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Civil society in ASEAN: a healthy development?

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Across southeast Asia, local citizens engage in collective action for health, the basis of networks of trust that are often overlooked by state agencies and external observers. Informal groups and Buddhist monks provided first aid and food assistance to survivors after Myanmar's cyclone Nargis in 2008, in the absence of governmental and external assistance.^{1,2} In Vietnam, support provided by local Buddhist and Catholic congregations, and organisations such as the Women's Union, have expanded to fill the increase in demand for local health services as the previously subsidised state monopoly splintered into an uneven mixture of public and private health providers. Civil society in Thailand has contributed to major innovations in family-planning programmes, ensured universal access to antiretroviral drugs, and challenged international trade regimens to enable the licensing of

domestically produced medicines.³ The outcomes of action by civil society vary widely across the region and have not always been positive, as conflicts emerged within civil society and between society and the state.

Citizen-based action on health takes place against the backdrop of varied political regimes in southeast Asia. Although authoritarian and illiberal democratic states attempt to restrict civil society, by a combination of legal and extra-legal means, citizens still organise ways of improving their health and environment.⁴⁻⁶ These improvements are achieved in cooperation with the state and donors when possible, but separately and informally when not. The resulting mix of opportunities for civil society does not correspond easily with the usual ideas of civil society as autonomous and independent from separate state and market sectors. In reality, the situation in southeast Asia is characterised by degrees of state–society interpenetration, from positive synergies to co-optation of social forces by the state.⁷

Perhaps the most celebrated cases of civil-society involvement in southeast Asia have been in HIV care and prevention. Local networks and organisations, particularly groups of people living with HIV, have had a prominent role in responding to the burden of caring for patients and ensuring that those living with the disease in Cambodia and Thailand have a place in society. In Vietnam, funding has been channelled to grassroots networks that support patients by global health initiatives such as the US President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria.⁸ Although the Vietnamese Government has encouraged religious groups to care for underserved and stigmatised populations,⁹ groups operating programmes might nevertheless encounter difficulties with legal registration due to suspicion from some local government agencies.



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Informal civil-society groups and networks throughout the region are more likely to receive funds from private donors than through official channels.

Diversity in the region challenges the often unstable balance between civil-society and non-governmental organisations (NGOs). International and domestic NGOs do participate in some programmes, but are absent in other cases. Many NGOs depend entirely on grants and contracts, operate as consultancy companies, or are set up by government or businesses with little resemblance to grassroots civil society. Instead of focusing on organisations, civil society should be approached as a process of organising citizens' action, the effectiveness of which should be proven rather than assumed.

The future prospects of civil-society involvement seem to be uncertain. Civil-society efforts have been effective in providing services to people affected by HIV in some areas, but have delivered less on other areas and public health issues that extend beyond one disease. Many donor and governmental organisations favour direct service-delivery to advocacy or reform, offering limited space for citizens' action. As a result, civil society is often passive when advocating about major issues, such as health insurance for poor people, the high price and often dubious quality of drugs, or pandemic preparedness. These concerns will probably increase in coming years if external donor funding to middle-income countries in southeast Asia decreases or internal conflicts arise unexpectedly, as in Thailand during 2009–10. New health threats are also likely to emerge, including those relating to climate change. These changes might lead to opportunities for civil-society action, but

need to be balanced against existing legal and capacity restraints. We will see and understand more of these complex dynamics if we discard the idea that civil society is made up only of formal organisations and look instead to the local networks and religious and citizens' groups that are forming at the grassroots.

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Mobilising the Americas for dietary salt reduction

People are over-consuming salt, causing up to 30% of all cases of hypertension.¹ In the Pan-American region, hypertension prevalence ranges from 20% to 35%, with the higher proportions more often seen in Latin America.^{2,3} Salt intake, where measured, can be as high as 11.5 g a day per person, with by far the largest source in most cases being commercially processed foods.^{4,5} The Pan American Health Organization (PAHO) has responded with an initiative, "Cardiovascular Disease Prevention through Dietary Salt Reduction". For a 2-year period, beginning in September, 2009, it is supporting a Regional Expert Group: 18 leaders in nutrition

and chronic diseases from universities, government agencies, and research institutions in north, south, and central America, the Caribbean, and Europe.

The Group first developed a policy statement with the rationale and recommendations for a gradual and sustained population-wide drop in dietary salt across the Americas. Its audience is policy and decision makers in government, leaders in non-governmental organisations (representing consumers and scientific and health-care professionals), civil society, the food industry (including food processors and distributors), among food importers and exporters, and in PAHO.⁶



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