households was 39 (2005). Almost all were farmers; there was one electrical engineer and one teacher. The subsistence structure was complex, as in other area of Laos. The main subsistence activity was the cultivation of glutinous rice in paddy fields. Fishing in the river and rice fields and hunting and gathering in the forest also occurred regularly. Each household kept some domestic animals, such as buffalo, cows, pigs, chickens, or ducks, and cultivated a small garden. The main source of income was selling vegetables, livestock, and surplus rice. In addition, some females could earn wages by contracting with a textile company. Electricity and a water supply had been utilized since about 2000.

Lebar and Suddard (1963: 172) pointed out "the Lao have retained many of their traditional ideas and practices relating to illness and disease while at the same time accepting some of the methods and ideas of the West". This is true to this day: both biomedical and folk health resources are utilized (*cf.* Halpern 1963; Westermeyer 1988). LHN is near enough to the district's center, with its hospital and two clinics, that villagers can utilize those institutions to some extent (Iwasa 2009b). People in the village coped with minor illnesses by buying medicine at the health center or at pharmacies. If people were very sick or seriously injured, they tended to go directly to the district or provincial hospital. Folk practitioners (*mo*) such as herbalists frequently played a role in preventative care and the treatment of chronic illnesses (Iwasa 2009a: 120–145).

This chapter draws on the findings of my fieldwork in LHN, especially in DB, which took place between 2004 and 2006. My main focus was on practices, ideas, and attitudes of elder and end-of-life care in the socio-cultural context of rural lowland Laos. The research consisted mainly of participant observations in the care of the elderly and the dying, as well as open-ended interviews with those who had experience caring for the dying. Surveys were also carried out regarding medical anthropological issues in the health care system, health seeking behavior, and local understandings of health and illness.

In addition, some findings are derived from conversations with Lao at various places and opportunities. In particular, in order to grasp professional understandings and policymaking attitudes toward caring for the elderly and the dying, the fieldwork included interviews with doctors, nurses, and other health workers at the local health center and at district and provincial hospitals, as well as discussions with the staffs of the Ministry of Health and the National Institute of Public Health.

3. Aging and Caring for Elder People

3.1. *Sabai*: Local Understanding of Well-Being

The term ‘well-being’ generally describes the subjective condition in which people feel good mentally, physically, and social-economically (Diener *et al.* 1999; Diener and Suh eds. 2000). There is a degree of resemblance between conditions of well-being in various cultures; however, well-being “is conceived of, expressed, and experienced in different ways by different individuals and within the cultural contexts of different societies: different societies may have distinctly different culturally shaped visions of well-being.” (Mathews and Izquierdo 2009: 5). For this reason, we need to approach the concept of “well-being” in socio-cultural context “from the native’s point of view” (Geertz 1983).

In Lao there are several words that can express the state of being well, but the term ‘*sabai*’ will be used in this article. *Sabai* is described in a Lao dictionary (Viravongs 2006) as “being well and healthy (*yu di mi heang*)” or “being happy and joyous (*pen suk sam ran*)”, and in a Lao-English dictionary (Kerr 1992) it is translated as “comfortable, at one’s ease, happy; well, healthy.”

This word has a range of meanings and is explained variously by Laotians (*cf.* Lundberg 2008). According to my survey in DB village (Iwasa 2006; 2009a: 109–117), the elderly described the following as *sabai*: physical toughness, good sleep and diet, having no trouble in activities of daily living (ADL), and having neither pains nor illness; thus I found their interpretation of the word approximated that of “healthy”. From the mental side, on the other hand, they described: stability, spiritual happiness attained through religious practices, and the absence of difficulties—all of which imply something more like “happiness”. Finally, from a socioeconomic perspective, the following examples of *sabai* were given; building good relationships with family members and relatives able to help one another, having life’s necessities, having enough foods such as glutinous rice, and having enough saved money for daily life.

Given the above, *sabai* implies a stable condition in which an individual’s physical and mental states, social relations, and everyday life are “as same as usual” without urgent or seri-

ous problems (Iwasa 2009a: 276–280). It is thought that “the negative valuation on all of these ‘excesses’ is consistent with the overall Lao cultural value upon balance, harmony, and equanimity, in personal as well as social realms” (Westermeyer 1988: 770–771). *Sabai* is a local concept composed of various and interrelated meanings in the socio-cultural contexts of Laos (Lundberg 2008: 75).

The comfortable circumstances described by the word *sabai* are especially evident in secularized images of *savan* (heaven). One middle-aged woman explained that “if you go to *savan*, all of your problems will disappear and you will have nothing to worry about, no starvation, no work, and you will be released from all difficulties and be happy.” A man in his 20s said, “When you are alive, you have to work and take many responsibilities which make your life very hard. When you die, you don’t have to work and are released from all responsibilities, and then all you have to do is to just sleep, so it’s not a bad thing to die.” In their statements the elements of *sabai* are featured prominently.

Such heavenly conditions will never be realized on Earth, and no one expects them to be. The question, then, is that what *sabai* looks like in everyday earthly life. One answer is provided by the daily life of the elderly.

In Lao, “the elderly” is translated as ‘*khon thaw kae*,’ which literally means “old person.” On the other hand, senior citizens are generally called ‘*pho thaw/mae thaw*,’ which can be translated as “grandfather/grandmother”, by their relatives. The age of 60 seemed to be the cutoff point for these titles, and this was true in the broader social system as well. For example, candidates in the 2005 election of DB’s new chief were required to be under 60 years old,



Photo 1 Old women worked together

and the ‘*new hom*’ (group of village elders) was organized by those over 60.

Elderly people in the area often said in conversation that they were comfortable living freely despite physical decline, chronic pain, and the absence of economic wealth. This much is in fact evident from a consideration of their daily lives. According to my observations, even when they participated to some degree in daily sustenance activities, they had retired from the frontline and were doing whatever they liked in their own time. Men sometimes made baskets or fishing equipment with bamboo, women sometimes wove textiles, and they enjoyed visits and chats with friends and relatives. If they were hungry they ate; if they were tired they rested. Furthermore, in this Theravada Buddhist region, many people spent more time engaged in religious activities as they grew older. The elderly also had certain duties—as supervisors at religious ceremonies, advisers at village meetings, and so on—but even so, they tended to spend their retirement largely as they pleased.

Such a life in old age, considered *sabai* by other generations and by the elderly themselves, is made possible only by the presence of caretakers. But who are they? The next section will focus on living arrangements and the support and care of the elderly.

3.2. Living Arrangement and Caring for the Elderly

At the time of my research in DB, there were 18 senior citizens (6 women and 12 men); 8 were married couples, which meant that there were 14 households with elderly members in total (March, 2004). There were 6 households with members in their early 60s, 5 of whom were living with single children or a nephew, and the last of whom was living with a married daughter and her family. The other 9 senior citizens, all in their late 60s, were living with a married child and his/her family and other single children.

These household compositions stemmed from typical family cycles in rural lowland Laos (*cf.* Evans 1995: 124–128; Iwasa 2009a: 59–62). Married children live with their parents and siblings for a while, during which time they all cultivate and consume glutinous rice together. Though there is no specific rule regarding residency, of the 11 households in which parents and a married child lived together, only 3 of the young couples lived with the husband’s parents; all others lived with the wife’s parents. During this period, the new couple saves money and materials to build their own home, constructing it step by step until it is ready to house them.

As children are marrying and moving in and out, parents are beginning to age. They retreat from the frontline of daily activity, replaced and cared for by their children instead. The villagers generally cited a rule of female ultimogeniture: the youngest daughter (*luk saw la*) is the one to care for elderly parents and their house, as in other lowland rural areas of Laos (*cf.* Evans 1990: 124). This is because, as explained above, a son usually moves out to live with his wife’s parents, while a daughter lives with her parents for a time even after marriage; consequently, the youngest daughter is the last child remaining in the parents’ house. However, there are always exceptions. Neither parents nor children adhere strictly to this pattern, emphasizing rather the balance of family members’ lives and the health of the parents. When the latter grow too old or become ill, it is likely the children living with them at the time will continue to care for them.

Children living with their parents ‘take responsibility’ (*hap phit sop*) for elder care.

They provide economic support and necessities such as clothing, food, and housing. They also take care of everyday chores such as cooking and laundry. They nurse the parents through illness and pay for medical care. When the parents get physically weak, they help them walk. All these facts indicate that the parent-child relationship is the basic unit of elder care here.

Children living with their parents are not the only source of care for the elderly. In DB the basic unit of social life is a household, and everyone in a household contributes to everyday labor (*cf.* Evans 1990: 123–149, Ireson 1996; Rigg 2005). Chores are divided mainly by gender and age. Women prepare meals, clean house, do laundry, and tend gardens; men fish, hunt, or tend livestock such as buffalo and cows. The elderly and young children help with these activities. Elder care is the province of women in most cases, though there is no rule to this effect and circumstances do vary.

Take Mr. Som and his wife Mrs. Tim,²⁾ both over 80 and the oldest in the village. Both were declining physically, but both the nature and severity of their ailments and the care they required were different. Though Som sometimes needed help navigating stairs, he could generally take care of himself, going for a walk to visit friends and even raising ducks and dogs with no problems. Tim, however, was both physically weak and showing signs of dementia. She seldom went out, and though she sometimes wove textiles, most of her time was spent in the house. She sometime required help getting dressed.

They lived with 8 other people: third daughter Mon (41) and her husband Pen (43) and oldest daughter (19), second son (17) and second daughter (14), 2 nephews (9 and 7), and a niece (4) whom they were taking care of temporarily. Of these, Mon and her two daughters were Som and Tim's primary caretakers. When the two daughters were at school or doing other chores Mon attended her parents, and when Mon was weaving or gardening or even watching the little niece, the two daughters prepared their grandparents' meals or helped them walk. As with other chores, Mon and her daughters did their part for elder care.

In contrast, Pen and second son did not participate much in daily nursing. From the perspective of division of labor, however, it would be unfair to accuse them of neglecting the elderly. Even if their parents need assistance, they cannot ignore the daily activities that sustain their family's lives. Pen and his son went fishing, hunting and gathering to procure food. Pen sometimes worked for money to maintain the house. Their nephew helped feed the cows and, as described above, Som tended the ducks and chickens. The household was thus sustained by many daily activities that also contributed to the well-being of its oldest members.

Although everyone recognizes the time and energy Mon and her husband put into caring for Som and Tim, it's also true that their direct care is made possible by the cooperation of all members of the household. This means that caretaking and sustenance are not totally different things.

As this pattern illustrates, as children take over household responsibilities from their parents, they also take on the responsibility of caring for those parents, and these two sets of duties are intertwined. Thus elder care is not only nursing but also just another component of daily life—one that continues to make possible what the villagers call *sabai*.

4. Dying and Caring for the Dying

4.1. Place of Death

It is said that in developed countries death now occurs primarily at medical institutions rather than in the home or community, and also that caregivers are now more professionals than family members. These trends are collectively called the “medicalization and institutionalization of dying” (Green 2008; Walter 1994).

The situation is different in Laos. Biomedicine is available in the researched area: as described in section 2, hospitals and other medical institutions were sometimes utilized at the end of life. Such cases were rare, however. The 39-year-old doctor at SK district hospital described the process of dying in this area as follows:

Low and middle level examinations and surgeries can be performed at district hospitals, but when more serious problems occur and treatment there becomes impossible, it becomes necessary to decide whether to attempt other treatment. If a patient decides to continue treatment, he or she will go to the provincial hospital in Savannakhet or the hospitals in Vientiane (the capital city) or Pakse (the central city of Campasak province). Generally it is decided to transfer the patient to the provincial hospital, in which case we will help with logistics. If treatment is discontinued, there are two choices: to receive basic quality-of-life care at the district hospital, or to return home to a folk practitioner and wait there for the time to come. If no treatment is possible, or if no improvement is possible even with treatment, most patients prefer to die at home with family and folk practitioners. If they die in a hospital, they might hold a funeral there, but this is very rare. As each decision becomes necessary, we show them their choices but do not tell them what to do. This is because such decisions are made by the patient and his family members who accompany the patient to the hospital.

Statistics from the district hospital tell the same story. During the period from 1993 to 2003, outpatients numbered 55,290 in total (yearly avg. 5,026), and inpatients numbered 18,039 (yearly avg. 1,640). Of the latter, only 175, or 1%, died in the hospital. Of course the number of deaths varies by year, but the rate is almost the same for all 10 years. I also found the numbers of total deaths in the district for the years 2002 and 2003: in 2002, the number of people who died in the hospital was 11 out of 410 total deaths, while in 2003 the proportion was 9 of 357. That is, only about 3% of people spend their last days in a hospital, which clearly means that this is not the preferred option³).

The difficulties and costs of medical access are often given as reasons for this trend. Socioeconomic factors do contribute, but so does the cultural background of this area. In DB, the body of someone who died elsewhere is not allowed inside the village. This custom is related to the tradition (*hit*) regarding the ‘village guardian spirit’ (*phi pu ta*), which prevents incursions of exterior spirits and vicious people. In Laos, a corpse is generally thought to become *phi* (spirit). The body of someone who died outside the village amounts to a foreign *phi*, so bringing it into the village means breaking the custom regarding village guardian spirits.

This is not a rule prohibiting dying outside the village; it is a prescription for dealing with the body of one who does so. It does dissuade people from dying outside the village if



Photo 2 Houses of the ‘village guardian spirit’

possible, however. It is avoided if possible that the villager dies at district or provincial hospital where located in the outside of the village. The doctor at the district hospital recalled one patient who, realizing that he could not be cured, received life-prolonging treatment at the hospital in order to return home and die there. It can be said that this patient and his family avoided death in a hospital for cultural reasons.

All of the above indicates that dying in DB typically occurs at home. In the district that includes the village studied, I confirmed 18 cases of death between August 2004 and May 2005; all of these took place at the deceased’s home except one case of drowning. As the doctor at the district hospital stated, the place for dying in DB village is not the hospital but home.

People might go to a hospital sometime during the process of dying of old age. This is most like to happen when they first become bedridden. This may be when some people form a habit of visiting hospitals. When their health deteriorates and they begin to spend more time in bed, their families might take them to the hospital. In any case, though, the time spent in hospitals throughout the process of dying is minimal. As described above, the elderly are cared for by their families and extended families, especially their children, in their own homes. Most return to their houses when treatment options are limited, as the doctor stated. In DB, the home is the place of death as well as that of daily life, caring for the sick, and caring for the aged. Accordingly, the main caregivers are not health care professionals but other members of the household. Next, I will focus on the process of dying and caretaking at home in the researched area.

4.2. Dying and Caretaking at Home

At the time of my research, Mr. Won was a very nice man of about 80. He died at the end of October 2004. He had been sick for 2 months before that, grown worse at the beginning of October, become bedridden, and eventually passed away at home with his family. When he had first fallen sick, he had gone to see the district hospital and had an examination, but his illness remained undiagnosed and the cause of death was never explained. His family explained that he died of *lok sala* (senility or death from natural causes).

He was second son of 7 brothers and sisters. His youngest sister had married an American and lived in the United States, but the others all lived nearby. His wife had passed away, but they had 2 sons and 4 daughters, most of whom also lived nearby. Many *phi nong* (relatives) also lived in the neighborhood, including his wife's family. His second daughter Suk (40s) lived with him, along with her husband and 6 children (1 son and 5 daughters). They were the ones who sustained Won and nursed him at the terminal phase.

Daughters, especially those in the prime of life, are the main caretakers of the dying here. At first, their duties are limited to preparing meals and clothing, helping with mobility, and so on. As the elderly person becomes bedridden and weak, their caretaker begins to accompany them more and attend to more details of their lives. A daughter might prepare food and drink, bathe the parent and change clothing, attend to all personal needs, help turn over and change body positions, and massage sites of pain. It is the daughter's role to perform housework and care for elderly parents. The one doing these things for Won was his daughter Suk, and her daughter helped her with chores as well.

When Won became bedridden, his children and family members living nearby often visited and assisted him. For example, his youngest daughter Nok (20s) visited frequently and provided some food. Even his siblings and their families and his *siauw* (close friend) who was less involved than his children visited Won many times.

As just described, many people visit those who are bedridden, but elder and end-of-life care in this area centered on the parent-child relationship. The main caretakers are members of the immediate household, but here I would like to focus on the involvement of independent children in the neighborhood. To understand this point, we need to focus on something that has been present but not explicitly discussed in the above descriptions of aging: the importance of paddy farming to subsistence in this area.

I have mentioned that young people living with older generations (usually a daughter and her husband) move into their own home at some point. In the process of looking for land on which to build the new house, the preference is to take some portion of the parents' premises; only if this is impossible does the couple look elsewhere in village. Thus even financially independent households often cultivate and live off the same land. Such households might also cooperate in fishing and gathering, share use of their property, and divide among themselves everyday chores such as housework, management of livestock, and gardening.

The "multi-household compound" (Evans 1990: 124) may also cooperate in caring for and nursing elderly parents. This is especially true at the very end of life. As Won became bedridden and weak, Suk began to accompany him and attend to many details of his life. On the other hand, she could not ignore everyday necessities. At the beginning of terminal phase, her husband and son engaged mainly in fishing, livestock management, and so on, but as time

went on, the division of labor between households became more important than ever.

As previously noted, Won fell ill early in October, when paddies are usually harvested. At the time, Suk and her husband were living in a field house about 3 km from their home to facilitate cultivation. When Won first became sick, he could still get up and eat by himself, and he was cared for by Suk's daughter, who was staying at the house to go to school. But as Won's condition deteriorated and constant attention became necessary, Suk and her husband entrusted the agricultural work to their siblings' households and moved back to the main house.

This flexibility and cooperation in everyday labor maintains the relationship between a parent and child who live in the same neighborhood but in separate households. Children who live separately do not have primary responsibility for parental care, but they do remain involved in some way. This relationship of mutual aid between parent and child becomes prominent at the end of life.

This raises the question of who makes decisions for and about the dying. In case of Won, before he became bedridden, he had been deciding what to do by himself. When he wanted to take a rest or wanted to go to the hospital, he asked Suk and her husband for advice and they respected his will as far as possible. After he became bedridden, unfortunately, he could no longer assert that will. Sickness made asserting himself difficult, of course, but as far as I know he also refrained from telling them what to do.

When I asked the aged about decision-making, I sometimes received answers like "I have no responsibility for it," because, they explained, of the nature of the relationship between care-giver and care-receiver. In this area, to care for someone at the end of life also means to take responsibility for dying process. That is to say, for the dying, receiving care means relying on caregivers and surrendering responsibility to them—and for their part, the caregivers must accept that responsibility.

No decision is made unilaterally. In case of Won, choices—whether he should go to the hospital and when he should contact whom, for example—were made mainly by Suk's husband. But what he insisted was these decisions were not his alone: that they came about through conversations with Suk, with her middle-aged siblings' families, and with elders in the village. His role was rather to enact the decisions agreed upon by all stakeholders than to make the choices himself.

5. Aging Ordinarily, Dying Ordinarily: Interpreting Local Understandings of Aging and Dying

In the previous two sections, aging and dying in the area being studied were described with a focus on the relationship between care-giver and care-receiver. Using these descriptions, this section will interpret local understandings of aging, dying and caring.

Let us begin by considering their explanations of dying as a point of departure. Generally, there are two types of death in Laos: 'natural death' by sickness and other non-violent causes, and 'accidental or violent death' (*tai hung*) including "drowning, falling, shooting, animal attack, snake bite, childbirth, car or plane accident" (Westermeyer 1988: 771). This classification reflects funeral procedure. The body of someone who has died naturally is cremated

at *pa sa* (a communal graveyard in the forest), with the bones then placed in *that duk* (a small stupa with bones of the dead) at the temple following Buddhist funeral procedure. The victim of an accidental or violent death, however, is buried at *pa sa*.

Villagers can use different categories when they explain the situation of someone's death: '*tai thammada*' (ordinary death) and '*thai bo thammada*' (extraordinary death)⁴). These are unrelated to funeral procedures but helpful in understand their concepts of aging and dying. What does *tai thammada* imply? Reviewing papers and articles on perceptions of "a good death" across cultures and times, Seale and van der Geest (2004: 885) said that "some ideals about dying well seem nearly universal: a death occurring after a long and successful life, at home, without violence or pain, with the dying person being at peace with his environment and having at least some control over events." This image approximates that of *tai thammada*. Summarizing the explanations of the people in the area, *tai thammada* is death in old age from senility (*lok sala*) or common sickness, at home in the care of one's family. For example, one old man described the death of Mr. Won, mentioned above, as *tai thammada*. It seems, however, that the expression "dying ordinarily" has other implications. Here I focus on two of these implications.

One relates to the time that relatives and friends spend with the dying, which in turn is strongly related to the place of death. Another case study serves to clarify this relationship between time and space.

Mr. Pu, 60, lived at the center of SK district. He died in late 2005. He had become aware of ill health that summer and told this to only his wife, Mrs. Kew. In early October his condition had worsened suddenly, bringing him to the provincial hospital. The results of two medical examinations had found liver cancer. That doctors had explained this to Kew and their children, and she had asked that Pu not be informed. Instead, she had told Pu only that he suffered from liver failure. They had discussed the situation and decided to care for him at home. In the middle of December, he had died at home with his family, relatives and friends. When I visited Kew early in the next year, we talked about Pu's death. She spoke as follows.

I think he was happy to die at home, not in the hospital. My children and I were very sad, but we were satisfied to spend his last days with him. ... And you visited him and us many times, a lot of his relatives and friends also visited him and us many times. I think your visiting pleased him. ... If he had entered the hospital, few people would have come to visit him.

Kew's narrative shows "ordinary death" must allow relatives and friends to spend time with the dying, and the place where this happens is home. Home is the center of village life and the main place where relatedness between family members and friends are constructed and reconstructed through the activities of everyday life (*cf.* Carsten 1997). Death at home is death at the center of the social relatedness built throughout life course, which the villagers respect during the dying process. In contrast, hospitals staffed by professionals generally impede the involvement of relatives. Therefore death in a hospital, distant from home both physically and socially, is death outside social relatedness. People avoid dying in hospitals not only because of the guardian spirits mentioned above but also in order to die an ordinary death at home with others. As one 40-year-old woman said, "Most of us die at home, while

death in the hospital is rare. We prefer to die with family, relatives and friends, and dying like that is an ordinary death.”

Another implication of the phrase “ordinary death” is the importance of being cared for by family members, especially children, in old age. Again, elder and end-of-life care are mainly the responsibilities of adult children in the household, as mentioned in previous sections. As implied by the absence of Lao terms corresponding to “terminal care” or “end-of-life care”, these things are considered part of caring for one’s elderly parents. The social environment necessary for *sabai* in old age is thus another important criterion for dying ordinarily.

How then did villagers explain that adult children generally care for their aging parents? Elders in the area researched frequently said “I cannot work because of my age, but my grown children support me.” Meanwhile, those children said, “We care for our parents since they brought us up.” In their explanations, elder and terminal care was often connected with the parents’ child-rearing efforts when they were young (*cf.* Iwasa 2009a: 211–232).

But it is not sufficient to understand raising children and caring for the old dichotomously. It is more appropriate to regard relatedness between parents and children as processual (*cf.* Carsten 2000), with the direction of care shifting gradually throughout life and elder care being simply one stage in the ongoing process of mutual care. From this perspective, it is one important aspect of aging in the research area to have appropriately constructed and reconstructed relatedness with children (and others) in each life stage. Villagers regarded such a successful aging process as “ordinary”.

The well-being of the elderly who receive satisfactory support and care from their adult children (and others), expressed as the word *sabai*, demonstrates that they have constructed rich relatedness throughout their lives, and also implies that they can die with their children and loved ones—that is, *tai thammada*.

6. Conclusion

In his review of changing patterns of mortality worldwide, focusing especially on differences between developed and developing countries, Seale (2000) raised some questions for the consideration of health care research and terminal care from a global perspective. One that seems to relate to this chapter is the following: “[t]o what extent are Western models of terminal or palliative care applicable in developing countries?” (Seale 2000: 927). In this concluding discussion, I will examine the question briefly.

Accounts and analyses in the preceding sections reveal some differences in the processes of aging and dying between the rural lowlands of Laos and developed regions. One of the most remarkable contrasts is spatial. Seale (2000) described the places of aging and dying in developed regions as follows.

The widespread institutional care for elderly people is very much a phenomenon of developed countries, adopted as a solution to the shortage of informal care in families available to elderly people. This in turn is caused both by demographic factors and features of the social organization of advanced industrialised societies that often separate elderly people from mainstream

social and family life. ... Although most people who enter a residential institution for the elderly will eventually die there, these are not generally perceived as places primarily devoted to the care of 'dying' people. This is more normally the perception of hospices, although caring for 'the dying' is also seen as a legitimate part of general hospital care. A large proportion of people in developed societies die in hospitals, rather than at home or indeed in hospices. (Seale 2000: 924)

This so-called "modernization of death" (*cf.* Green 2008; Walter 1994) has been criticized as dehumanizing elements of a medical world dominated by sequestration, institutionalization and professionalization. On the other hand, alternative ideas of terminal care such as hospice and palliative care have attracted attention since the 1960s and recently begun to spread throughout the wider field of elder care. These so-called "holistic approaches" have made "significant contributions to loosening up the strict dividing lines between the medical and the social perspectives" (Whitaker 2010: 97).

When we consider Seale's question, we should recognize its assumption that only developed regions have experienced the modernization of aging and dying. The assumption separates the processes of aging and dying from those of life, relegating them to institutionally timed phenomenon constructed by professional administration and 'jargon' such as self-esteem, autonomy, integrity, quality-of-life and dignity (*cf.* Green 2008). We must also be aware of the individualized perspective, which is popular in hospice and palliative care in developed regions and should be understood within a broader cultural context of late modern societies, in which the tendency to plan for and control major life events is already an important feature of self-identity (Giddens 1991) and death is shaped by dying, dead or bereaved individuals themselves linking "a culture of individualism that values a unique life uniquely lived" (Walter 1994: 2).

Though it seems that perspective is conducive to constructive effective health care systems in developed regions as Seale describes them, there remains the question of whether it applies to Lao experiences of aging and dying.

As mentioned in the introduction, Laos has been experiencing demographic transitions such as prolonged life expectancy as well as socioeconomic changes. The possibility of the transformation of social relations caused by the changing life courses of younger generations can be seen in rural areas, as described in another article (Iwasa 2011: 607–610). I should also admit that the descriptions and interpretations above are fragmentary and slanted: it goes without saying that the processes of aging and dying vary greatly depending on the person and situation. The accounts here did seem accurate to most villagers I know, however, so it is reasonable to suppose that aging and dying in rural lowland areas of Laos, or at least in the area I visited, are different from the medicalized and institutionalized processes that characterize more developed regions.

In the rural lowlands of Laos, there is a degree of continuity between aging and dying and the rest of life. All of these take place not at medical institutions but home, the center of village life, and caregivers are in general not health care professionals but family members, especially children within the household. The 'ordinariness' of aging and dying is determined by relatedness with family and friends that have been constructed and reconstructed through-

out life. In order to understand the situation appropriately, we need to employ processual and relational approaches (*cf.* Carsten 1997; 2000; Rosaldo 1989).

Theories arising from research in developed regions are not entirely useless in studies of aging and dying in Laos or other developing regions. They may help identify appropriate approaches to demographic transitions and socioeconomic changes. But it is unrealistic and problematic to apply ‘modern-Western perspectives’ on aging and dying to developing regions directly and uncritically (Singer and Bowman 2002). Consequently, it is indispensable both to acquire culturally and socially sensitive perspectives on developing regions and to practice “cultural critiques” (Marcus and Fisher 1986) or “ethnographic critiques” (Fisher 2001) of concepts of aging and dying in developed regions. Continuing efforts in these endeavors, a further goal of our project will be to establish cross-cultural and global approaches to the well-being of the aging and the dying, transcending dichotomies between developed and developing regions.

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Notes

- 1) They often identified them as ‘*lao lum*’ also. This is one of three categories of ethnic groups calcified according to habit location: *lao lum* (lowlander), *lao thoeng* (midlander), and *lao sung* (highlander) (Iwasa 2009a: 16). These distinctions are not formal now, but they are usually used by Lao people.
- 2) All such names in this article are fictitious.
- 3) Williams and his colleague (1996) reported similar aspects of dying in northeast Thailand, where there are some cultural and social similarities to lowland rural areas of Laos. Thai methods of elder care are also similar to those in the area I studied (*cf.* Kondel and Chayovan 2009; Siriboon and Knodel 1994).
- 4) The Lao adjuncts ‘*thammada*’ or ‘*pokhathi*’ are used in discussions not only of death but also of delivery (*cf.* Shimazawa 2009: 57).

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