ASEAS

5(1) 2012

Österreichische Zeitschrift für Südostasienwissenschaften
Austrian Journal of South-East Asian Studies

FOCUS HEALTH

ASEAS

Österreichische Zeitschrift für Südostasienwissenschaften, 5(1), 2012
Austrian Journal of South-East Asian Studies, 5(1), 2012

MEDIENINHABERIN & HERAUSGEBERIN / PUBLISHER
SEAS – Gesellschaft für Südostasienwissenschaften / Society for South-East Asian Studies
ZVR-Zahl 786121796; Penzinger Straße 60/12, 1140 Wien, Austria

GEGENSTAND / PURPOSE
Der Verein SEAS bezweckt unter anderem die Förderung der Südostasienwissenschaften und der Bildung des wissenschaftlichen Nachwuchses, sowie des Stellenwertes und der Auseinandersetzung mit der Region Südostasien in Österreich und darüber hinaus.

OFFENLEGUNG / DISCLOSURE (§ 25 MEDG)
Der Verein SEAS ist zu 100 Prozent Eigentümer von ASEAS. Die namentlich gekennzeichneten Beiträge enthalten die Ansichten der AutorInnen und nicht notwendigerweise jene der Redaktion.

REDAKTIONSANSCHRIFT / EDITORIAL ADDRESS
Penzinger Straße 60/12, 1140 Wien, Austria; E-Mail: aseas@seas.at

CHEFREDAKTEUR / EDITOR-IN-CHIEF
Christian Wawrinec

KOORDINATOR DIESER AUSGABE / MANAGING EDITOR
Michelle Proyer

REDAKTION / EDITORIAL BOARD
Christian Bothe, Alfred Gerstl, Iris O'Rourke, Dayana Parvanova, Melanie Pichler, Michelle Proyer, Alexander Trupp

REDAKTIONELLE UNTERSTÜTZUNG / EDITORIAL SUPPORT
Markus Pfister

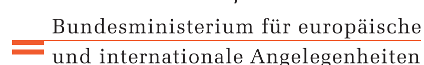
WISSENSCHAFTLICHER BEIRAT / ADVISORY BOARD
Ramses Amer (Stockholm University, Sweden), Karl Husa (University of Vienna, Austria), Harold R. Kerbo (California Polytechnic State University, USA), Huong Thanh Bui (Hanoi University, Vietnam), Rüdiger Korff (Passau University, Germany), Prasit Leepreecha (Chiang Mai University, Thailand), Susanne Schröter (Goethe University Frankfurt/Main, Germany)

TITELFOTO / COVER PHOTO
Lukman Hakim Bin Yahya (ManBooX Photography): *Hijamah - Wet Cupping,* Indonesia, 2012

LAYOUT
Christian Bothe

ISSN: 1999-2521 (Print), ISSN 1999-253X (Online)

UNTERSTÜTZT VON / SUPPORTED BY



MEHR INFORMATIONEN / FURTHER INFORMATION
www.SEAS.at

LIZENZ / LICENCE (CREATIVE COMMONS)
Namensnennung / Keine kommerzielle Nutzung / Keine Bearbeitung
Attribution / Noncommercial / No Derivative Works

01 — *Editorial: Determinants of Health in South-East Asia / Umfeldfaktoren öffentlicher Gesundheit in Südostasien*
Pranee Liamputtong & Michelle Proyer

10 — *Water Supply or 'Beautiful Latrines'? Microcredit for Rural Water Supply and Sanitation in the Mekong Delta, Vietnam*
Nadine Reis & Peter P. Mollinga

30 — *Environmental Policy Coordination in ASEAN: The Case of Waste From Electrical and Electronic Equipment*
Armin Ibitz

52 — *Health and Environmental Risk Communication in Thailand: An Analysis of Agency Staff's Perspectives on Risk Communication With External Stakeholders*
Seth Tuler, Uma Langkulsen, Caron Chess & Nuntavarn Vichit-Vadakan

74 — *Combating SARS and H1N1: Insights and Lessons From Singapore's Public Health Control Measures*
Allen Yu-Hung Lai & Teck Boon Tan

102 — *On the Edge of Crisis: Contending Perspectives on Development, Tourism, and Community Participation on Rote Island, Indonesia*
Cassandra Wright & Belinda Lewis

»

Forum Südostasien / Forum South-East Asia

128 — *Pro- oder Anti-Life? Die katholische Kirche in der Debatte um reprodukive Gesundheit auf den Philippinen*
Marina Wetzlmaier

139 — *Customer Empowerment in Healthcare Organisations Through CRM 2.0: Survey Results from Brunei Tracking a Future Path in E-Health Research*
Muhammad Anshari, Mohammad N. Almunawar, Patrick K. C. Low & Zaw Wint

152 — *Consumption and Nutritive Values of Traditional Mon Food*
Kanvee Viwatpanich

Forschungswerkstatt / Research Workshop

161 — *Das philippinische Gesetz zur reproduktiven Gesundheit und seine Bedeutung für feministische sowie entwicklungspolitische (Bildungs-)Arbeit*
Michael Reckordt

Im Dialog / In Dialogue

166 — *Der lange Schatten struktureller Fehlentscheidungen: FachärztInnenmangel in der Frauenheilkunde in Laos und Vietnam. Im Gespräch mit Michael Runge (Universität Freiburg)*
Lan-Katharina Schippers

174 — *Entwicklungs- und Gesundheitsarbeit des Österreichischen Roten Kreuzes in Südostasien: Im Gespräch mit Max Santner und Gerlinde Astleithner*
Anna-Sophie Tomancok

Netzwerk Südostasien / Network South-East Asia

186 — *Südostasienforschung in Österreich: Die Sammlung Insulares Südostasien des Museums für Völkerkunde Wien*
Sri Tjahjani Kuhnt-Saptodewo

190 *Gainsborough, Martin (2010).*
Vietnam: Rethinking the State.
Lan-Katharina Schippers

194 *Yahuda, Michael (2011).*
The International Politics of the Asia Pacific (Third Edition).
Alfred Gerstl

Editorial

Determinants of Health in South-East Asia / Umfeldfaktoren öffentlicher Gesundheit in Südostasien

Pranee Liamputtong[1] & Michelle Proyer[2]

Citation Liamputtong, P. & Proyer, M. (2012). Editorial: Determinants of Health in South-East Asia / Umfeldfaktoren öffentlicher Gesundheit in Südostasien. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 1-9.

This special issue of the *Austrian Journal of South-East Asian Studies* has its focus on 'Health in South-East Asia'. Health, illness, and well-being have always played a part in the life of all human beings, and situated within the new public health perspective, health, illness, and the well-being of individuals, groups, and communities are determined by a diverse range of complex personal, social, cultural, environmental, and economic factors as well as health care systems (Australian Institute of Health and Wellbeing [AIHW], 2010). This is also referred to as determinants of health (Liamputtong, Fanany, & Verrinder, 2012; Marmot & Wilkinson, 2006; Taylor,

Das vorliegende Themenheft der *Österreichischen Zeitschrift für Südostasienwissenschaften* präsentiert einen Überblick zum Thema „Gesundheit in Südostasien". Gesundheit, Krankheit und Wohlbefinden spielten schon immer eine Rolle im Leben aller Menschen. Die neue Perspektive auf öffentliche Gesundheit (*Public Health*) zeigt, dass Krankheit, Gesundheit und Wohlbefinden auf individueller, gruppenspezifischer und kommunaler Ebene vordergründig von einer Vielfalt an komplexen persönlichen, sozialen, kulturellen, ökologischen und wirtschaftlichen Faktoren sowie durch das Gesundheitssystem bestimmt sind (Australian Institute of Health and Wellbeing [AIHW], 2010). Diese werden auch

1 Pranee Liamputtong is professor at the School of Public Health and Human Biosciences, Faculty of Health Sciences, La Trobe University, Melbourne, Australia. As a qualitative researcher her central foci are related to topics regarding the interrelations between health issues and gender, HIV/AIDS, immigration, as well as reproduction. Regionally, she is focusing on South-East Asia and the health situation of Asian females immigrating to Australia. Contact: pranee@latrobe.edu.au

2 Michelle Proyer studied Education in Vienna and Berlin. She is assistant professor (*Universitätsassistentin*) at the Department of Education (*Research Unit Special Needs and Inclusive Education*), University of Vienna, Austria and member of the ASEAS Editorial Board. Currently, she is working on her PhD thesis in the area of comparative special needs education within the CLASDISA project with a focus on Thailand. Contact: michelle.proyer@univie.ac.at

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-1

BY-NC-ND creative commons

2008). Conceptually, the focus of this perspective is on factors which could influence and determine the health of people, instead of on the state and outcomes of their health. It also underscores the prevention of ill health, rather than the measurement of illness (Keleher & Murphy, 2004; Rumbold & Dickson-Swift, 2012; Taylor, 2008).

The determinants of health are characteristics or factors which can bring about a change in the health and illness of individuals and populations, either for better or for worse (Liamputtong et al., 2012; Taylor, 2008). These determinants include biological and genetic factors, health behaviours (such as risky lifestyles, abuse of alcohol, and cigarette smoking), socio-cultural and socio-economic factors (such as gender, ethnicity, education, income, and occupation), and environmental factors (including housing, social support, social connection, geographical position, and climate). Resources and systems such as access to health services, health care policy, and the health care system also have effects on the health and well-being of individuals and populations (Liamputtong et al., 2012; Najman, 2001).

The important connection between the environment in which individuals

als Gesundheitsdeterminanten bezeichnet (Liamputtong, Fanany, & Verrinder, 2012; Marmot & Wilkinson, 2006; Taylor, 2008). Konzeptionell liegt der Fokus dieser Perspektive auf den Faktoren, welche die Gesundheit von Menschen beeinflussen und bestimmen können, anstatt auf Gesundheitszuständen und gesundheitlichen Prognosen. Dementsprechend wird auch die Prävention im Verhältnis zur Messung von Krankheiten hervorgehoben (Keleher & Murphy, 2004; Rumbold & Dickson-Swift, 2012; Taylor, 2008).

Gesundheitsdeterminanten sind Eigenschaften oder Faktoren, die einen Einfluss auf den individuellen und gemeinschaftlichen Gesundheitszustand haben können. Dieser kann positive, aber auch negative Auswirkungen haben (Liamputtong et al., 2012; Taylor, 2008). Die Determinanten beinhalten biologische und genetische Faktoren, Gesundheitsbewusstsein (riskante Lebensführung, Alkoholmissbrauch oder Zigarettenkonsum), soziokulturelle und sozioökonomische Faktoren (Gender, Ethnizität, Bildung, Einkommen und Beschäftigung) und Umweltfaktoren (Unterkunft, Wohlfahrtssysteme, soziale Anbindung, Geographie und Klima). Ressourcen sowie der Zugang zum Gesundheitswesen, zu Gesundheitspolitik und zu medizinischer Versorgung wir-

live and their health and well-being has long been observed (Griffith et al., 2010; McMichael, 2001; Nicholson & Stephenson, 2009). Historically, environmental dangers to people's health tended to be related to issues of underdevelopment such as insufficient water quality, the absence of sanitation, and poor housing. Although these 'traditional' threats have been managed successfully in the more affluent areas, there are still problems among socially disadvantaged and vulnerable groups of developed nations and also in the poorer countries of the globe, including most of South-East Asia. Nowadays, we see 'modern' threats, which have emerged because of overconsumption and overdevelopment in industrialised nations. These modern threats, including climate change and risk from e-waste, have now become global hazards. South-East Asia is one of the regions that is also highly susceptible to the impacts of these modern threats.

The papers in this special issue point to the many issues that we have suggested above. Nadine Reis (Munich School of Philosophy) and Peter P. Mollinga (University of London) examine the effectiveness of micro-credit programmes for rural water supply and sanitation in the Mekong

ken sich ebenfalls auf die Gesundheit und das Wohlbefinden von Individuen und Gruppen aus (Liamputtong et al., 2012; Najman, 2001).

Die Wechselbeziehung zwischen dem Umfeld, in dem Individuen leben und daraus resultierenden Auswirkungen auf ihre Gesundheit und ihr Wohlbefinden wird seit längerem beobachtet (Griffith et al, 2010;. McMichael, 2001; Nicholson & Stephenson, 2009). Ursprünglich standen umweltbedingte Gefahren für die Gesundheit der Menschen mit Problemen von „Unterentwicklung", beispielsweise unzureichender Wasserqualität, dem Fehlen sanitärer Einrichtungen und schlechter Wohnverhältnisse, in Verbindung. Wenngleich diese „traditionellen" Bedrohungen in wohlhabenden Regionen erfolgreich bewältigt wurden, gibt es weiterhin Probleme für sozial benachteiligte und von sozialer Benachteiligung bedrohte Gruppen – sowohl in „entwickelten" Staaten wie auch in den ärmeren Weltregionen, zu denen auch die meisten Länder Südostasiens zählen. Gegenwärtig entdecken wir zunehmend „moderne" Bedrohungen, die durch Überkonsum und Überentwicklung in den Industrieländern entstehen. Moderne Bedrohungen wie Klimawandel oder das Risiko von elektronischem Müll sind mittlerweise globale Gefahren, wobei Südostasien eine

Delta in Vietnam. They show that the programme has improved the conditions regarding safer disposal of human excreta and the water quality in rivers and canals. However, it has only a minimal effect on poverty reduction because it mostly benefits better-off households who have already had access to clean water.

Armin Ibitz (Wenzao Ursuline College of Languages) presents the case of waste from electrical and electronic equipment in ASEAN nations. It is suggested that economic progress in ASEAN countries has also brought about huge environmental deterioration and risk to human health. This is particularly so for the rapid growth of volumes of waste from electrical and electronic equipment (e-waste). Severe water and soil contamination are the marked outcomes of inadequate treatment of discarded electric and electronic appliances. Despite this massive problem, ASEAN seems to be unable to find a common solution for this urgent issue. Ibitz attempts to find the determining factors that have prevented ASEAN to agree on a common policy for dealing with e-waste.

Globally, we are now living in a risk society (Giddens, 1991). In their paper, Seth Tuler (Social and Environmental Research Institute), Uma Langkulsen

Region ist, die von deren Auswirkungen stark betroffen ist.

Die Beiträge in der vorliegenden ASEAS-Ausgabe behandeln einige der Themen, die wir oben angeführt haben. Nadine Reis (Hochschule für Philosophie München) und Peter P. Mollinga (University of London) untersuchen die Effizienz eines Mikrokreditprogrammes für ländliche Wasser- und sanitäre Grundversorgung im Mekong-Delta in Vietnam. Die AutorInnen zeigen, dass das Programm die sichere Entsorgung von Fäkalien und die Wasserqualität in Flüssen und Kanälen verbesserte, jedoch nur einen begrenzten Beitrag zur Armutsbekämpfung leisten kann, da hauptsächlich finanziell besser gestellte Haushalte erreicht werden, die bereits Zugang zu sauberem Wasser haben.

Armin Ibitz (Wenzao Ursuline College of Languages) präsentiert seine Forschungsergebnisse zu Elektroschrott in ASEAN-Mitgliedern. Der wirtschaftliche Fortschritt in diesen Ländern führte zu weitreichenden Umweltschäden und Gesundheitsrisiken. Durch unzureichende Entsorgung elektrischer und elektronischer Geräte kommt es zu massiven Verunreinigungen von Gewässern und Böden. Eine dringend notwendige regionale Koordinierung wurde von ASEAN noch nicht in Angriff genommen. Der Beitrag geht der Frage nach, warum auf

(Thammasat University), Caron Chess (Rutgers University) and Nuntavarn Vichit-Vadakan (Thammasat University) write about health risk communication in Thailand. They examined the perceptions of staff and officers about risk communication in a single regulatory agency in Thailand – the Pollution Control Department. It is argued that it is essential for health and environmental agencies to communicate information about health risks to local people. Risk communication is a Western concept and it is problematic when using it in a different cultural context. Their paper provides an in-depth understanding about the ways that staff and officers within a national agency, who have important responsibilities for health and environmental risk communication in Thailand, make sense of their responsibilities and how to accomplish them.

South-East Asia has been a site of many infectious diseases. Recently, we have witnessed the devastating impact of the SARS epidemic and H1N1 pandemics. These infectious diseases are the outcomes of complex dynamic systems where biological, social, ecological, and environmental factors are interconnected (Coker et al., 2011). How do South-East Asian nations deal with these epidemics and pandemics?

regionaler Ebene keine einheitlichen Lösungsansätze zu dieser Problematik zu erwarten sind und definiert die Faktoren, welche die ASEAN-Mitglieder hindern, eine gemeinsame Politik für den Umgang mit Elektroschrott zu finden.

Wir leben in einer globalen Risikogesellschaft (Giddens, 1991). Seth Tuler (Social and Environmental Research Institute), Uma Langkulsen (Thammasat University), Caron Chess (Rutgers University) und Nuntavarn Vichit-Vadakan (Thammasat University) behandeln in ihrem Beitrag den Informationsaustausch zu Gesundheitsrisiken in Thailand. Sie untersuchen die Wahrnehmungen von MitarbeiterInnen in einem öffentlichen Amt, der Umweltschutzbehörde. Es ist essentiell, dass Gesundheits- und Umweltämter Informationen über Gesundheitsrisiken an die lokale Bevölkerung weitergeben. Kommunikationstheorien in diesem Bereich basieren jedoch auf einem westlichen Konzept, und es ist mitunter schwierig, diese in unterschiedlichen kulturellen Kontexten anzuwenden. Der Artikel bietet eine tiefgehende Analyse über die Verantwortung der MitarbeiterInnen und BeamtInnen für den Informationsaustausch zu öffentlicher Gesundheit in Thailand sowie darüber, wie diese ihre Verantwortung wahrnehmen und umsetzen.

Lai Yu-Hung Allen and Tan Teck Boon (National University of Singapore) discuss the evolution of public health control measures from 2003 SARS to 2009 HINI in Singapore. Their paper attempts to identify the measures which have been taken to manage the pandemics and the learning process regarding policy adaptation for pandemic preparedness planning.

In the section 'Forum', Marina Wetzlmaier (FoodFirst Information and Action Network) provides an overview on the past and current debates concerning the Reproductive Health Bill in the Philippines. Michael Reckordt (Philippinenbuero) also covers this controversial topic. In the section 'Research Workshop', he summarises different perspectives presented during a workshop in Essen, Germany, in March 2012.

On a different subject matter, Muhammad Anshari, Mohammad N. Almunawar, Patrick K. C. Low and Zaw Wint (Universiti Brunei Darussalam) explain the results of their study on social network-based customer relationship management in healthcare organisations in Brunei, which adds valuable insights to the possible impacts of new media on health care systems. Furthermore, Kanvee Viwatpanich (Thammasat University)

Südostasien wurde zum Schauplatz vieler Infektionskrankheiten. Erst kürzlich erlebten wir die verheerenden Auswirkungen der SARS-Epidemie und der H1N1-Pandemie. Diese Infektionskrankheiten sind Ergebnisse komplexer dynamischer Systeme, bei denen biologische, soziale, ökologische und Umweltfaktoren miteinander verwoben sind (Coker et al., 2011). Wie bewältigen südostasiatische Nationen diese Epidemien und Pandemien? Yu-Hung Lai und Tan Teck Boon (National University of Singapore) diskutieren die Entwicklung von Kontrollmaßnahmen im Gesundheitsbereich in Singapur von SARS 2003 bis H1N1 2009. In ihrem Artikel identifizieren sie die Maßnahmen, die ergriffen wurden, um den Ausbruch der Pandemien zu bewältigen, und den politischen Lernprozess zur besseren Vorbereitung für zukünftige Pandemien.

In der Rubrik „Forum" erläutert Marina Wetzlmaier (FoodFirst Information and Action Network) die vergangenen und aktuellen Debatten über das Gesetz zu reproduktiver Gesundheit auf den Philippinen. Auch Michael Reckordt (Philippinenbüro) behandelt dieses kontroverse Thema. In der Rubrik „Forschungswerkstatt" dokumentiert er unterschiedliche Perspektiven, die während eines Workshops in Essen, Deutschland, im März 2012 präsentiert wurden.

analyses the nutritive values and food consumption patterns of Mon Food, therefore highlighting the connection between food and health issues.

In addition, this special issue contains two interviews. First, Lan-Katharina Schippers talked to Dr. Michael Runge, gynaecologist and professor at the University of Freiburg, Germany, about his over 25 years of experience in improving women's health in South-East Asia, particularly Lao PDR and Vietnam. Secondly, Anna-Sophie Tomancok interviewed Max Santner and Gerlinde Astleithner on the activities of the Austrian Red Cross and the International Red Cross and Red Crescent Movement in South-East Asia, particularly Myanmar, Lao PDR and Timor-Leste.

Outside this special issue's focus on health, Cassandra Wright and Belinda Lewis (Monash University) provide an analysis of tourism and development in eastern Indonesia, particularly on Rote Island. Within the context of globalisation and Indonesia's ongoing transitions in governance, the future direction for Rote is a hotly debated topic amongst community members, development workers, businesses, and other stakeholders.

Finally, as in previous issues, ASEAS continues the introduction of Austrian

Muhammad Anshari, Mohammad N. Almunawar, Patrick K. C. Low und Zaw Wint (Universiti Brunei Darussalam) präsentieren die Ergebnisse ihrer Studie zu Customer-Relationship-Management in Bruneis Gesundheitswesen und den möglichen Auswirkungen neuer Medien und sozialer Netzwerke auf Gesundheitssysteme. Des Weiteren analysiert Kanvee Viwatpanich (Thammasat University) die Nährwerte und Konsummuster von Mon-Lebensmitteln und beleuchtet die Verbindung zwischen Ernährungs- und Gesundheitsfragen.

Darüber hinaus enthält das Themenheft zwei Interviews. Lan-Katharina Schippers diskutierte mit Michael Runge, Gynäkologe und Professor an der Universität Freiburg, Deutschland, über seine mehr als 25 jährige Erfahrung in der Entwicklungszusammenarbeit in Südostasien, vor allem im Bereich Frauengesundheit in Laos und Vietnam. Außerdem sprach Anna-Sophie Tomancok mit Max Santner und Gerlinde Astleithner über die Tätigkeiten des Österreichischen Roten Kreuzes und der Internationalen Rotkreuz- und Roter-Halbmond-Bewegung in Südostasien, insbesondere in Myanmar, Laos und Timor-Leste.

Außerhalb des Themenschwerpunkts „Gesundheit" analysieren Cassandra Wright und Belinda Lewis (Monash University) Tourismus und Ent-

research institutes working on South-East Asian related topics: Sri Tjahjani Kuhnt-Saptodewo presents the collection 'Insular South-East Asia' at the Museum of Ethnology in Vienna.

In South-East Asia, a region showing constant economic growth, health continues to be a central issue and current insights into advances as well as into enduring problems present valuable components for further analysis of prospective solutions. Certainly, the articles in this ASEAS special issue will provide valuable insights and hopefully contribute to the rising interest in further research and co-operation.

wicklung auf der Insel Rote in Ostindonesien. Im Kontext der Globalisierung und Indonesiens aktuellem politischen Wandel ist die zukünftige Richtung für die Entwicklung Rotes ein viel diskutiertes Thema zwischen Mitgliedern der Lokalbevölkerung, EntwicklungshelferInnen, UnternehmerInnen und anderen Interessensgruppen.

Schließlich stellen wir, wie schon in früheren ASEAS-Ausgaben, ein weiteres österreichisches Forschungsinstitut vor, an dem zu Südostasien gearbeitet wird: Sri Kuhnt-Tjahjani Saptodewo präsentiert die Sammlung Insulares Südostasien des Museums für Völkerkunde in Wien.

In Südostasien, einer Region mit konstantem Wirtschaftswachstum, wird Gesundheit weiterhin ein zentrales Thema bleiben. Aktuelle Einblicke in Fortschritte sowie Herausforderungen in diesem Bereich sind wertvolle Voraussetzungen für die weitere Analyse potenzieller Lösungsansätze. Die Artikel des vorliegenden Themenheftes liefern wertvolle Ideen und werden hoffentlich zum steigenden Interesse an der weiteren Forschung und Zusammenarbeit beitragen.

***References** / Bibliographie*

Australian Institute of Health and Welfare (AIHW). (2010). *Australia's health 2010* (Australia's Health series No. 12). Cat No. AUS 122. Canberra, Australia: Australian Institute of Health and Welfare.

Coker, R. J., Hunter, B. M., Rudge, J. W., Liverani, M., & Hanvoravongchai, P. (2011). Emerging infectious diseases in Southeast Asia: Regional challenges to control. *The Lancet, 377*, 599-609.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age.* Cambridge, UK: Polity Press.

Griffith, L., Raina, P., Wu, H., Zhu, B., & Stathokostas, L. (2010). Population attributable risk for functional disability associated with chronic conditions in Canadian older adults. *Age and Ageing, 39*(6), 738-745.

Keleher, H., & Murphy, B. (Eds.) (2004). Understanding health: *A determinants approach.* Melbourne, Australia: Oxford University Press.

Liamputtong, P., Fanany, R., & Verrinder, G. (2012). Health, illness and well-being: An introduction. In P. Liamputtong, , R. Fanany, & G. Verrinder (Eds.), *Health, illness and well-being: Perspectives and social determinants* (pp. 1-17). Melbourne, Australia: Oxford University Press.

Marmot, M., & Wilkinson, R. G. (Eds.) (2006). *Social determinants of health*. Oxford, UK: Oxford University Press.

McMichael, A. J. (2001). *Human frontiers, environments and disease: Past patterns, uncertain futures*. Cambridge, UK: Cambridge University Press.

Najman, J. (2001). A general model of the social origins of health and well-being. In R. Eckersley, J. Dixon, & B. Dixon (Eds.), *The social origins of health and well-being* (pp. 73-83). Melbourne, Australia: Cambridge University Press.

Nicholson, R., & Stephenson, P. (2009). Natural environments as a determinant of health. In H. Keleher & C. MacDougall (Eds.), *Understanding health: A determinants approach* (2nd ed., pp. 112-133). Melbourne, Australia: Oxford University Press.

Rumbold, B., & Dickson-Swift, V. (2012). Social determinants of health: Historical developments and global implications. In P. Liamputtong, , R. Fanany, & G. Verrinder (Eds.), *Health, illness and well-being: Perspectives and social determinants* (pp. 177-196). Melbourne, Australia: Oxford University Press.

Taylor , S. (2008). The concept of health. In S. Taylor, M. Foster, & J. Fleming (Eds.), *Health care practice in Australia* (pp. 3-21). Melbourne, Australia: Oxford University Press.

Water Supply or 'Beautiful Latrines'? Microcredit for Rural Water Supply and Sanitation in the Mekong Delta, Vietnam

Nadine Reis[1] & Peter P. Mollinga[2]

Citation Reis, N., & Mollinga, P. P. (2012). Water Supply or 'Beautiful Latrines'? Microcredit for Rural Water Supply and Sanitation in the Mekong Delta, Vietnam. *ASEAS – Austrian Journal of South-East Asian Studies, 5*(1), 10-29.

Around half of the Mekong Delta's rural population lacks year-round access to clean water. In combination with inadequate hygiene and poor sanitation this creates a high risk of diseases. Microcredit schemes are a popular element in addressing such problems on the global policy level. The present paper analyses the contradictory results of such a microcredit programme for rural water supply and sanitation in the context of the Mekong Delta, Vietnam, through a qualitative study primarily based on semi-structured interviews in rural communes of Can Tho City. We come to the conclusion that the programme has a positive effect regarding the safer disposal of human excreta as well as surface water quality, but a marginal impact on poverty reduction as it only reaches better-off households already having access to clean water. The paper shows how the outcome of rural water supply and sanitation policies are strongly influenced by the local ecological, technological, and social settings, in particular by stakeholders' interests. The authors challenge the assumption that water supply and sanitation should be integrated into the same policy in all circumstances.

Keywords: Water; Sanitation; Microcredit; Mekong Delta; Vietnam

Etwa die Hälfte der ländlichen Bevölkerung des Mekong-Deltas hat nicht das ganze Jahr über Zugang zu sauberem Wasser. Zusammen mit unzureichender Hygiene und mangelnder sanitärer Grundversorgung erhöht diese Situation das Krankheitsrisiko. Auf globaler Ebene sind Mikrokreditprogramme eine gefragte Strategie, um diese Probleme zu behandeln. Der vorliegende Artikel analysiert die widersprüchlichen Ergebnisse eines solchen Mikrokreditprogramms für ländliche Wasser- und sanitäre Grundversorgung im Mekong-Delta in Vietnam im Rahmen einer qualitativen Studie, die auf halbstrukturierten Interviews im Raum Can Tho City basiert. Die Studie kommt zu dem Schluss, dass das Programm eine positive Wirkung in Bezug auf die sichere Entsorgung von Fäkalien und die Qualität des Regenwassers hat, jedoch nur einen begrenzten Beitrag zur Armutsbekämpfung leisten kann, da hauptsächlich finanziell besser gestellte Haushalte erreicht werden, die bereits Zugang zu sauberem Wasser haben. Der Artikel zeigt, dass die Wirkung von ländlicher Wasser- und sanitärer Grundversorgung maßgeblich von lokalen ökologischen, technologischen und sozialen Verhältnissen beeinflusst wird, allen voran von den unterschiedlichen Interessensgruppen. Die AutorInnen stellen die Annahme in Frage, dass Wasser- und sanitäre Grundversorgung unter allen Umständen in die gleiche politische Strategie integriert sein sollten.

Schlagworte: *Wasser; sanitäre Grundversorgung; Mikrokredit; Mekong-Delta; Vietnam*

creative commons BY-NC-ND
doi 10.4232/10.ASEAS-5.1-2
www.seas.at SEAS

1 Nadine Reis has completed her PhD in development sociology at the University of Bonn, Germany. She is currently a researcher at the Institute for Social and Development Studies, Munich School of Philosophy, Germany. Contact: nadine.reis@hfph.de (Corresponding author)

Introduction[3]

Microfinance instruments in poverty alleviation programmes have classically been geared towards the provision of midget credits with which the borrowers are able to finance small-scale business activities and thereby improve their livelihoods. Recently, the approach has been transferred to other areas of development policy (Saywell & Fonseca, 2006). Due to the pressure to meet the Millennium Development Goals (MDGs) and the popularity of cost recovery policies, microcredit is now also applied in the Water Supply and Sanitation (WSS) sector (Mehta & Knapp, 2004; Saywell & Fonseca, 2006). For sanitation it is seen as a useful approach because the supply-driven strategy of building toilets with household subsidies often resulted in unused facilities (Mehta & Knapp, 2004, p. 10). The paradigm shift in global sanitation policy has been described as a shift from "financing sanitation facilities" to "funding sanitation promotion and leveraging resources" (Mehta & Knapp, 2004, p. 16).

As an element of its National Rural Water Supply and Sanitation Strategy (NRWSS)[4], and with the support of an international donor consortium, the Vietnamese government approved a loan programme for Rural Water Supply and Sanitation (RWSS) in April 2004. This aims to "increase quickly the rate of rural households having access to clean water and hygienic constructions" (Vietnam Bank for Social Policies [VBSP], 2008). However, research on water and sanitation has pointed out that "policy debates and often generalised, globalised arguments that underpin them often remain disconnected from the everyday experiences of poor and marginalised women and men", while current approaches fail to address "the patterns of complexity and interaction between the social, technological, and ecological/hydrological dimensions of water and sanitation systems" (Mehta et al., 2007, p. 2).

This paper analyses the microcredit component of the Vietnamese government's RWSS policy. First, it aims to assess the programme's effectiveness in reaching its goals. In doing so, it contributes to the question if and in which way microfinance

2 Peter P. Mollinga is Professor of Development Studies at the School of Oriental and African Studies, University of London, UK.

3 This paper is an edited version of an article first published as a Working Paper at the Center of Development Research, University of Bonn (Reis & Mollinga, 2009).

4 The NRWSS was approved by the Prime Minister in 2000. The main responsible agency for its implementation is the Ministry of Agriculture and Rural Development (MARD), including its sub-branches and departments. The national goal is to provide all rural people with sufficient clean water and hygienic latrines by 2020 (MoC & MARD, 2000, p. 11). NRWSS is supported by a consortium of international donors (Denmark, Australia, the Netherlands, and recently, the UK).

is a useful approach for solving the financing gap in RWSS. Second, the paper goes beyond mere policy evaluation by showing how the local outcome of RWSS policies is strongly connected to the socio-political dynamics in complex water supply and sanitation systems, particularly with the interests of involved stakeholders.[5]

Research was carried out during a one-year stay in Can Tho City[6] in 2008/2009 as part of the BMBF[7]-funded interdisciplinary research project *Water-related Information System for the Sustainable Development of the Mekong Delta, Vietnam* (WISDOM). The paper draws on 28 semi-structured interviews with officials on four administrative levels (commune, district, province, and national government), staff of donor agencies as well as households in three rural communes of Can Tho City.[8] Study communes were chosen based on selecting typical cases that represent a larger number of communes as well as geographical distribution. Interviews were conducted with the aid of interpreters and analysed by using qualitative data analysis software.

Water Supply and Sanitation in the Mekong Delta

The Vietnamese Mekong Delta is an area where water is naturally abundant. In spite of that, the population faces increasing problems with regards to domestic water supply. Because of the settlement pattern, which follows the Delta's dense network of rivers and canals, rural households almost exclusively used rain and river water for domestic purposes until recently. River water is usually filled into buckets, transported to the house and stored in jars. Since the 1980s, surface water has been polluted through the intensification of agriculture, the establishment of industrial parks, the rise in industrial fish production, and population growth. Therefore, it has become popular to drill private wells, which is, however, expensive due to groundwater depths of 60 to 100 metres and only affordable for relatively wealthy households. The government agency responsible for managing water supply in the rural areas, *Centre for Rural Water Supply and Environmental Sanitation* (CERWASS), exclusively focuses on the construction of

---

5 For general discussion on water management in the Mekong Delta, see Kakönen (2008), Miller (2003), and Molle (2005). For a discussion on the politics of donor policy in the Vietnamese water sector, see Molle & Hoanh (2007).

6 In spite of Can Tho's administrative status as city, many areas remain peri-urban or rural, with a large share of the population depending on agriculture for their livelihoods.

7 BMBF = German Ministry for Education and Research.

8 The communes are Thanh Quoi in Vinh Thanh district, Truong Long in Phong Dien district, and Truong Xuan in Co Do district.

small-scale piped water supply schemes which abstract groundwater. This approach has so far not been able to solve the problems the rural population faces. This is related, firstly, to the difficult economic situation of the piped water systems, which prohibits the comprehensive coverage of all areas with water supply stations and the connection of all households to the networks.[9] Secondly, the use of groundwater is ecologically not sustainable due to the fast depletion of the resource (MONRE, 2009; Nuber et al., 2008).

Our assessment is that official government statistics significantly underestimate the percentage of rural households that lack year-round access to clean water (for a detailed discussion on the compilation of statistics, see Reis, 2012, pp. 134-142) Based on an evaluation of numerous interviews with local authorities, water supply station managers, and households, our estimate is that around 30 to 50 percent of the population lack year-round access to clean water in the rural areas of Can Tho City. The situation is especially problematic in areas without public water supply networks and in the dry season when rainwater is not available (Reis, 2012, pp. 56-59).

For sanitation, people traditionally use fishpond or river toilets. Only 26 percent of households are reported to have hygienic latrines in the Mekong Delta (Ministry of Health & United Nations Children's Fund, 2007). A fishpond toilet consists of two planks, installed above the fishpond that rural households very commonly have near the house, surrounded by a visual cover made of leaves, plastic sheets or other materials. People believe the excreta make the fish grow faster. The water of fishponds is regularly released into the river or canal for exchanging the water. According to authorities, about one third of the waste is eaten by the fish and two thirds are released into rivers and canals. If the household has no fishpond, the excreta are directly disposed into the river or canal. Current sanitation practices pose a health risk as excreta contaminate the water resource used for drinking and other domestic activities.

The question is whether the RWSS microcredit programme is a useful instrument for improving access to clean water and hygienic sanitation in the delta region. How is policy "digested" (Molle, 2005, p. 25) when it meets the complex socio-political, technological, and ecological local setting?

---

9 That piped water supply is economically not feasible in the study area is related to different factors. Most importantly, the diversity of water sources available in the rural areas of Can Tho implies that, unlike in many other areas of the world, piped water supply does not have a 'natural monopoly', as it is not an exclusive good but instead 'competes' with other water sources, in particular rainwater and private well water (cf. Spencer, 2005). Moreover, the administrative division of urban and rural water supply impedes subsidising the unprofitable rural areas with revenues from densely populated, profitable areas (for detailed discussion, see Reis [2012, pp. 90-101]).

The VBSP Microcredit Programme on RWSS

The *Vietnam Bank for Social Policies* (VBSP) was established in 2003 and is charged by the government with implementing microcredit programmes.[10] The VBSP loan programmes are group-based lending schemes, which are usually operated through the Vietnamese mass organisations. Besides the Farmers Union (FU), Veterans Union (VU), and Youth Union (YU), microcredit programmes are most often administered by the Women's Union (WU).

In order to receive a microcredit in the RWSS programme, which is meant to go towards constructing water supply and sanitation facilities, a household has to join a local credit group that is managed by a Credit Group Leader. The credit group decides which households can take a loan, and the amount and terms of the loan (Cuong, 2008, p. 156). After the Commune People's Committee has approved the list of the demanding households, it is sent to the VBSP on district level. The VBSP approves the list and asks Credit Group Leaders to make the credit contracts. In order to make sure that the money is spent for the right purpose, local credit officers stated that they have made arrangements with construction companies. Local companies provide the construction material to the assigned households for three days without payment. During this time, 30 to 40 percent of the construction has to be completed. Then the Credit Group Leader and the staff from local health stations check the quality of the construction. If it complies with the standards, the credit officers of the local VBSP branch disburse the money.

The microcredit programme for RWSS started in 2004. Initially, it was run as a pilot project in ten provinces; from 2006 on it was implemented throughout the country (Government of Vietnam [GoV], 2004; Ministry of Agriculture and Rural Development [MARD] & Vietnam Bank for Social Policies [VBSP], 2005). Beneficiaries of the programme should be households that do not have water supply and sanitation constructions yet, or that have constructions that do not meet the national standards. According to the regulations, households can take a loan of maximum VND 8 million (ca. EUR 329), if they implement both a water supply and a sanitation con-

10 The former Vietnam Bank for the Poor under the Bank for Agriculture and Rural Development was closed in 2003 and the new VBSP was established, when the government decided to expand loan programmes for the poor (Cuong, 2008, p. 155). The VBSP's funds derive from legal capital, income surplus, savings, loans funds under the programmes for poverty reduction and other social policies, and official development assistance funds (An, 2004, p. 4).

struction, whereas the maximum for one construction is VND 4 million (ca. EUR 165). The loan period can be adapted to the debt paying ability of the household but may not exceed 60 months.

Together with the VBSP, the Ministry of Agriculture and Rural Development (MARD), including its departments and offices, is the main responsible agency for implementing the credit programme. The departments of MARD are also responsible for issuing feasible WSS models including the technical design and the estimated construction cost. On provincial level, CERWASS and the Centre for Preventive Health (CPH) are the two government agencies assigned to carry out the loan programme in collaboration with VBSP and the mass organisations.

Since the government established the VBSP as an institution that is supposed to carry out humanitarian programmes with a focus on assisting the poor, interest rates charged by the VBSP are very low and the loans subsidised (Lenhart, 2000, p. 6). For 2009, the interest rates were negative because they were lower than the inflation rate.[11] Under commercial circumstances, the interest rate would be substantially higher. Some microfinance experts point out that subsidised interest rates undermine the viability and sustainability of the lending institution because they often affect repayment rates and breed "under the table payments" to credit officers (H. D. Seibel, personal communication, 15 July 2009; Seibel, 1992, p. 93). However, it has also been pointed out that most microfinance programmes rely on subsidies as "it remains far more costly to lend small amounts of money to many people than to lend large amounts to a few" (Morduch, 1999, p. 1609). Besides, Morduch has asked why microfinance should not continue to be subsidised "if money spent to support microfinance helps to meet social objectives in ways not possible through alternative programs" (Morduch, 1999, p. 1571). Does the RWSS microcredit programme meet such social objectives in Can Tho?

11 At the beginning of the programme, the monthly interest rate was 0.65 percent, in 2008 it was increased to 0.9 percent, i.e. a yearly rate of 10.8 percent. Considering the high inflation rate of 24.4 percent in 2009, the real interest rate was minus 13.6 percent.

Microcredit in RWSS: The Politics of Policy in Can Tho City

Loans disbursed

At the time of the field research the programme was implemented in four rural districts in Can Tho. Up to May 2008, 68 percent of the constructions implemented within the programme were for sanitation and 32 percent for water supply. Based on official data, between 12 and 18 percent of all households in the rural communes had taken a loan before the end of 2008. National statistics indicate that the programme reached more and more households over time.[12] The total amount of money borrowed in Can Tho in 2008 was VND 61.130 billion (ca. EUR 2.5 million), with the average loan for one household lying between VND 4.4 million and 6.4 million (ca. EUR 181 to 264).[13]

Sanitation

The CPH regularly sends two staff out to the communes in order to inform local authorities about the hygienic latrine models. They hold a meeting, which they invite the People's Committee, members of mass organisations, hamlet leaders, and staff from local health stations to. At these meetings, the CPH staff also provide information about other water and hygiene related issues. It is the responsibility of local authorities to spread the information.

There are four latrine models that the Ministry of Health (MoH) classified as hygienic and can be constructed with the loan (MoH, 2005).

1. *Double vault latrine:* The latrine is operated without water ('dry option'). One vault is used for around six months until it is full (in a household with six persons), then it is covered and the second vault is used. After six months, the remains can be taken out and used as fertiliser. The liquid residues flow into

12 While in 2006 84,192 households took a loan, in 2007 the number was already 158,207 and in 2008, 248,145 households (figures were obtained from the National VBSP office in Hanoi).

13 Calculated with data from VBSP Can Tho for the number of implemented constructions in 2008 (14,011), and the amount of money that was borrowed for these constructions (VND 61,130 million). The average loan would be VND 6.4 million if it was assumed that 32 percent that implemented a water supply construction are included in the 68 percent that constructed a hygienic latrine because they took a loan for both constructions. The average loan would be VND 4.4 million if it was assumed that every household took the loan only for one construction.

a separate tank and can be used to water trees immediately. This latrine is relatively cheap to construct with only ca. VND 1 million. However, the latrine is inconvenient to handle, as ash must be applied every time it is used, and the latrine has to be covered after use. Moreover, people in South Vietnam are reluctant to use human excreta as fertiliser. Hence, the double vault latrine is not considered a suitable model for the Mekong Delta by the CPH in Can Tho.

2. *VIP latrine:* A simple latrine type with a tank/hole in the ground; air flows out into the open through a pipe. When the tank is full, a new hole has to be dug. According to CPH in Can Tho, it is cheap but inconvenient because of the smell.
3. *Pour flush water seal latrine:* This latrine is recommended by the CPH in Can Tho because with a cost of only ca. VND 1 million it is cheap to construct. It has one tank with small holes, where bacteria in the underground decompose the organic substance. Liquids are disposed through the holes. After ca. five years the residues have to be dug out and put into another hole.[14]
4. *Septic tank latrine:* It is the type of latrine that is common in cities. It is operated with water ('wet option') and the excreta are decomposed in a large tank that is installed under the house. However, the residues cannot be fully decomposed and the tank has to be pumped out every few years (varying between 5 and 20 years, depending on the size of the tank and the number of people in the household). It is considered to be the safest and cleanest latrine, but it is also the most expensive one. According to the CPH, it can be constructed with the 4 million loan, but local people said that meanwhile (due to the high inflation rate) it is not enough and they have to add own money.

Only models number 3 and 4 are considered feasible by the Can Tho CPH and are introduced to the local authorities. However, data from the three study communes suggests that in practice, only the septic tank latrine is constructed with the loan. No other hygienic latrine type was observed, and officials from the VBSP as well as union representatives take it as a matter of course that 'hygienic latrine' means 'septic tank latrine'. This is illustrated by the fact that in all study communes and also at district level VBSP branches, respondents complain that 4 million is not enough to construct a latrine.

14 The effluent is still potentially dangerous as it always contains fresh faeces (i.e. there is a risk to ground water pollution in areas with high groundwater tables).

Statements from interviewees like the following suggest that there is a lack of cheap models for hygienic latrines that people consider better than the conventional fishpond or river toilets: “The health station also informed about another latrine type, which costs around VND 500,000 to 600,000. But the people want to have a sustainable construction and only invest once.” (WU representative from Thanh Quoi commune, Vinh Thanh district, personal communication, 13 January 2009)[15]

Though informed about models such as the pour flush water seal latrine, people consider the difference between that latrine and a traditional toilet too small to spend money. The septic tank latrine is the only model for which there is demand.

The interviews showed that the ‘modernity’ factor is a major incentive for rural households regarding the construction of a new latrine. This observation is in line with the study conducted by Herbst et al. (2008). This study found that 77 percent of surveyed respondents were satisfied with their traditional sanitary situation, while in the course of in-depth interviews conducted later in the same study, it was found that the same people could still imagine having a ‘modern’ toilet. Having a septic tank latrine plays the role of a status symbol, which a simple latrine model cannot fulfil. This is also illustrated by the term ‘beautiful latrine’, which was often used by interviewees to describe their new toilets, and by the pride with which households presented them.

As latrine coverage has increased between 12 and 18 percent due to the RWSS microcredit programme, it can be assumed that the direct disposal of human excreta into the surface water has been reduced to the same degree. However, what remains unclear is the future disposal of the residues in septic tanks. In urban areas, the tanks are emptied on demand by trucks of the Can Tho Urban Public Works Company (UPWC). According to CPH, the same company is responsible for rural areas. However, cars or trucks cannot enter the narrow rural paths and the staff from UPWC does not seem to have a solution. Asked about the construction of latrines in rural areas and how they would be pumped out if the streets were this narrow, the Vice Office Manager of UPWC replied:

> *They will pump them out by hand. They have double-vault latrines, so it takes five to ten years until they are full. . . . [For the disposal of the waste,] maybe they will call the company, or they will use the waste as fertiliser. (Vice Office Manager of UPWC Can Tho, personal communication, 4 December 2008)*

---

15 For a similar finding see Kar & Pasteur (2005).

It also occurred that rural households were not aware of the fact that the tanks have to be pumped out or do not consider this question relevant.

> *It is not necessary [to discharge the waste], the latrine cannot be full. It is a two vault septic tank latrine. If it is full, maybe it takes 15 or 20 years. (Representative of a household in Truong Xuan commune, Co Do district, personal communication, 21 October 2008)*

Neither households nor authorities have paid attention to this issue so far.

Water supply

During field research on the RWSS loan programme, local authorities only presented latrines but no facilities for water supply. On the question what households do with the loan for water supply, the interviewees gave evasive responses. In some cases, it was stated that the money had been used for digging wells. However, it is no longer allowed to dig wells with the loan as wells are said to pollute groundwater resources.[16] In Vinh Thanh and Phong Dien districts, the staff from the VBSP stated that the loans were used for constructing water filters or containers for rainwater. However, in Thanh Quoi not a single such construction could be found constructed with a loan. In another commune of Phong Dien, one water filter construction at a household was presented but people said there were "only very few" such filters in the area. In Truong Xuan, WU representatives explained that the loan budget was only for sanitation. The FU had a budget for water supply in the beginning of the programme but since 2008, the budget was only for sanitation. "Previously, the VBSP gave a 1 million loan for connecting to the water supply station, but now there are only loans for latrines." (WU representative of Truong Xuan commune, Co Do district, personal communication, 23 October 2008). Asked for the reason, a FU representative again answered in an evasive manner:

> *The budget of the government is not enough, so they give priority to the poor households. . . . I do not know [why the government gives priority for latrines and not for water supply], but the decision is related to the area served by the water supply stations." (FU representative of Truong Xuan commune, Co Do district, personal communication, 21 October 2008)*

16 Digging wells is not generally prohibited. It is very common that households that have the financial resources dig their own well. However, the VBSP loans cannot be used for it anymore.

When officials were asked directly which percentage of the loans was for water supply and which for sanitation, nearly all of them said it was mostly for sanitation. If not, they would say something like "It depends on the local areas' demands". One VBSP representative explained: "Around 90 percent are for sanitation. The rate is higher because the demand for beautiful and good latrines is very high." (Vice Director of VBSP district level, personal communication, 25 September 2008)

Some other reasons were also given for using loans mostly for latrines. "Most loans in the RWSS programme are for latrines because the budget is higher." (PC president, Truong Long commune, Phong Dien district, personal communication, 28 October 2008)

> *The households can supply water on their own, contain it in jars. But for sanitation, they do not have enough money. (Director, VBSP district level, personal communication 22 September 2008)*

However, it was found that the main reason why RWSS loans are not used for water supply is that there are no models introduced by provincial authorities, like this representative from the FU stated:

> *No, they have no models. They only offer the loan for the ones that live in the station network area but do not access the station. (FU representative of Truong Xuan commune, Co Do district, personal communication, 10 March 2009)*

Only after a long investigation it was revealed by a government official that CERWASS does not fulfil its responsibility to introduce suitable models for water supply to the local authorities: "Actually it is the responsibility of CERWASS, but in reality the VBSP introduced the systems to the local authorities." (Anonymous, personal communication, 5 March 2009)

VBSP staff attempted to source feasible models from local companies which they introduced in some communes, but "the technology is not very good, it cannot meet our expectations. . . . When constructing a filter system, the people research how to construct on their own, they were not informed much." (Anonymous, personal communication, 5 March 2009)

A large share of rural households relies on using polluted river or canal water for their daily activities, and it is financially and ecologically unlikely that all of these households can be connected to piped water supply schemes in the near future (Reis,

2012, pp. 90-101). Hence, household water treatment facilities may be the only way to increase the rate of households with access to clean water.

In An Giang province, the province north of Can Tho, a model for household water treatment was developed by a local consultant who was hired by the RWSS NTPII.[17] The model could be feasible as it can be constructed with locally available materials and is easy to operate and maintain. According to the consultant, the filter delivers sufficient water for one household, and the CPH in An Giang qualified the water quality as good. The filter is made of sand, charcoal, and gravel, and is able to remove organic waste and even pesticides and other chemicals from the river water. The price for construction was estimated VND 2.25 million by a private company; hence it would be possible to finance the model with a VBSP loan. However, also in An Giang, CERWASS has not made progress in realising such household water treatment facilities as solutions to the water problem in rural areas. An interviewee with insider knowledge about CERWASS said the following about the agency.

> *Sometimes they know the idea is good, but they do not like it . . . They see that the filter is good, but they prefer the schemes. . . [because] the benefit is for them . . . The filter is a benefit for the people. . . . It is very sensitive [to say why CERWASS is not interested in introducing the household filter system], it is difficult to answer. (Anonymous, personal communication, 11 December 2008)*

The reason why household water treatment models are beyond the interest of responsible agencies is related to the hybridisation of bureaucracy and private business, which has intensified since the economic liberalisation in 1986 (*doi moi*) (Evers & Benedikter, 2009, p. 18; Gainsborough, 2005a; 2005b; 2007; 2009). In the course of the economic liberalisation and privatisation in Vietnam, the old planned economy of state-owned enterprises was taken over by a "new form of state-interventionism" (Gainsborough, 2009, p. 258). The interests of government agencies as well as officials as private persons are highly interwoven with the business interests of private enterprises that are contracted to carry out public tasks. In his study about strategic groups in the water sector in Can Tho, Benedikter (personal communication, 20 February 2009) found that several cadres from CERWASS have invested private capital into a company that constructs water supply stations and sells water-purifying technology. An interviewee with close relations to the political leadership in Can Tho put it very directly:

17 An Giang is one of the nine pilot provinces for NTPII in Vietnam, which were selected in the beginning of the donor support and receive additional funding and consulting from international experts.

> *Nowadays, the people in high government positions all become very rich. . . . [At CERWASS] the director, vice director, all have own companies that implement the constructions. (Anonymous, personal communication, 30 September 2008)*

Developing household water treatment models is currently beyond the interest of responsible agencies because it does not offer a business opportunity. Government officials are currently doing their business in the construction of piped schemes and are therefore not keen on implementing policies that take a different approach to rural water supply. Household water treatment systems are so far not considered a potential income source for CERWASS officials in Can Tho. As a result, there is a lack of action with regard to water supply in the RWSS microcredit programme, and local authorities and households are not informed about suitable water supply models that could be implemented with the loan.

There is also evidence that the available data on the distribution of loans for water supply and for sanitation within the microcredit programme is unreliable. According to the data obtained on provincial level, 7,963 sanitation constructions and 3,522 water supply constructions were implemented in Can Tho between January and May 2008. However, it was found in all three study communes that, against the regulations, more than VND 4 million were disbursed to households for implementing only one construction, i.e. a septic tank latrine. For example in Thanh Quoi commune, the interviewed households received VND 6 or even 8 million for constructing a latrine. Considering that the average loan in Vinh Thanh district was already VND 5.3 million in 2008 if it is assumed that all households implemented only one construction[18], and that models for water supply constructions are unavailable, it is questionable whether loans declared for water supply were not in fact used for sanitation.

Summarising, the data suggest that the largest share of funds in the RWSS microcredit programme is spent for the construction of septic tank latrines, whereas the water supply component is mostly neglected.

Allocation of loans among rural households

Local mass organisations, especially the WU, are very actively promoting the RWSS microcredit programme, as shown by the high adoption of the loan programme.

18 2,336 constructions were implemented in Vinh Thanh with a budget of VND 12,345 million.

Many interviewees also stated that the demand for participation in the programme was very high. However, many people said that the funding from the VBSP was not sufficient to give a loan to all households on the demand list. Before the Credit Group Leader compiles the list of households, the VBSP informs the local authorities about the available budget, i.e. it is already known to the Credit Group Leader how many households can receive a loan in one period. Moreover, Credit Group Leaders stated that credit officers from the VBSP would only take households off the lists if they did not possess legal residence permits or identification documents. Dufhues et al. (2002, p. 10) also found that credit officers usually approve the lists that they receive from Commune People's Committees. Consequently, the decision about who has access to a microcredit loan is taken at the commune and hamlet level.

The first and most important mechanism to select the households that get to participate in the programme is the creditworthiness of a household. Credit groups and the commune People's Committee are highly responsible for the repayment of credit group members (Cuong, 2008, p. 156), and local authorities and mass organisations are careful in selecting the households, like a VBSP officer explained: "The authorities are afraid of giving money to the people because the unions are afraid that they will not pay the money back." (Director of VBSP, district level, personal communication, 16 September 2008)

Moreover, the officer explained that the local unions receive a certain percentage of the monthly interest rates as a service fee, which is calculated with a formula included in the contract between the unions and the VBSP. In the case that a household does not pay the money, they will lose the service fee.

A local WU manager stated that poor households are generally not taken into account when it comes to setting up a list of demanding households.

> *Only the nearly poor can become member of the Women's Union. Poor households[19] cannot become members, because the VBSP is afraid that they cannot pay back the money. DOLISA[20] will take care of them. (WU representative, Truong Xuan commune, Co Do district, personal communication, 22 October 2008)*

It remained unclear whether this was a regulation decided on by local WU groups, or

19 The official poverty line fixed by the Can Tho City People's Committee is VND 200,000 (ca. EUR 8.20) per person per month. Local authorities decide which households are given a poverty certificate (Reis, 2012, p. 82). In this context, however, it remains unclear what defines a "nearly poor" household.

20 DOLISA = Department of Labour, Invalids and Social Affairs. Households classified as poor receive certain benefits from the government, such as reduction of school fees, or in the case of RWSS, free connection to piped water schemes. However, poor households are often not connected to water supply networks in practice (Reis, 2012, pp. 81-85).

whether the interviewee just referred to the common practice. In any case, it seems to be contradictory to the stated aim of the VBSP to be an institution that serves the poor. Cuong (2008) and Dufhues et al. (2002) also found that poor households in most cases lack access to the VBSP's credits. They are not only considered as a credit risk but are in addition excluded from the powerful social and political network that determines the access to information about available credit funds (2002, p. 10).

The selection process further considers whether the household had previously received a loan in another programme. Several Credit Group Leaders mentioned that this was a criterion for being considered for the RWSS programme, like this group leader in Thanh Quoi commune: "The other women [in the group] already got a loan for breeding, so I gave the loans to those that had not received a loan yet." (Local WU group leader of Thanh Quoi commune, Vinh Thanh district, personal communication, 13 January 2009)

Moreover, interviewees explained that households belonging to the lower income groups would give priority for a loan with which they could directly increase their income, such as a loan for raising animals.

The focus on septic tanks is another issue that plays an important role in determining which households are reached by the programme. As demonstrated earlier, the largest share of the budget is used by households that construct septic tank latrines. These households usually have access to tap or well water because the latrine requires a lot of water for flushing. None of these households lacked access to tap or well water. This indicates that the programme mainly reaches medium-income and better-off households, for which clean water supply is mostly not problematic.

Conclusion

The analysis has shown that the RWSS microcredit programme within the NTPII has a positive impact on the latrine coverage in Can Tho and thus contributes to the safer disposal of human excreta and improved water quality in rivers and canals. In this sense, the programme also has an indirect impact on poverty reduction as it improves the water sources of the poor. However, it is still unclear how the remaining waste in septic tanks will be disposed of when that issue becomes relevant in a few years. It has to be ensured

that – given the lack of possibilities for disposal – the waste is not dumped into rivers and canals.

Moreover, while increasing the latrine coverage is an important element of improving the water quality of surface water, it is only one of the causes of water pollution in the Mekong Delta. The disposal of large amounts of pesticides and artificial fertilisers, solid waste, residues from animal husbandry and fish farming, and untreated wastewater from industrial parks into rivers and canals are very complex problems that remain unsolved. In addition, the central government irrigation policy, focused on the construction of large-scale infrastructure, exacerbates the scarcity of clean water in the rural areas of Can Tho (Reis, 2012, pp. 50-52). Considering the number and intensity of other causes of water contamination, increasing the number of hygienic latrines can only have a limited impact on the improvement of domestic water sources. This suggests firstly that the outcome of RWSS policy is strongly interlinked with and dependent on other policies. For Can Tho, it is particularly essential to include urban wastewater and solid waste management into RWSS policy, if it is to have any success in improving surface water quality.

Besides the moderate impact on surface water quality, the programme has a marginal impact on poverty reduction as it reaches only better-off households that already have access to clean water. There are several reasons for this. First, there are no models for water supply that could be implemented with the loan, while it is the poor that are in need of such models. The present approach of constructing groundwater based piped schemes is not a sustainable way of ensuring access to clean water for the rural population (Reis, 2012, pp. 90-101). Microcredit for household water treatment systems carries the potential for achieving the goals of the NRWSS, but that potential has not been utilised in Can Tho so far. Secondly, there is also a lack of cheap latrine models acceptable to the local population, which do not require access to tap or well water and additional own funds, like the septic tank latrine does. Experience from other world regions shows that affordable and acceptable latrine designs are a key success factor in microfinance for sanitation (Saywell & Fonseca, 2006). It is therefore likely that the demand for loans within the present programme will come to an end as soon as all better-off households have been covered. The third reason lies in the exclusion of poor households from the microcredit scheme because they are not considered creditworthy and they do not have the social relations that determine the access to VBSP credits. This result stands in contrast to the idea of donors and the government to subsidise the loans because they are

targeted to the poor, and also to the fact that poor water and sanitation is particularly problematic for the poor. A study carried out by the Australian Agency for International Development (AusAID) in 2004 found that in contrast to the past, when poverty was a mass phenomenon in Vietnam, it is now focussed on particular groups such as landless and ethnic minority groups. Those poor have become "harder to reach" (AusAID, 2004, p. 18).[21] The present study has shown that this assessment is highly relevant for the RWSS microcredit programme, which has currently no mechanisms for pro-poor targeting and thus misses to reach those that lack access to safe water.

As pointed out by Mehta et al. (2007), local WSS systems are characterised by the interaction of complex environmental, technological, and social dimensions. The case of Can Tho has illustrated how locally specific water supply and sanitation systems affect the outcome of RWSS policies. Socio-political factors, in particular the construction interests of local political elites, play a key role in the adaptation of policies framed on the national and global level. The programme reaches its limit at the point where it requires procedural changes at CERWASS, which may interfere with or be unsuitable for officials' business interest. National policy provides models for hygienic latrines that can be implemented within the microcredit programme, but implies that provincial authorities develop models for water supply that are adapted to the local conditions. However, it is – at least until now - beyond the interest of bureaucratic elites to engage in finding small-scale solutions for water supply. Hence, only the sanitation part of the programme is implemented. The combination of water supply and sanitation into one programme thus leads to the canalisation of money and resources towards the wealthier rural population that already has access to clean water. As a result, the programme misses out the water supply needs of the poor. The present case supports the point made by Weber that while "microfinance was developed as an instrument to fight global inequality in practice it turns out often to exacerbate adverse social conditions" (2002, p. 132).

This paper's findings do not implicate that it is useless, or even counterproductive, to emphasise the importance of improved sanitation facilities for development. Especially as groundwater is not a sustainable option for water supply in Can Tho, it is in the long term essential to counter the pollution of surface waters with human excreta. The findings do, however, challenge the common trend in policy making that water supply

21 Moreover, WISDOM project research has found that landless people in the Mekong Delta face an increasing pressure on their livelihoods due to declining fish resources, on which they most often depend (Gerke & Ehlert, 2009).

and sanitation should under all circumstances be integrated into the same programme. Moving "the sanitation crisis to the top of the agenda" (United Nations Development Programme, 2005, p. 166) should not mean that the problem of insufficient emphasis on sanitation within RWSS policies is turned upside down. Many reports and donor staff argue that an increased focus on sanitation is necessary as it usually falls behind the planning for water supply. It has been shown that the implementation of sanitation policies, in particular if they are not clearly pro-poor[22], can also be at the expense of improving the water supply of the poor.

References

An Nguyen Thanh. (2004). *Notes from preliminary review on micro-finance for poverty reduction in Vietnam.* Retrieved 30 May 2012, from http://www.microfinancegateway.org/gm/document-1.9.25784/25697_file_Ford_NotesonmicrofinanceinVietnam.pdf

Australian Agency for International Development (AusAID). (2004). *Mekong Delta Poverty Analysis.* Retrieved 25 July 2009, from http://www.ausaid.gov.au/publications/pdf/mekong_poverty_report_04.pdf

Cuong N. V. (2008). Is a governmental micro-credit program for the poor really pro-poor? Evidence from Vietnam. *The Developing Economies, XLVI*(2), 151-187.

Dufhues, T., Oanh, N. Q., Dung, P. T. M., Hanh, H. T., & Buchenrieder, G., & Buchenrieder, G. (2002). *Fuzzy information systems in rural financial intermediation in Northern Vietnam.* Paper presented at the International Symposium 'Sustaining food security and managing natural resources in Southeast Asia – Challenges for the 21st century' from 8-11 January 2002, Chiang Mai, Thailand.

Evers, H.-D., & Benedikter, S. (2009). *Strategic group formation in the Mekong Delta - The development of a modern hydraulic society* (Working Paper No. 35). Center for Development Research, University of Bonn.

Gainsborough, M. (2005a). Between exception and rule. Ho Chi Minh City's political economy under reform. *Critical Asian Studies, 37*(3), 363-390.

Gainsborough, M. (2005b). Rethinking Vietnamese politics – Will the real state please stand up? Retrieved 20 February 2008, from http://www.bristol.ac.uk/politics/grc/bvp/bvpworkingpapers/rethinking.doc

Gainsborough, M. (2007). Globalisation and the state revisited – A view from provincial Vietnam. *Journal of Contemporary Asia, 37*(1), 1-18.

Gainsborough, M. (2009). Privatisation as state advance: Private indirect government in Vietnam. *New Political Economy, 14*(2), 257-274.

Gerke, S., & Ehlert, J. (2009). *Water livelihoods in the Mekong Delta. Local knowledge as a strategic resource* (Working Paper No. 50). Center for Development Research, University of Bonn. Retrieved 14 December 2011, from http://www.zef.de/fileadmin/webfiles/downloads/zef_wp/WP50_Gerke-Ehlert.pdf

22 A counterexample is established by first experiences with the Community-Led Total Sanitation (CLTS) approach in North Vietnam, which has considerably improved poor households' sanitation and hygiene awareness (SNV, 2010).

Government of Vietnam (GoV). (2004). *Decision No. 62/2004/QD-TTg. Decision of Prime Minister on credit for implementation of RWSS strategy*. Hanoi, 16 April 2004.

Herbst, S., Benedikter, S., Koester, U., Phan, N., Berger, C., Rechenburg, A., & Kistemann, T. (2009). Perceptions of water, sanitation and health – a case study from the Mekong Delta, Vietnam. *Water Science & Technology, 60*(3), 699-707.

Käkönen, M. (2008). Mekong Delta at the crossroad: more control or adaptation? *Ambio, 73*(3), 205-212.

Kar, K., & Pasteur, K. (2005). *Subsidy or self-respect? Community led total sanitation. An update on recent developments* (IDS Working Paper 257). Brighton, UK: Institute of Development Studies. Retrieved 20 April 2012, from http://www.ids.ac.uk/files/Wp257.pdf

Lenhart, K. (2000). *The influence of donors on microcredit sustainability. A case study of three microcredit programs in Vietnam: the Vietnamese Bank for the Poor, Save the Children-UK, and NIKE*. Daniel J. Evans School of Public Affairs, University of Washington. Retrieved 25 May 2012, from http://www.microfinancegateway.org/gm/document-1.9.25914/Microcredit_Vietnam.pdf

Mehta, L., Marshall, F., Movik, S., Stirling, A., Shah, E., Smith, A., & Thompson, J. (2007). *Liquid dynamics: challenges for sustainability in water and sanitation* (STEPS Working Paper 6). Brighton, UK: STEPS Centre.

Mehta, M., & Knapp, A. (2004). *The challenge of financing sanitation for meeting the Millenium Development Goals*. Nairobi, Kenya: WSP. Retrieved 25 June 2009, from http://www.wsp.org/wsp/sites/wsp.org/files/publications/af_finsan_mdg.pdf

Miller, F. (2003). *Society-Water Relations in the Mekong Delta: A Political Ecology of Risk*. Doctoral Book, Division of Geography, University of Sydney.

Ministry of Agriculture and Rural Development (MARD), & Vietnam Bank for Social Policies (VBSP). (2005). *Instruction No. 472/VB-LT-BNN-NHCS. Implementation of decision No. 62/2004/QD-TTg dated April 16th, 2004 of the Prime Minister regarding the credit implementation of the NTP on rural water supply and sanitation*. Hanoi, 4 March 2005.

Ministry of Construction (MoC), & Ministry of Agriculture and Rural Development (MARD). (2000). *National rural clean water supply and sanitation strategy up to year 2020*. Retrieved 15 February 2008, from http://www.cerwass.org.vn/English/index_e.htm

Ministry of Health (MoH). (2005). *Decision No. 08/2005/QD-BYT dated 11.03.2005 regarding issuing the sector standards: Hygiene standards for various types of latrines*.

Ministry of Health (MoH), & United Nations Children's Fund (UNICEF). (2007). *A summary of national baseline survey on environmental sanitation and hygiene situation in Vietnam*. Hanoi, Vietnam: MoH & UNICEF.

Ministry of Natural Resources and Environment (MONRE). (2009). *Experts warn that southern Vietnam aquifers seriously depleted*. Retrieved 1 July 2009, from http://www.monre.gov.vn/monreNet/Default.aspx?tabid=255&ItemID=67935

Molle, F. (2005). *Irrigation and water policies in the Mekong region: current discourses and practices* (Research Report 95). Colombo, Sri Lanka: International Water Management Institute.

Molle, F., & Hoanh, C. T. (2007). *Implementing Integrated River Basin Management. Lessons from the Red River Basin, Vietnam*. Retrieved 23 November 2007, from http://www.sea-user.org/download_pubdoc.php?doc=4167

Morduch, J. (1999). The microfinance promise. *Journal of Economic Literature, 37*(4), 1569-1614.

Nuber T., Stolpe, H., Vinh, K. Q., & Nam, V. V. (2008). Modelling the groundwater dynamics of Can Tho city – challenges, approaches, solutions. In SANSED project (Ed.), *Decentralised water treatment systems and beneficial reuse of generated substrates*. Proceedings of the international SANSED workshop, 15-18 April 2008, Can Tho University, Vietnam.

Netherlands Water Partnership (NWP), & International Water and Sanitation Centre (IRC). (2007). *Microfinance for water, sanitation and hygiene. An introduction*. Retrieved 23 June 2009, from http://www.waterland.net/showdownload.cfm?objecttype=mark.hive.contentobjects.download.pdf&objectid=19CE8B1E-DE1E-B77E-09D6D4AC29CCADE9

Reis, N. (2012). *Tracing and making the state. Policy practices and domestic water supply in the Mekong Delta, Vietnam*. Berlin, Germany: LIT Verlag.

Reis, N., & Mollinga, P. P. (2009). *Microcredit for Rural Water Supply and Sanitation in the Mekong Delta: Policy implementation between the needs for clean water and 'beautiful latrines'* (Working Paper 49). Bonn, Germany: Centre for Development Research, University of Bonn.

Saywell, D., & Fonseca, C. (2006). *WELL factsheet: microfinance for sanitation*. Retrieved 23 June 2009, from http://www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-htm/mcfs.htm

Seibel, H. D. (Ed.). (1992). *The making of a market economy: monetary reform, economic transformation and rural finance in Vietnam* (Kölner Beiträge zur Entwicklungsländerforschung 19). Saarbrücken, Germany & Fort Lauderdale, FL: Breitenbach.

SNV. (2010). *SNV Vietnam sanitation demand creation. A strengths-based review*. Retrieved 11 March 2012, from http://www.communityledtotalsanitation.org/resource/snv-vietnam-sanitation-demand-creation-strengths-based-review

Spencer, J. H. (2005). *Natural water and natural monopolies: Competition for and within the market for clean water in Can Tho, Viet Nam*. Paper prepared for 'Regenerations: New leaders, new visions in Southeast Asia', 11-12 November 2005, Yale University, USA.

United Nations Development Programme. (2005). *Health, dignity and development. What does it take?* UN Millennium Project, Taskforce on Water and Sanitation. Retrieved 11 July 2009, from http://www.unmillenniumproject.org/documents/WaterComplete-lowres.pdf

Vietnam Bank for Social Policies (VBSP). (2004). *Instruction No. 1411/NHCS-KHNV. Specialist knowledge of rural water supply and sanitation program*. Hanoi, 3 August 2004.

Vietnam Bank for Social Policies (VBSP). (2008). *Report on rural water supply and sanitation programme. 4 years (2004-2007), up to 30/06/2008*. (Unofficial translation).

Environmental Policy Coordination in ASEAN: The Case of Waste From Electrical and Electronic Equipment

Armin Ibitz[1]

Citation Ibitz, A. (2012). Environmental Policy Coordination in ASEAN: The Case of Waste From Electrical and Electronic Equipment. *ASEAS – Austrian Journal of South-East Asian Studies*, 5(1), 30-51.

Among numerous environmental challenges in the ASEAN region, the rapid growth of volumes of waste from electrical and electronic equipment (e-waste) has increasingly drawn international attention. Economies face huge demands for electrical and electronic products, while governments are confronted with difficulties dealing with mounting volumes of e-waste. Furthermore, lucrative transnational shipment of discarded electric and electronic devices calls for a regional response to the issue. While ASEAN has failed to come up with a common policy response, certain member states have pushed ahead with their own legislation in an attempt to address this urgent issue. This study sets out to identify the determining factors which have disabled ASEAN in terms of agreeing on a common policy response in the case of dealing with e-waste. Based on the assumption that states act according to expected gains, the study applies a game theoretical approach to analyse the developments.

Keywords: *Policy Coordination; E-waste; Electric and Electronic Equipment; Trade; ASEAN*

Die Bewältigung der rasant anwachsenden Menge an Elektroschrott zählt zu den großen umweltpolitischen Herausforderungen der ASEAN-Staaten. Während sich die Volkswirtschaften einer immer größer werdenden Nachfrage nach elektrischen und elektronischen Geräten gegenübergestellt sehen, vermögen es die meisten Länder nicht adäquate Entsorgungswege für Altgeräte aufzubauen. Zusätzlich zur inländischen Produktion gilt es auch mit oftmals als Gebrauchtprodukt getarntem, importiertem Elektroschrott umzugehen. Eine dringend notwendige regionale Koordinierung wurde von ASEAN noch nicht in Angriff genommen. Diese Studie geht der Frage nach, warum auf Ebene von ASEAN keine Lösungsansätze zu dieser Problematik zu erwarten sind. Zur Analyse der Entwicklungen bedient sich die Arbeit eines spieltheoretischen Ansatzes.

Schlagworte: *Politikkoordinierung; Elektroschrott; elektrische und elektronische Geräte; Handel; ASEAN*

Introduction

Over the past decades, solid waste has become one of the most visible environmental

1 Armin Ibitz is Assistant Professor at the Wenzao Ursuline College of Languages, Kaohsiung, Taiwan. He received his Ph.D. from the National Sun Yat-sen University, Taiwan. His research interests are in trade and the environment, and environmental governance. Contact: armin_ibitz@mail.wtuc.edu.tw

creative commons BY-NC-ND

doi 10.4232/10.ASEAS-5.1-3 www.seas.at SEAS

issues of countries in the ASEAN region, and the rapid rise in the volume of discarded electrical and electronic equipment (waste electrical and electronic equipment/WEEE) represents another emerging challenge for South-East Asia. Due to economic growth and increased living standards, demand for electrical and electronic equipment (EEE) is growing, but so are streams of waste from these same devices. Volumes of e-waste are growing three times faster than volumes of average solid waste (Goosey, 2004). The volume of obsolete PCs in developing countries is estimated to surpass those of the developed countries by 2016 to 2018. And by 2030, some 400 to 700 million personal computers will become obsolete in the developing countries (Yu, Williams, Ju, & Yang, 2010). Many Asian countries are experiencing a rapid rise in the volume of e-waste. Thailand has reported a rise in the volume of e-waste by an annual 12 percent. Inappropriate handling of e-waste causes severe harm to the environment and to human health since many electronic components contain hazardous substances, such as lead or cadmium. Since recycling, dismantling, and disposal of WEEE requires appropriate facilities, advanced methods, and trained personnel, mounting streams of waste represent a massive ecological threat and pose risks to human health, particularly in the developing countries. Inappropriate methods of treatment first result in a localised contamination of the soil, the aquatic systems, and the air. Eventually, pollutants spread over a larger region, flow down the water system, and enter the food chain.

Besides the issue of domestically generated WEEE, there is rising concern about transboundary shipments of WEEE (Greenpeace, 2008). Large amounts of discarded EEE and second-hand EEE are shipped across the globe for the purpose of recycling, reuse, or disposal. Some estimated 50 to 80 percent of the collected domestic e-waste of the United States is not recycled domestically but exported to developing nations (Puckett & Smith, 2002). Increasing amounts of e-waste and second hand EEE are shipped from developed nations to developing countries (mainly to Africa and Asia) but also within the developing nations. Many countries in Asia are actively trading second hand appliances (Puckett, Westervelt, Gutierrez, & Takamiya, 2005). Hong Kong, China, Singapore, and Malaysia are the main recipients of shipments of discarded EEE from the EU. Electronic scrap and second hand EEE contain valuable components, and imports have been a source of secondary raw materials. Trade of discarded EEE provides a lucrative business opportunity for international traders and

generates income for thousands of operators in the informal sector, at the cost, however, of human health and the environment. With the number of personal computers and electronic devices correlating to the gross domestic product of an economy, we can expect continuous growth rates of WEEE in the near future (Robinson, 2009). As a result, the region will be increasingly affected by the mounting volumes of WEEE and the consequences of inadequate treatment, recycling, and disposal of e-waste. When addressing the issue, environmental efforts often come in conflict with economic interests.

The main purpose of this article is to identify the factors that disable ASEAN from agreeing on a common policy response on e-waste. While many claim that lack of political will and awareness is the main reason for the failure of policy coordination, this study attempts to go beyond that point and seeks to reveal the underlying incentives for decision makers which prevent them from proceeding with environmental cooperation. Based on the assumption that states act according to expected gains, the study applies a game theoretical approach to analyse the developments.

Regional Integration and Policy Coordination

Across the globe, we can witness the formation of regional cooperation. However, joint efforts and cooperation between countries rarely occur out of altruistic reasons but are rather driven by potential benefits in respect of each country's national interests. A major benefit from cooperation lies in the reduction of transaction costs, such as easier access to information. However, cooperation often entails a loss of sovereignty which leaves decision makers reluctant to cooperate. Given that political will is shaped by the involved actors' perceptions of the situation and the expected gains from cooperation, we can assume that cooperation is more likely in cases where the problem identification of the negotiating parties is identical and win-win-situations occur. Therefore, the overall pace and intensity of regional integration and policy coordination is determined by the capabilities of resolving disputes, overcoming obstacles of cooperation, and balancing distributive gains among the members.

From a game-theoretical point of view, inter-state cooperation is described by the collective action problem, including two kinds of situations: collaboration and coor-

dination games. Collaboration games describe a situation where actors are attracted to defect from an existing agreement due to short-term benefits. As a consequence, policy makers may opt for decisions that lead to situations which are not-pareto efficient (Ostrom, 1990). Unless the dominant strategies can be broken down, actors will defect from cooperation and the agreement is doomed to fail. Coordination games describe a situation where actors face difficulties to reach an agreement in the beginning. Here, the main concern lies in the coordination of the varying interests of all involved parties. While actors share an identical set of goals, specific differences prevent them from reaching an agreement. Setting the board for repeated games, the distribution of gains needs to be taken into consideration as changes in the gains may influence the actors' interests.

The perception of achievable benefits plays a significant role in the formation of agreements. The greater the gains an actor expects from cooperation, the more likely the member state will opt for joint action. With the rise of environmental challenges, the potential gains from cooperation also rise. Regional environmental cooperation is most likely to emerge when all parties perceive the issue as an immanent threat that causes economic losses or hinders further development, but is less likely when an agreement runs counter to national interests or contradicts existing sets of policies.

In general, collective action problems can be overcome by two responses. First, by the emergence of an international institution that serves as a mediator between the interests of countries and takes over major coordination functions. While negotiations through an existing institution reduce transaction costs, a central body provides a platform for resolving disputes and stimulating negotiations. The institution is set in charge of information gathering and engages in informal consultation about preferences and state policies. It thus functions as a mediator between the bargaining parties (Snidal, 1985). Second, the existence of a leader may ease substantial obstacles for policy coordination and cooperation. For fear of the consequences, a strong leader may prevent free-riding. The leader may be from within the group (focal point) or an extra-regional actor with strong acceptance and influence. As the European integration process has shown, the road to interstate cooperation and regional integration is often bumpy, requires time and a substantial amount of political will, and is also influenced by external developments.

ASEAN and Environmental Governance

Environmental issues first appeared in the Association's political agenda during the late 1970s. Environmental awareness and environmental regionalism have evolved slowly and in three major phases (Elliott, 2011). In the first phase, ASEAN introduced the first subregional environment program (ASEP I) which mainly emphasised securing the availability of natural resources for economic development. Over time, environmental ambitions evolved and a growing commitment to accepting common environmental norms and principles could be witnessed. During the second phase (from the late 1980s until the late 1990s), the focus shifted to transnational threats. Environmental awareness in many countries has grown. In 1993, the ASEAN Senior Officials on the Environment (ASOEN) agreed to develop the *ASEAN Strategic Plan of Action on the Environment*. The new Action Plan should shift focus towards sustainable development strategies, and greater emphasis was placed on the creation of networks that should contribute to the policy making process. The third phase is characterised by the formation of formal relations within the community. ASEAN established a system of environmental goals and objectives. Under the *Bali Concord II* (2003) the organisation of ASEAN reiterated its intention to strengthen the institutional mechanisms and to form an ASEAN Community based on three pillars: the *ASEAN Political-Security Community* (APSC), the *ASEAN Socio-Cultural Community* (ASCC), and the *ASEAN Economic Community* (AEC). Regarding regional environmental governance, the three pillars created new possibilities to integrate environmental topics to a broader forum. First, the formation of the APSC mainly aims to strengthen cooperation on political and security issues (ASEAN, 2009). Second, with the creation of the AEC the region aims to form a single market and transform into a single production base. As the case of the EU showed, market integration requires advances in the harmonisation of the regulatory frameworks in order to rule out obstacles in the flow of goods due to varying environmental standards and regulations. Third, the establishment of the ASCC provides even more opportunities to strengthen environmental cooperation across numerous fields, such as sustainable development, unemployment, environmental degradation, transboundary pollution, and disaster management.

The *ASEAN Charter* of 2007 marked an important step in the evolution of ASEAN, since it not only provides a basic framework that governs relations among the mem-

ber states but also transforms ASEAN into a more rule-based organisation with a legal character (Lin, 2010). The missing legal identity has been blamed as one of the reasons why ASEAN not only reacted slowly in reaching agreements but also failed to implement them at the national levels. The charter marks an improvement for policy coordination by providing a constitution that governs the relations between the member states and by allowing leaders to meet more frequently. But deeper integration requires a substantial strengthening of institutional structures, decision-making processes, and a solid enforcement system. On the one hand, regional leaders are attempting to emulate an EU-like community but on the other hand they are reluctant to cede power to a central body and the organisation is still left without a binding community law. Competition among ASEAN member countries, a narrow focus on national interests, and the fear of losing sovereignty hinder deeper cooperation and policy coordination in ASEAN. As a direct consequence of the conflicts of interest among the member states, ASEAN leaders have come up with a more flexible concept of consensus finding by introducing two formulas: “ASEAN minus X” and “2 plus X”. While the “ASEAN minus X” formula allows specific member states to join ASEAN agreements at a later point in time, the “2 plus X” formula explicitly allows ASEAN states to form new sub-regional agreements within the ASEAN framework (ASEAN, 2006). However, since there is neither an institutional body in charge of controlling the sub-regional groups nor a limit to the number of agreements, such agreements contradict efforts to cooperate and may eventually lead to a weakening of the overall regime (Chiou, 2010).

From the establishment of ASEAN on, the decision making process can be described as informal elite-based diplomacy based on consultation and consensus. As decision makers did not want to see their newly independent nations put under the control of an external power again, member states only agreed to cooperate as long as decision making respected each member state’s sovereignty. The association has strictly followed the principle of non-interference in other member states’ domestic affairs, and any form of coercion among member states is ruled out. While these principles may have been useful to avoid internal conflict, they also slowed down progress in regional integration. Scholars have repeatedly pointed to the principle of non-interference as a major obstacle for deeper integration and collective action (Haacke, 2003; Tay, Estanislao, & Soesastro, 2001). Like other issue areas, environmen-

tal governance follows the common principles of the ASEAN community. In general, decision making in ASEAN takes place at two main levels, the inter-state and the domestic level. Major agenda setting and decision making regarding ASEAN takes place by informal diplomacy through government channels, where the Summit of the ASEAN heads of state and government is the highest decision making body. In the meetings about specific issues, participants represent the positions of the individual states. Environmental issue such as e-waste only have a chance to be dealt with by ASEAN when they are put on the agenda of this highest level of decision making. The second level consists of political decision making processes within each member country. Actors at the national level include the political parties, interest groups, and NGOs. On several occasions, business associations have been invited by the governments to consultations and hearings. ASEAN encourages the participation of civil society organisations in its regional programmes, but there has been slow progress in the overall integration of non-state actors in the policy formation process of the environment protection area. Although several countries across the region possess an active NGO sector, access to policy makers seems to be more difficult for NGOs since they typically have limited access to decision making processes. As a consequence, ASEAN governance is mainly determined by government officials and has a top-down hierarchical structure. Transboundary issues, such as haze from forest fires, climate change or trade of e-waste, connect the inter-state and the domestic decision making since implementation and enforcement remains a domestic issue. Since member countries have the final decision making power in environmental policy making, the organisation's structure favours environmental cooperation by implementing soft laws which leave compliance at the national levels. While ASEAN environmental programmes and agreements are highly ambitious in their wording, they often lack effective implementation and enforcement mechanisms. As a member state faces no serious consequences in the case of non-compliance, incentives for implementation and enforcement are low (Aggarwal & Chow, 2010). The principle of non-interference and safeguarding member states' sovereignty is continued at the cost of the environment (Koh & Robinson, 2002, p. 679). So far, there has been no agreement, declaration or common policy output from ASEAN that explicitly targets improving the emerging situation of e-waste in the region.

The Basel Convention

During the 1970s and 1980s many industrialised countries exported their hazardous waste to developing nations for final disposal. After two decades of negligence, the *Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and their Disposal* (*Basel Convention*) – which came into force in 1992 – should have brought an end to the malpractices by providing mechanisms to control international movements of hazardous substances. The *Basel Convention* includes lists of hazardous and non-hazardous wastes, including several types of e-waste, such as batteries, cables which contain lead, CRT glass etc. In order to ban illegal shipments, the *Basel Convention* requires notification of the importing country about the export of hazardous waste prior to shipment. As a result of the *Basel Convention*, the shipment of hazardous waste for disposal substantially declined. However, now there is great concern about the shipment of EEE for the purpose of reuse and recycling, since goods that are exported for the purpose of reuse do not require pre-shipment notification of any form or pre-shipment approval. Due to that loophole, the *Basel Convention* is limited in its ability to restrict the trade of discarded EEE, shipped as second hand appliances. The *Ban Amendment* restricts the export of hazardous waste from developed countries to developing countries and is applicable to exports of hazardous waste for any kind of purpose – including recycling. However, many countries have not signed the Amendment yet (see Table 1).

Table 1: ASEAN Parties to the *Basel Convention* and *Ban Amendment*

Brunei Darussalam	*Basel Convention* ratified **16 Dec 2002**	*Ban Amendment* accepted **16 Dec 2002**
Burma/Myanmar	-	-
Cambodia	*Basel Convention* ratified **02 Mar 2001**	-
Indonesia	*Basel Convention* ratified **20 Sep 1993**	*Ban Amendment* accepted **24 Oct 2005**
Lao PDR	*Basel Convention* ratified **21 Sep 2010**	-
Malaysia	*Basel Convention* ratified **08 Oct 1993**	*Ban Amendment* accepted **26 Oct 2001**
Philippines	*Basel Convention* ratified **21 Oct 1993**	-
Singapore	*Basel Convention* ratified **02 Jan 1996**	-
Thailand	*Basel Convention* ratified **24 Nov 1997**	-
Vietnam	*Basel Convention* ratified **03 Mar 1998**	-

Source: Author's Compilation

Existing Legislation on E-Waste in ASEAN

Unlike other forms of waste, treatment of WEEE follows a different logic, since it contains both hazardous as well as valuable materials. A tonne of discarded mobile phones contains about 240 g gold, 2.5 kg silver, 92 g palladium, 92 kg copper, and 38 kg cobalt, worth about EUR 10,000. In 2008, about 1.3 billion mobile phones were sold worldwide and the worth of gold alone accounts to USD 1.1 billion. An estimated USD 1.35 worth of retrievable materials per mobile phone makes trade a lucrative business (Hagelüken, 2010). Countries in the region have witnessed the formation of large informal sectors that engage in collecting, reselling, refurbishing, dismantling, and recycling obsolete and second hand EEE. Trade flow of discarded and second hand EEE has intensified across the globe. Although the largest sources of discarded EEE are still the OECD countries, non-OECD countries are increasingly active in the trade of used EEE. Particularly, Asia has become a hotspot for shipments of WEEE and second hand EEE. Large amounts of second hand appliances are shipped to Hong Kong and Singapore, mainly for the purpose of re-export (Ministry of the Environment Japan, 2011). However, also other ASEAN countries are actively importing various kinds of wastes, including used EEE and WEEE (Yoshida & Terazono, 2010). As the region lacks a common policy on the issue, we can find a patchwork of regulations across the ASEAN member states. The following section provides an overview of existing legislation regarding the treatment of WEEE and trade of WEEE in ASEAN member states. With the exception of Burma, all ASEAN member states have ratified the *Basel Convention*, by which they agree to follow the procedures of notification laid out by the Convention.

Vietnam has no restrictions on the export of hazardous wastes and other wastes for recovery or final disposal. The country has not yet formally ratified the Amendment to the *Basel Convention* but has indicated that it is in a preparatory process to do so. In 2004, Vietnam prohibited the import of e-waste for the purpose of re-export and in 2005 it tightened the ban on imports of e-waste, regardless of its purpose. With the lack of stringent import controls, the illegal influx of EEE continued. A major route for regional trade of second hand EEE is between China and Vietnam. Beijing promotes the trade in the region with the reduction of value-added tax on exports of second hand EEE. By importing used EEE from industrialised countries, repairing

or refurbishing, and then re-exporting them to developing countries, Chinese actors are utilising the high demand for second hand appliances in the region (Shinkuma & Huong, 2009). A growing domestic industry and lower tax for imports of brand new EEE will reduce the demand for used EEE in the long run. In general, Vietnam still lacks high awareness of the ecological risks connected to the treatment of WEEE.

Indonesia restricts the import and the export of hazardous wastes and other wastes for recovery and final disposal.[2] The country follows the provisions of the *Basel Convention* regarding exports of hazardous waste, e-waste, and used EEE. In 1994, Indonesia has enacted national regulations on hazardous waste management but the general awareness of threats from e-waste remains low. Since the issue of e-waste receives no big public attention, policy makers see no immediate need to deal with the problem and trade continues to flourish due to weak enforcement. There is only one facility that is able to treat hazardous waste properly for the whole country. E-waste is still shipped to Indonesian markets, and illegal imports of second hand electronics and e-waste continue (Gross, 2010; Kojima, Yoshida, & Sasaki, 2009). Indonesia is largely dependent on imports of EEE since the domestic electronic industry is not yet fully developed. There are only about 80 large and 150 small-medium electronic manufacturers. As a result, more than half of the required components need to be imported. Due to the lack of a strong domestic electronic industry, demand for cheap EEE is met by imports or second hand products. In Indonesia, about half of the overall electrical and electronic goods market is estimated to be smuggled. Currently, the government aims to stimulate the domestic industry by restricting the import of used electronics for direct reuse.

In Thailand, e-waste is defined by domestic regulations and declared as hazardous material. All trade of e-waste officially requires governmental approval. Additionally, also the import of used EEE for reuse requires governmental permission. Thai regulations request registration for producers, importers, exporters, and sellers of WEEE and used EEE. However, besides this comprehensive regulatory framework, Thailand faces massive problems enforcing the regulations. As of now, WEEE is largely dismantled by the informal sector, despite the existence of a subsidised national collection system. From an economic perspective, the electrical and electronic sector plays a

---

2 According to the regulations, waste exports are allowed provided that the shipment has received a written permission from the competent authority of the destination as well as the exporting country.

crucial role as the country has a strong domestic EEE industry. Thailand has over 800 electrical and over 900 electronic factories. While most electric suppliers are domestic SMEs, electronic suppliers are mainly international joint-ventures (Electrical and Electronics Institute Thailand, 2007). As a large producer of EEE with a strong export focus, Thailand is concerned about legislation implemented by its trading partners. The EU represents Thailand's second largest export destination. As a response to the EU environmental directives on electrical and electronic equipment (EU-WEEE and EU-RoHS), Thailand has introduced a domestic standard on RoHS-conformity including a labelling scheme that was launched in early 2009.

Malaysia has national definitions of waste used for the purpose of transboundary movement. Export of e-waste for the purpose of final disposal is prohibited. Malaysia restricts the import of hazardous wastes and other wastes for final disposal and for recovery.[3] Import of hazardous wastes for recovery requires written approval by government authorities. The country restricts the export of hazardous wastes and other wastes for final disposal. Malaysia lacks a domestic recycling scheme that can handle the mounting streams of WEEE adequately. The amount of WEEE being discarded is estimated to equal 1.165 billion units (or over 21,000 million tonnes) by 2020 (Basel Convention, 2009). The country suffers from a huge divide between the largest sources of WEEE and the number of licensed e-waste collectors. In 2008, the whole country only had 107 licensed contractors for collecting and processing e-waste (Agamuthu & Victor, 2011). As a consequence, only a small fraction of the e-waste is treated properly. The government of Malaysia is currently working on a draft for regulating the control and management of e-waste. Meanwhile, public awareness of the issue of WEEE remains generally very low.

Similar to other countries, the Philippines also struggles with rising volumes of e-waste and trade of electrical and electronic equipment. Electrical and electronic equipment accounts for about 40 percent of the country's total imports. The number of clearances regarding the importation of second hand EEE and e-scrap issued by the government is rising over time. In 2005, nearly 100,000 tonnes were imported from Korea and Japan (Peralta & Fontanos, 2006). The country lacks a comprehensive policy framework for e-waste, and authorities have failed to issue an official definition

3 For details, see: *The Environmental Quality Act* 1974, (Amendment 1996) Section 34B; and the Customs (Prohibition of Import) Order 1998 Amendment 2006.

of e-waste (Alegre & Borcena, 2010). While the country has a vibrant market for used EEE, recycling of electronics is a rather new development. Thus, only a small fraction of the obsolete electronic items are brought to recycling facilities or to final disposal at the landfills. Obsolete equipment is either stored or reused (Terazono et. al., 2006).

Singapore has definitions of waste used for the purpose of transboundary movement and restricts the import and export of hazardous wastes and other wastes for final recovery and final disposal under the *Hazardous Waste Act* which went into force in 1998. The Act requires permission from the Pollution Control Department prior to any export, import or transit of hazardous wastes (National Environmental Agency, 2009). While in general Singapore does not allow export of waste for disposal, the export of hazardous wastes can be allowed for recovery purposes if there are no waste treatment facilities available domestically. The import of hazardous wastes for recovery is granted on a case-by-case basis. In Singapore, the electronics industry takes a vital position for the country's overall economic strategy. Singapore enjoys a high level of environmental awareness. Despite all the regulations and requirements, cases of illegal shipment of hazardous waste are still reported.

Cambodia – due to its rapid economic development – has developed an enormous demand for EEE. Since it lacks its own domestic EEE industry it is heavily dependent on the import of brand new and second hand EEE. While Cambodia does not produce any kind of EEE at all, the country possesses a large second hand market, and cheap second hand products play a dominant role in satisfying the domestic demand. Second hand appliances are imported from China, Finland, France, Hong Kong, Japan, Malaysia, the Republic of Korea, Singapore, Thailand, and the USA (UNEP, 2007). In order to meet growing domestic demand, national regulations allow the import of used EEE for reuse and do not require government approval prior to shipments of used electronics for reuse. Between 2000 and 2006, Cambodia imported almost a million units of TV sets, about 200,000 air-conditioners, about 91,000 refrigerators and about 30,000 washing machines. For fear of an influx of malware, the government bans the import of second hand computers, while other kinds of WEEE are unregulated. Cambodia does not consider used EEE with the purpose of reuse as a hazardous waste and in 2007 there was no record of a single e-waste recycling facility in the country. As a consequence, WEEE and used EEE are collected, renewed, recycled, dismantled, and disposed of by the informal sector (UNEP, 2007). Sorting materials at the scrap yards

is often done by children. The country lacks a legal framework on e-waste and thus has no specific regulations on e-waste. No specific governmental agency has been put in charge of managing the increasing streams of used EEE, and environmental considerations are not taken into account when dealing with WEEE. Awareness of the negative consequences from improper treatment of e-waste is generally at a very low level in Cambodia (Basel Convention, 2007). Valuable materials such as metals are sold abroad for recycling purposes (UNEP, 2008).

Brunei Darussalam is in the preparatory process of restricting the import and export of hazardous wastes and other wastes for final disposal and for recovery. The country is currently drafting legislation aimed at controlling trade in hazardous wastes in accordance with the *Basel Convention*. Regulations will be implemented in the *Draft Environmental Order* of Negara Brunei Darussalam. In Brunei, e-waste accounts for about one percent of the total generated waste (Department of Environment, Parks and Recreation, Ministry of Development, 2006). While the country has disposal facilities, it lacks facilities for recycling, recovery or re-use.

Extended Producer Responsibility in ASEAN

In recent years, there have been increasing efforts across the globe to address the emerging issue of e-waste by reorientation of the management approaches. In tackling environmental challenges, the concept of extended producer responsibility (EPR) has received increased interest. Originally defined by T. Lindhqvist (2000), it represents an environmental protection concept which makes manufacturers of products responsible for the whole life cycle of their manufactures, including the post-consumption phase.

The EU adopted two directives with the aim of tackling the issue of e-waste: the *Waste Electrical Electronic Equipment Directive* (WEEE-Directive 2002/96/EC) and the *Restriction of Hazardous Substances* (RoHS-Directive 2002/96/EC). While the EU WEEE directive mainly aims to reduce concerns about waste-management, the EU RoHS directive restricts the use of hazardous substances contained in EEE. The ban of six hazardous substances aims to prevent contamination from hazardous substances in the case of improper treatment or disposal. Only products that fulfil the require-

ments are allowed to be sold on the EU market. The implementation of the directives has also triggered reconsideration of policies regarding WEEE among non-EU countries, particularly in those with close trade links with the EU (Ibitz, 2009). In general, the concept of EPR has drawn the attention of policy makers in Asia. Thailand, for instance, has responded with national legislation with similar aims ("Thailand RoHS") (Tingsabadh & Jantarasarsophon, 2007). However, due to varying trade dependencies, not all ASEAN member states feel similar pressure to respond. In 2005, Thailand published draft legislation aimed at tackling the stream of e-waste.[4] This regulation can be seen as a direct response to the EU WEEE-Directive. Thailand has adopted regulations that shift the financial responsibilities for recycling of e-waste to the producers. The overall policy includes measures that require electrical and electronic producers to use a certain minimum level of recycled input (Manomaivibool & Vassanadumrongdee, 2011). Also, Vietnam has revised its *Environmental Protection Law* (2005) to include the financial responsibilities of producers for the collection for EoL products. The concept of EPR can also be found in the Indonesian *Law on Rubbish Management* (2008), where manufacturers are given more responsibility for dealing with EoL products (Saputra, 2011). In Malaysia, the 2007 *Solid Waste and Public Cleansing Management Act* allows the government to put responsibility for the collection of products on the manufacturers, assemblers, and importers. There is hope that in the long run, such environmental considerations may well spread to some other ASEAN countries. However, the successful application of EPR is difficult in developing countries, since – as is the case for e-waste – the informal sector takes centre stage in recycling. Since formal recyclers have to comply with certain kinds of environmental standards and follow the labour protection measures, the informal sector – which ignores such regulations – receives a competitive edge that leads to a weakening of the regulated sector. Furthermore, EPR implementation is facing difficulties as it is often not easy to identify the producers or the importers. For products that are assembled by small-scale businesses, it seems infeasible to put responsibility on the producers. In the case of smuggled items or product imitations, it seems infeasible to apply this approach.[5] With a background of such high rates of smuggled and imitated equipment in the region, the application of EPR based legislation seems not viable.

4 The *Act on the Promotion of Hazardous Waste Management from Used Products*

5 For more please refer to Hotta, Elder, Mori, & Tanaka (2008).

Analysis

Although problem awareness about e-waste has sharpened among the leaders of ASEAN, the issue has clearly not gained enough political weight to find its way to the top levels of ASEAN decision-making. While regional integration could be strengthened by the harmonisation of regulations and standards on the treatment of WEEE as well as common definitions of e-waste, major challenges arise from the region's diversity in terms of economic development and market structure which makes policy coordination harder to achieve. The integration of the new members between 1995 and 1999 was mainly driven by security concerns and less by economic considerations, but it is also interfering with environmental policy coordination. Preferences and interests of member states diverge greatly in the region, and member states see no immediate need for action as a stricter framework would limit the inflow of secondary raw materials and/or hinder the development of a strong domestic EEE industry. The experiences of dealing with e-waste vary largely among the member countries and so do the perceptions of the benefits and gains from the issue. Thus, neglecting the e-waste issue at the highest political talks avoids the emergence of potential conflicts.

The logic of markets and economic considerations are definitely crucial factors in this complex matter. The ASEAN region is characterised by economies that engage as exporters as well as importers of used EEE. From an economic perspective, e-waste represents a valuable resource that may lower the production costs for the domestic industry. While the founding members all engage in the production of EEE, the least developed countries do not even possess their own domestic industry. Richer nations, such as Singapore, Thailand, and Malaysia are both importers and exporters of second hand equipment. Countries tightening the regulations on imports of obsolete EEE would cut off local industries from cheap supplies which would run counter to national economic development strategies. Thailand's move to enact national regulations similar to those of the EU derives more from national economic interests than environmental concerns. Bangkok aims to promote domestic industry actors to adjust their products to comply with European requirements to keep up market access to the EU market. Domestic demand in less developed countries is met by imports of brand new and second hand equipment or by the refurbishment of discarded prod-

ucts. Their dependence on foreign producers results in a more cautious approach regarding any regulation of used EEE and second hand equipment. Countries such as Indonesia and Vietnam are now in the initial phase of building up a domestic EEE manufacturing industry. For other countries, such as Thailand, the Philippines, Malaysia, and Singapore, the electronic industry already enjoys a vital position within the overall economy. With rising prices of raw materials in international markets, competition for secondary resources generated from e-waste will stiffen. While countries with higher economic development and higher income levels, such as Singapore, Malaysia, and to a lesser degree also Thailand and the Philippines, have already had experience of setting up advanced recycling stations for hazardous wastes, countries with relatively low economic development (CLMV) have not developed adequate recycling and treatment facilities. Since landfills of the least developed nations do not report that large streams of e-waste as expected, it can be assumed that large parts of the equipment is repaired, refurbished, stored, and disposed of by the informal sector. Less advanced economies in the region do not possess formal waste management schemes where e-waste streams could be integrated (Damanhuri, 2009). Across the region, the collection and recycling of WEEE is largely accomplished by the informal sector, which provides income for thousands of people. In most member states, the informal sector is the largest player in the collection and recycling of WEEE and is in competition with the formal sector. Since the former operates under a lower cost structure, it is able to pay higher prices for discarded EEE and thus undermines the formal national collection and recycling schemes (Liu, Tanaka, & Matsui, 2006). So far, only the more advanced economies were able to establish facilities that can deal with the large amounts of hazardous waste in a more appropriate manner.

Regional trade of WEEE and second hand EEE is driven by economic incentives such as cheap and abundant labour, low environmental standards, and a high demand for second hand EEE or secondary raw materials. National governments have no immediate incentives to favour a ban on international trade of WEEE and used EEE since this would cause economic losses and an increased need for raw material imports for production processes. Due to fears of potential economic losses, it seems unlikely that regional governments will agree unanimously on a regional framework to tighten regulations on the import of WEEE and trade of e-waste. The import ban on second hand EEE – as implemented by Vietnam – is rather an effort to promote the

build-up of a domestic industry than an environmental protection effort. While at first glance a ban on the transboundary shipment of WEEE (*Basel Convention*) seems to be an appropriate method for limiting the flow of e-waste, in practical terms the attempt fails due to implementation and enforcement issues at the national level. Although most countries have laws and regulations in place to restrict the trade of hazardous waste, enforcement of the regulations represents a major issue.

Effective regional cooperation can only emerge on the basis of mutual trust. However, as the case of e-waste demonstrates, ASEAN is not able to mediate interests to shape a consensus to implement a common position on dealing with e-waste. Besides, the region lacks a clear frontrunner that pledges to address the issue. In all countries economic interests prevail over environmental considerations and the competition among the economies prevents closer cooperation and policy coordination. Furthermore, from major debates about the classification of e-waste as hazardous waste and the ban on hazardous-waste exports, we know that also several external actors do not want to see the emergence of a strong environmental regime in the region. As long as member states continue to focus on short-term economic gains while neglecting benefits from cooperation such as health improvements, productivity increases, reduction of transaction costs or information sharing, progress in integration and regional policy coordination will be slow.

Conclusion

Since transboundary challenges can be addressed more efficiently by joint regional efforts, ASEAN is discussed as the potential promoter of environmental protection in the region. Although the challenge of e-waste has received increased attention from various actors in the region over the last years, ASEAN has failed to come up with a common policy response in order to tackle the issue. The Association faces strong need to step up its efforts and reconsider its position towards regional environmental governance. Effective regional environmental governance must be based on cooperative policy formulation in combination with concrete mechanisms to facilitate the implementation of policies. As of now, ASEAN environmental governance allows member states to set their national efforts according to their individual national

interests. Due to its weak institutional structures and its fragile legal framework, ASEAN is not equipped with enough authority to enforce existing agreements, and so it is unable to adopt EU-like-directives.

There is a strong need to establish ASEAN community law to govern the Association with principles that can be applied at the national level. Without the adoption of a binding community law, ASEAN will not be able to develop into an effective and successful community. Major obstacles derive from its organisational structure as well as the massive gap in the member state's economic development and their national interests. Although the leadership seems to be increasingly aware of the rapidly worsening environmental base in the region, concerted efforts in environmental cooperation seem to be harder to achieve than economic cooperation – simply because the mutual gains are not perceived immediately, and it does not provide exploitable gains for the domestic politics.

In the case of e-waste, ASEAN is facing difficulties agreeing on a common policy response due to the complex situation of varying perceptions and diverging interests. In cases where interests and perceptions among member countries diverge, the decision-making principles lead to a standstill. Thus, ASEAN fails to act as a mediator for policy coordination. Regional integration can only be intensified when member states are aware of the potential gains from cooperation and cede a certain degree of sovereignty to a central authority. For enhanced regional environmental governance, ASEAN would need to form a central bureaucracy with enforcement authority. However, the organisation suffers from a general resistance to legalism and formalism as its member states are reluctant to show political commitment to hand over power to a central body due to a lack of regional identity but also due to misunderstandings of potential gains from cooperation. Individual countries would rather follow their self-interest than seek collective benefits. Given the large variations in levels of economic development, market structure, institutional structures, technological capabilities, environmental awareness, and the progress of basic environmental protection legislation, it seems unlikely for the ASEAN region to implement a common policy for the issue of e-waste. As a consequence, the first steps to address the issue need to take place at the national levels by promoting national recycling industries under stricter regulations, and establishing organisational linkages between the formal and the informal sector. A further fruitful step could be the introduction of a certifica-

tion scheme for facilities with proper methods of recycling. In addition, specific tax policies and subsidies could direct waste streams towards government approved and certified facilities (ASEAN Secretariat, 2009).

A redefinition of environmental degradation (such as from improper treatment of e-waste) as a security threat could raise awareness of the issue at the regional level and bring new impetus for action (Dokken, 2001). Since the current emphasis on consultation and consensus building hinders the overall progress of regional integration and policy coordination, a redefinition of the range of application of the principles could launch new dynamics (Wiebe, 2000). The environmental realm could provide a first testing ground for fundamental reforms of the application of the principles, such as setting environmental measures with a binding character. Furthermore, since a region-wide policy response on e-waste is unlikely to be achieved, a multi-phased approach under the formula of ASEAN minus X could provide a viable option (Akenji, Hotta, Bengtsson & Hayashi, 2011). In such a case, several more developed ASEAN countries could move ahead with an agreement based on common interests. After gaining benefits from the agreement, other countries may follow the example. However, such as multi-phased approach must be implemented with care, since it also includes a risk of further weakening the overall community. The existence of a frontrunner could ease the path to set out a more rigid policy framework, such as in the EU, where integration processes in certain issues areas are driven by individual member states. However, ASEAN lacks an accepted frontrunner in the case of dealing with e-waste. Although Thailand, Malaysia, and Singapore are actively promoting the production of green electronics, their main motivation derives from economic benefits by gaining access to developed nations' markets. Their path could provide a model for other countries to follow.

As an organisation ASEAN must focus more on the potential gains from cooperation. The region could benefit greatly by strengthening its regional environmental governance and creating regional mechanisms to manage cross-border environmental issues better. A concerted effort could provide competitive gains, boost productivity, and provide public goods that are unlikely to be produced by markets or individual economies, such as connected infrastructure and platforms of information sharing.

References

Agamuthu, P., & Dennis, V. (2011). Policy trends of extended producer responsibility in Malaysia. *Waste Management and Research, 29*(9), 945-953.

Aggarwal, V. K., & Chow, J. T. (2010). The Perils of Consensus: How ASEAN's Meta-regime Undermines Economic and Environmental Cooperation. *Review of International Political Economy, 17*(2), 262-290.

Akenji, L., Hotta, Y., Bengtsson, M., & Hayashi, S. (2011). EPR policies for electronics in developing Asia: an adapted phase-in approach. *Waste Management and Research, 29*(9), 919-930.

Alegre, A. G., & Borcena, P. G. (2010). *Philippines – Foundation for media Alternatives (FMA)*. Retrieved 6 June 2011 from Global Information Society Watch website: http://www.giswatch.org/sites/default/files/gisw2010countryphilippines_en.pdf

ASEAN. (2006). *Report of the Eminent Persons Group on the ASEAN Charter*. Retrieved 10 November 2011 from ASEAN website: http://www.asean.org/19247.pdf

ASEAN. (2009). *ASEAN Political-Security Community Blueprint*. Retrieved 12 December 2011 from ASEAN website: http://www.asean.org/22337.pdf

ASEAN Secretariat. (2009). *Fourth ASEAN State of the Environment Report 2009*. Retrieved 12 December 2011 from ASEAN Secretariat website: http://www.scribd.com/doc/22458510/Fourth-ASEAN-State-of-the-Environment-Report-2009-Full-Report

Basel Convention. (2007). *Technical Report on National Inventory of used EEE in Cambodia*. Cambodia Environmental Association. Retrieved 6 June 2011 from Basel Convention website: http://basel.int/techmatters/e_wastes/report_cambodia_11-05-07.pdf

Basel Convention. (2009). *The e-waste inventory project in Malaysia*. Retrieved 8 June 2011 from Basel Convention website: http://basel.int/techmatters/e_wastes/projReport30-07-09.pdf

Chiou, Y. (2010). Unravelling the Logic of ASEAN's Decision-Making: Theoretical Analysis and Case Examination. *Asian Politics & Policy, 2*(3), 371-393.

Damanhuri, E. (2009). Informal collectors of recyclable waste and used goods in Indonesia. In M. Kojima (Ed.), *Eria Research Project 2009, No.10, 3R Policies for Southeast and East Asia* (pp. 71-101). Jakarta, Indonesia: ERIA.

Department of Environment, Parks and Recreation, Ministry of Development. (2006). *Solid Waste Management in Negara Brunei Darussalam*. Retrieved 6 June 2011 from http://www.env.go.jp/recycle/3r/en/asia/02_03-3/11.pdf

Dokken, K. (2001). Environment, security and regionalism in the Asia-Pacific: is environmental security a useful concept? *The Pacific Review, 14*(4), 509-530.

Elliott, L. (2011). ASEAN and environmental governance: rethinking networked regionalism in Southeast Asia. *Procedia Social and Behavioral Sciences, 14,* (Special Issue), 61-64.

Electrical and Electronics Institute Thailand. (2007). *Final Report: Development of E-Waste Inventory in Thailand*. Bangkok, Thailand: Electrical and Electronics Institute.

Goosey, M. (2004). End-of-life electronics legislation - an industry perspective. *Circuit World 30,* 41-45.

Greenpeace. (2008). *Toxic Tech: Not in Our Backyard; Uncovering Hidden Flows of E-waste*. Amsterdam: Greenpeace International.

Gross, G. (2010, 1 March). Indonesia Rejects E-Waste Shipment From US. *The New York Times*. Retrieved 4 June 2011 from New York Times website: http://www.nytimes.com/external/idg/2010/03/01/01idg-indonesia-rejects-e-waste-shipment-from-us-27216.html

Haacke, J. (2003). ASEAN's Diplomatic and Security Culture: A Constructivist Assessment. *International Relations of the Asia-Pacific, 3*(1), 57-87.

Hagelüken, C. (2010). Wir brauchen eine globale Recyclingwirtschaft – mit völlig neuen Ansätzen. *Wie sicher ist die Rohstoffversorgung für die Energietechnologien der Zukunft?* 11 October 2010. Österreichische Gesellschaft für Umwelt und Technik. Vienna, Austria.

Hotta, Y., Elder, M., Mori, H., & Tanaka, M. (2008). Policy Considerations for Establishing an Environmentally Sound Regional Material Flow in East Asia. *The Journal of Environment & Development, 17*(1), 26-50.

Ibitz, A. (2009). Trade and the Environment: The Influence of the European Union's Environmental Directives on China. *Issues & Studies, 45*(3), 165-209.

Koh, K. L., & Robinson, N. A. (2002). Strengthening Sustainable Development in Regional Intergovernmental Governance: Lessons from the ASEAN Way. *Singapore Journal of International and Comparative Law,* Paper 371, 640-682.

Kojima, M., Yoshida, A., & Sasaki, S. (2009). Difficulties in applying extended producer responsibility policies in developing countries: case studies in e-waste recycling in China and Thailand. *Journal of Material Cycles and Waste Management, 11,* 263-269.

Lin, C. H. (2010). ASEAN Charter: Deeper Regional Integration under International Law? *Chinese Journal of International Law, 9*(49), 821-837.

Lindhqvist, T. (2000). *Extended producer responsibility in cleaner production*. Lund, Sweden: The International Institute for Industrial Environmental Economics, Lund University.

Liu, X., Tanaka, M., & Matsui, Y. (2006). Electrical and electronic waste management in China: progress and the barriers to overcome. *Waste Management and Research, 24*(1), 92-101.

Manomaivibool, P., & Vassanadumrongdee, S. (2011). Extended Producer Responsibility in Thailand Prospects for Policies on Waste Electrical and Electronic Equipment. *Journal of Industrial Ecology, 15*(2), 185-205.

Ministry of the Environment Japan. (2011). *Analysis of Transboundary Movements of Hazardous Wastes and Other Wastes in Asia* (2nd ed.). Retrieved 5 February 2012 from MoE website: http://www.env.go.jp/en/recycle/asian_net/Project_N_Research/PDF/TBM_Analysis_in_Asia[2nd].pdf

National Environmental Agency. (2009). *Management of toxic industrial waste in Singapore*. Retrieved 19 October 2011 from: http://app2.nea.gov.sg/data/cmsresource/20090316748986342293.pdf

Ostrom, E. (1990). *Governing the Commons - The Evolution of Institutions for Collective Action*. Cambridge, UK: Cambridge University Press.

Peralta, G. L., & Fontanos, P. M. (2006). E-waste issues and measures in the Philippines. *Journal of Material Cycles and Waste Management, 8*(1), 34-39.

Puckett, J., & Smith, T. (2002). *Exporting harm: the high-tech trashing of Asia*. The Basel Action Network. Seattle, Washington: Silicon Valley Toxics Coalition.

Puckett, J., Westervelt, S., Gutierrez, R., & Takamiya, Y. (2005). *The digital dump. Exporting re-use and abuse to Africa*. Report from the Basel Action Network. Seattle, Washington: Silicon Valley Toxics Coalition.

Robinson, B. H. (2009). E-waste: An assessment of global production and environmental impacts. *Science of the Total Environment, 408*(2), 183-191.

Saputra, H. (2008, 10 April). People's Legislative Assembly Passes Law on Rubbish Management. *Voice of Human Rights*. Retrieved 7 June 2011 from Voice of Human Rights website: http://www.vhrmedia.com/inggris/vhr-news/berita-detail.php?.g=news&.s=berita&.e=50

Shinkuma, T., & Huong, N. T. M. (2009). The flow of E-waste material in the Asian region and a reconsideration of international trade policies on E-waste. *Environmental Impacts Assessment, 29*(1), 25-31.

Snidal, D. (1985). Coordination versus Prisoners' Dilemma: Implications for International Cooperation and Regimes. *The American Political Science Review, 79*(4), 923-942.

Tay, S. S. C., Estanislao, J. P., & Soesastro, H. (2001). *Reinventing ASEAN*. Singapore: ISEAS.

Terazono, A., Murakami, S., Abe, N., Inanc, B., Moriguchi, Y., Sakai, S., et al. (2006). Current status and research on E-waste issues in Asia. *Journal of Material Cycles and Waste Management, 8*(1), 1-12.

Tingsabadh, C., & Jantarasarsophon, P. (2007). *Electrical and Electronic Equipment – Environmental impacts of trade liberalization*. International Institute for Sustainable Development (IISD). Retrieved 8 September 2011 from IISD website: http://www.iisd.org/pdf/2007/rtea_thai_electrical.pdf

UNEP. (2007). *E-waste Volume I*. Retrieved 8 September 2011 from UNEP website: http://www.unep.or.jp/ietc/Publications/spc/EWasteManual_Vol1.pdf

UNEP. (2008). *Policy and Regulations – Phnom Penh (Cambodia)*. Retrieved 12 December 2011 from UNEP website: http://www.unep.or.jp/ietc/GPWM/data/T2/EW_1_P_PolicyAndRegulations_ PhnomPenh.pdf

Wiebe, F. (2000). Environmental Cooperation in ASEAN. In D. Tussie, *The Environment and International Trade Negotiations* (pp. 205-223). London: Macmillan Press.

Yoshida, A., & Terazono, A. (2010). Reuse of secondhand TVs exported from Japan to the Philippines. *Waste Management and Research, 30*(6), 1063-1072.

Yu, J., Williams, E., Ju, M., & Yang, Y. (2010). Forecasting Global Generation of obsolete Personal Computers. *Environmental Science and Technology, 44*(9), 3232-3237.

Health and Environmental Risk Communication in Thailand: An Analysis of Agency Staff's Perspectives on Risk Communication With External Stakeholders

Seth Tuler[1], Uma Langkulsen[2], Caron Chess[3] & Nuntavarn Vichit-Vadakan[4]

Citation Tuler, S., Langkulsen, U., Chess, C., & Vichit-Vadakan, N. (2012). Health and Environmental Risk Communication in Thailand: An Analysis of Agency Staff's Perspectives on Risk Communication With External Stakeholders. *ASEAS – Austrian Journal of South-East Asian Studies, 5*(1), 52-73.

Health and environmental agencies are routinely called upon to provide risk-related information to the public-at-large and to more narrowly defined audiences, such as children, pregnant women, or labourers. While a large body of guidance is available, it is often general and transferability to new contexts is not well understood. In particular, the relevance of this guidance for South-East Asia is not clear. This paper reports the results of a study, using Q method, that aimed to develop a better understanding of officers' and staff's perspectives on health and environmental risk communication within a single regulatory agency in Thailand, the Pollution Control Department. The results demonstrate that there are multiple perspectives, and they are unrelated to roles or experience. This study contributes to a deeper understanding of the ways that officers and staff within a national agency with important responsibilities for health and environmental risk communication in Thailand think about these responsibilities and how to achieve them.

Keywords: *Risk Management; Health Communication; Organisational Studies; Q Method; Thailand*

Gesundheits- und Umweltbehörden erfüllen üblicherweise die Rolle der allgemeinen Öffentlichkeit, aber auch speziellen Zielgruppen wie Kindern, Schwangeren oder ArbeiterInnen, risikobasierte Informationen zur Verfügung zu stellen. Trotz vorhandener Beratung ist diese oft sehr allgemein gehalten und eine Übertragbarkeit auf neue Kontexte ist schwierig. Besonders die Relevanz der Beratung in Bezug auf Südostasien ist oft unklar. Dieser Artikel berichtet über die Ergebnisse einer auf der Q-Methode basierenden Studie, die versucht, ein besseres Verständnis über die Perspektiven von Führungskräften und MitarbeiterInnen in Bezug auf Gesundheits- und Umweltrisikokommunikation innerhalb der thailändischen Behörde für Umweltschutz zu gewinnen. Die Ergebnisse zeigen, dass es, unabhängig von den Rollen und Erfahrungen der Befragten, sehr unterschiedliche Perspektiven über Verantwortlichkeiten gibt. Die Studie gibt einen Einblick in diese Perspektiven und die Möglichkeiten der Umsetzung in einer verantwortungsvollen nationalen Behörde im Bereich Gesundheits- und Umweltrisikokommunikation.

Keywords: *Risikomanagement; Gesundheitskommunikation; Organisationstheorie; Q-Methode; Thailand*

1 Seth Tuler is research fellow at the Social and Environmental Research Institute, Inc., Greenfield, MA, USA. Contact: SPTuler@seri-us.org (Corresponding Author)

2 Uma Langkulsen is researcher at the Faculty of Public Health, Thammasat University, Thailand.

3 Caron Chess is professor at the Department of Human Ecology, Rutgers University, New Brunswick, NJ, USA.

4 Nuntavarn Vichit-Vadakan is associated professor at the Faculty of Public Health, Thammasat University, Thailand.

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-4

creative commons BY-NC-ND

Introduction[5]

A critical task of health and environmental agencies is to communicate information about health risks. "Risk communication" refers to activities that provide information to an audience about the risks (and benefits) of a particular activity or technology, and it is widely understood as an important function of government agencies at all levels (Kasperson & Stallen, 1991; Morgan, Fischhoff, & Bostrom, 2001; Renn, 1992; USFDA, 2011; USNRC, 1989). The audience of communication efforts can be the general public, targeted subgroups within a population, such as labourers or particularly vulnerable subgroups, or institutions. The task of risk communication may serve the purpose of informing people of options. For example, a community may be considering how to promote economic development through different industrial and agricultural activities; each will have a different mix of risks and benefits. A second purpose can be to persuade people to adopt particular behaviours, such as using condoms, reducing the use of pesticides in agricultural work, or stopping smoking. Risk communication is also used to build consensus around policy proposals, to disseminate information during a crisis, and to promote trust in hazard and health management agencies.

National government agencies in Thailand are routinely called upon to provide risk-related information to the public-at-large and to more narrowly defined audiences, such as children, pregnant women, or agricultural labourers. Information is provided about, for example, ways to prevent insect-borne viruses (e.g. dengue fever or malaria) (Academy for Educational Development, 2010; Heddini, 2009) and sexually transmitted diseases (Chamratrithirong & Boonchalaksi, 2009; Rao, 1998), how to reduce exposure to toxic chemicals (Regional Forum, 2009), the use of helmets among motorcycle riders (Ichikawa, Chadbunchachai, & Marui, 2003), and the dangers of smoking (Svenkerud & Singhal, 1998; Takeuchi, 2006). Labourers are also the subject of informational campaigns about, for example, exposures to chemical releases (Langkulsen, Vichit-Vadakan, & Taptagaporn, 2011), best practices for reducing exposures to pesticides (Bumbudsanpharoke, Moran, & Hall, 2009; Chalermphol & Shivakoti, 2009) and the

5 Support for the research was provided by a Fulbright Scholar Fellowship to Seth Tuler with the Faculty of Public Health, Thammasat University, Bangkok, Thailand during December 2008 to April 2009. Additional support for this project was provided by the New Jersey Agricultural Experiment Station and The Thai Fogarty ITREOH Center D43 TW007849 Fogarty International Center - National Institutes of Health. We are grateful for the assistance and support of Dr. Supat Wangwongwatana, Secretary General of the Office of Natural Resources and Environmental Policy and Planning and of officers of the PCD who participated in this study. We thank the anonymous reviewers for their advice. While helpful of course, we remain responsible for the content of this paper.

effects of heat stress (Langkulsen, 2011; Langkulsen, Vichit-Vadakan, & Taptagaporn, 2011; Tawatsupa et al., 2010). During the recent floods, the Ministry of Environment and Natural Resources, the Ministry of Public Health, and the Disaster Warning Centre provided information about exposure to contaminated foods and water, electrocution hazards, and drownings. Constitutionally required health impact assessments require that regulatory agencies consider public health risks associated with new industrial facilities (Jindawatthana, Sukkumnoed, Pengkam, Chuenchit, & Mathurapote, 2009; Phoolcharoen, Sukkumnoed, & Kessomboom, 2003).

The effective communication of information about health and environmental risks is not easy. A vast literature provides guidance, but insights are often difficult to generalise. Simplistic principles and checklists, like 'understand the needs of the community', may be difficult to achieve in practice and do not provide clear guidance in specific situations. What is understood to be the best practice in a particular situation will depend on what those organising and participating in the process think about the context, the objectives, their roles, the scientific understanding of the issues, and many other factors. Yet, this body of work does provide "enough evidence and experience to make good guesses at best general practices for communicating useful informative messages to help the public make informed decisions about their health" (USFDA, 2011, p. 107).

However, this is a statement applicable to the state of knowledge in the US and Europe. The relevance of this evidence and experience for South-East Asia is not clear. Despite a rapid growth in risk communication research and practice, little work has been grounded in the socio-cultural context of Thailand or elsewhere in South-East Asia. The implications for cultural preferences of, for example, saving face and avoiding conflict remain largely unexplored in the field of risk (and crisis) communication. Making good guesses by applying relevant knowledge and experience in the South-East Asian context suggests that health and environment agencies need to take a close look at their capacities and responsibilities, staff's understandings of roles, responsibilities, and priorities for communication efforts, and some kinds of assumptions that are made about the audiences of health communication efforts.

This paper contributes to our understanding of institutions responsible for health and environmental risk communication in Thailand. We report the results of a study investigating the perspectives of officers and staff about risk communication within a

single regulatory agency in Thailand, the Pollution Control Department. Our objectives were to understand (a) perspectives about risk communication needs, goals, organisational capacities, target audiences, and content of communication activities and (b) the degree to which perspectives varied by department, position in the organisational hierarchy, and depth of experience with risk communication. We focus on the views of agency officers and staff because formal rules and procedures for risk communication are not well developed within Thai government agencies. Thus, we expect to find a range of viewpoints based on how different individuals "understand their location, the norms that affect them and their interests" (Bevir & Rhodes, 2006, p. 6; Krueger & Gibbs, 2010): a combination of national and organisational cultures, organisational traditions, and personal beliefs and preferences. The next section of the paper describes our research methods, which employed *Q method* as the primary analytic approach, and a brief overview of the Thai Pollution Control Department. After discussing the results, which include the presentation of different perspectives among PCD officers about the purposes and methods of risk communication, we discuss the relevance to the practice of risk communication in the South-East Asian context.

Research Method

This study used Q method, a quantitative way for gathering information from a small group of people in structured interviews (Brown, 1996; Tuler & Webler, 2008). Q method has been applied to the study of a variety of issues related to environmental management, political ideologies, people's perceptions of animals and nature, pedagogy, personal relationships, and medical care as well as risk communication and public participation (Bumbudsanpharoke et al., 2009; Chess & Johnson, 2006; Kalof, 1998; Niemeyer, Petts, & Hobson, 2005; Tuler, Webler, & Finson, 2005). The goal of Q method is to reveal the range of viewpoints on a topic (such as the importance of external communications with the public and goals of risk communication) by asking different people to rank-order a group of 'Q statements' in response to a sorting instruction that sets the context. This is known as 'doing a Q sort'.

Determining the right number of Q participants means finding the right balance between two competing rules of thumb. On the one hand, it is good to have a certain

amount of redundancy among the Q participants. Normally a Q study will result in two to five shared perspectives as this is generally the number of distinct perspectives about any issue under consideration. For each perspective, it is ideal to have two to five individuals who 'define' it. According to this rule, the number of Q participants should be between 4 (2 factors x 2 people defining each factor) and 25 (5 factors x 5 people defining each factor). On the other hand, it is important to have fewer Q participants than Q statements.

The context for our study was the Pollution Control Department (PCD) of Thailand. The PCD was established in 1992 and is part of the Ministry of Environment and Natural Resources. The mission of the PCD is to control, prevent, reduce, and eliminate pollution as well as to conserve and rehabilitate the environment conductive for human life in Thailand. Its responsibilities require that the department develop and provide information about pollution sources, health risks, and hazard management within Thai society. It is organised into three bureaus: Air Quality and Noise Management, Water Quality Management, and Waste and Hazardous Substance Management.

Data for this study were gathered during September and October 2009 from 28 officers and staff working in the three bureaus of PCD: Air Quality and Noise Management (12 individuals), Water Quality Management (9 individuals), and Waste and Hazardous Substance Management (7 individuals). Officers from different organisational levels were interviewed, including bureau directors, operational officers, experts, special experts, and managers. These were categorised as senior level officers (8 individuals), middle level officers (13 individuals), and junior level officers (7 individuals, including one administrative officer). With the input of PCD managers we tried to select individuals with a range of a) experience with risk communication activities and b) responsibility for managing or implementing risk communication activities. The reason we selected people from the three bureaus was to investigate if there were different viewpoints about communication activities or if there was agreement about communication goals and objectives across the bureaus. This is also why we gathered data from individuals at different levels (senior officer, staff and so forth).

A key to any Q study is the sample of statements that respondents are asked to sort. These must represent all key aspects of likely perspectives on the issue of interest. Typically, 20 to 60 statements are selected to make up the Q sample. In this study, the Q statements were based on a review of scholarly literature on risk communica-

tion. Feedback about the relevance of possible statements was obtained from our Thai collaborators and contacts at the PCD. Ultimately, 35 statements were chosen and they are shown in Table 1.

In this study, the sorting instruction and the statements were developed in English and translated into Thai. Individuals completing Q sorts were asked to rank-order the statements according to a particular pattern. Both the sorting instruction and the pattern for rank-ordering statements are shown in Figure 1. The numbers in the bottom row refer to the number of statements that can be placed in each column. We asked each participant to read all the statements once. Then we asked them to sort the statements into three piles, the left-hand pile being the statements they

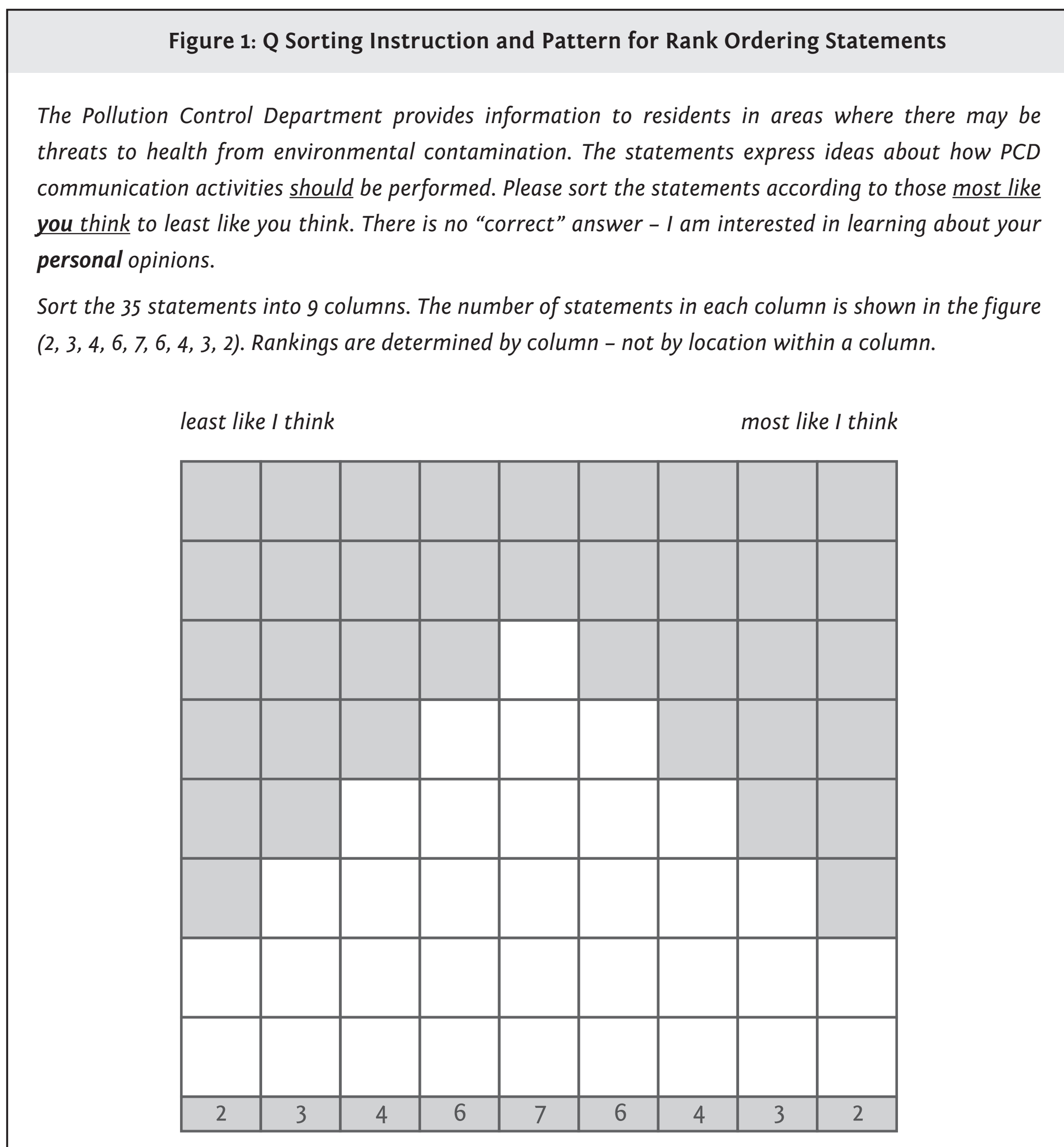


Figure 1: Q Sorting Instruction and Pattern for Rank Ordering Statements

Source: Authors’ Questionnaire

would least likely emphasise as important, the right-most pile being those they would most likely emphasise as important, and the middle pile being somewhere in between. They then continued by sorting the cards into a normal distribution as shown in Figure 1. Two cards could be placed in the left-most columns, three in the second-most left column, and so on. The scale was ordinal with the two endpoints subjectively anchored. In other words, a certain participant may have felt that *all* the statements were important, but he or she still had to differentiate between those that he or she would be *most unlikely* and *most likely* to emphasise. While this technique (like surveys) forces participants to provide information in a manner structured by the researcher, unlike surveys items are ranked relative to each other. The participants are also free to define their own scale, such as at what point statements move from being important to neutral in relative ranking. For example, someone could have defined the rightmost seven columns as statements considered *likely* or *most likely* and relegate only the leftmost two columns as objectives *unlikely* to emphasise. Moreover, objectives may be grouped by some underlying concepts rather than strictly rank-ordered. Participants can structure their rank-ordering of statements in a manner that makes sense to them. We sought to gather information about such issues by asking the participants to reflect on the pattern of cards they created.

After all the data were gathered, correlations among individuals' Q sorts were computed and factor analysed. In this study, three factors were identified. The factors are defined by an 'idealised' rank-ordering of the statements that best describes the individual sorts included in the factor. Thus, each factor can be described as its own Q sort, as shown by the data in Table 1. Based on these factors, three short narrative descriptions were written. They represent perspectives about how personnel view the risk communication activities with external stakeholders, the role of PCD, and the organisational issues the agency confronts. These descriptions were then shared with 12 people who participated in the study. Typically they were the individuals who loaded most highly on each factor. This allowed us to validate the accuracy of the descriptions of the perspectives. We received written feedback from 7 individuals. Based on feedback from these individuals we modified the narrative descriptions.

Q method is both similar and dissimilar to a survey. Like a survey, Q method is a technique to explore peoples' subjective beliefs and attitudes. As in a survey, people

react to statements by assigning them to categories according to extent of agreement or disagreement. However, Q method is unlike a survey by allowing participants far more flexibility to express their beliefs. It also forces people to express how strongly they believe something – they cannot say everything is important. In addition, they prioritise the statements relative to each other. In surveys each item is ranked independently of the others on a pre-defined scale. It is these features of Q that make it an important way to understand differences between people's viewpoints. Once the sorts have been entered into a computer, factor analysis is used to reveal the viewpoints within the population studied and patterns of similarities and differences.

In the following section we present the narrative descriptions that represent the three factors. Then, we go on to compare them.

Results

Three distinct and coherent factors – or what we will call perspectives on risk communication – emerged from the analysis. Information about the rankings for each statement in the three factors is provided in Table 1. These three factors explain 45 percent of the variance, which is considerable for a Q study.

Table 1: Q Statements and Their Rankings in Each of the Three Factors*

	FACTOR	*A*	*B*	*C*
1.	*The PCD and local communities should work together to solve environmental problems in the local areas.*	*1*	*1*	*4*
2.	*The PCD's communication with local communities should be based on the assumption that local people do not understand pollution and risk problems.*	*-4*	*-2*	*-1*
3.	*The PCD communication efforts should help reduce conflicts.*	*2*	*-2*	*-1*
4.	*The PCD should educate people about environmental threats to health.*	*0*	*-4*	*3*
5.	*The PCD should listen carefully to what people worry about.*	*4*	*-1*	*1*
6.	*Communication activities should help the PCD's officials understand what local people know.*	*1*	*2*	*1*
7.	*The PCD should give people all the information they want.*	*-2*	*-4*	*-3*
8.	*Communications should correct misunderstandings based on misinformation or lack of knowledge.*	*0*	*2*	*4*
9.	*The PCD should only communicate about what is required by law and regulation.*	*-4*	*1*	*-4*

10.	*The PCD should inform the local community residents about what they're doing and why they're doing it.*	-2	1	3
11.	*The PCD should explain what is being done by government and industry to manage environmental health problems.*	-3	-2	0
12.	*Government agencies and private organisations should coordinate the information given to communities in order not to confuse them.*	2	4	1
13.	*The PCD communications should be tailored to the specific local situation.*	1	2	2
14.	*The PCD should respond in a timely way to all questions, comments, and requests.*	0	-1	2
15.	*The PCD should tell people how to protect themselves from pollution problems.*	0	-1	3
16.	*The PCD managers should make communication with the community an important priority.*	3	0	2
17.	*Communication activities should mobilise communities to demand better pollution controls and reduction.*	-3	-3	-1
18.	*The PCD staff should learn to communicate better with community residents.*	4	-1	0
19.	*The PCD should gather information from the public that will help scientists and regulators do a better job.*	-1	0	-2
20.	*The PCD should explain information about pollution and risk by comparing levels to standards.*	0	2	0
21.	*Communication activities should target vulnerable groups.*	-1	0	0
22.	*The PCD should be very careful not to give the impression that it is taking sides in disputes.*	3	1	2
23.	*Information provided to the public should be based on the best available science.*	2	4	-1
24.	*The PCD needs to help local community leaders understand the science behind pollution control and mitigation activities.*	-1	3	0
25.	*The PCD should help people understand the limits and uncertainties of what is known about health risks.*	-2	0	0
26.	*The information given to people should focus on the most important risks they face.*	-2	0	1
27.	*The PCD's communication efforts should build trust with local communities.*	1	1	-2
28.	*The PCD's communication efforts should inform the agency's preventative measures to manage pollution problems in local areas.*	-1	0	0
29.	*The PCD should focus on local leaders, rather than the whole community when it gives out information or asks for input.*	-3	-3	-4
30.	*A commitment to programmes should be made that help PCD officers communicate better with each other.*	2	0	-2
31.	*PCD should invest the time, money, and staff needed for successful communication with the public.*	3	-1	-3
32.	*The PCD should have more scientific expertise*	0	-2	-3
33.	*Other government agencies should cooperate more with the PCD to achieve its communication goals.*	-1	3	-2
34.	*PCD should create an office with expertise on communication to support the activities of the Bureaus.*	1	-3	-1
35.	*If people make a good argument, PCD should be willing to change a project, programme, or activity.*	0	3	1

**Thai translations are available at www.seri-us.org/sites/default/files/35Qs%20for%20PCD_0.pdf*

Source: Authors' Questionnaire

The factor analysis revealed that some individuals contributed significantly to shaping one factor and had minor influence over other factors. Table 2 shows how closely each individual's rank ordering of statements matches those of the three factors – and, thus, how much each individual agrees or disagrees with the perspective represented by a factor. The degree to which an individual's beliefs share features with a factor is represented by 'factor loading scores'. A +1.00 indicates that a participant's rank-ordering of statements exactly matched the factor, a 0 means that there were no similarities at all, and a –1.00 indicates that a participant's rank-ordering was the exact opposite of the factor.

In this study, four individuals did not load significantly on any factor. Three individuals loaded significantly on two factors each, and an additional person loaded on all three factors. An additional individual had only a significant negative loading on one factor (which means significant disagreement with the factor). This suggests that these individuals expressed points of view that are unique and not captured by any of the three 'ideal types' emerging from this solution.

Table 2: Factor Loading Scores for Individuals Completing Q Sorts (N = 28)*

FACTOR A	*FACTOR B*	*FACTOR C*	*BUREAU*
0.7482	0.0747	-0.1638	Air
0.7369	-0.054	0.0877	Waste
0.6842	-0.067	0.1314	Air
0.6451	0.1235	0.2249	Air
0.6278	0.0878	**0.4618**	Water
0.5407	0.1191	**0.4865**	Air
0.503	0.1721	0.4236	Air
0.5003	**0.4547**	**0.5085**	Waste
0.4177	**0.6697**	0.2008	Air
-0.3305	**0.644**	0.2821	Water
0.2958	**0.6263**	0.06	Water
0.1168	**0.5625**	0.1983	Air
0.3538	**0.5076**	-0.1235	Air
-0.0562	**0.4934**	**0.4847**	Air
0.1818	0.019	**0.7573**	Air
-0.0653	-0.4293	**0.6865**	Air
0.1499	0.2	**0.6546**	Water
-0.0243	0.3852	**0.6262**	Water
0.3981	-0.1319	**0.5466**	Waste
-0.0112	-0.04	**0.5041**	Air
-0.0785	0.3475	**0.503**	Water
0.1705	0.4293	**0.4836**	Water
0.302	0.0178	**0.4712**	Water
0.0982	-0.6097	0.3749	Waste
-0.1827	-0.0743	0.3198	Water
0.0552	0.3257	0.1595	Waste
-0.1138	-0.1329	0.155	Waste
0.265	-0.069	0.128	Waste

** Variance explained by factor solution is 15 percent for Factor A, 13 percent for Factor B, and 17 percent for Factor C. Bolded factor scores are significant at 95 percent confidence. 0.4360 loading score is 5 percent significance for flagging factor.*

Source: Authors' Questionnaire

Perspective 1: PCD risk communication requires resources to reduce conflict

This factor represents a perspective on the role of PCD risk communication to reduce conflict (3).[6] As the focus is on reducing conflict, the PCD should not take sides – or be perceived as taking sides in disputes (22). Instead it should coordinate with private organisations about the information given to communities in order not to confuse them (12) and use the best available science (23). In some cases, this may mean going beyond what is required by law and regulation in communication activities (9). Furthermore, the PCD should not attempt to mobilise communities to demand better pollution controls and reduction (17) or just focus on community leaders (while ignoring the residents, 29) because both of these could be perceived as taking sides. The PCD does not need to explain what the agency or industry is doing and why they are doing it (10, 11).

To achieve risk communication goals, there is a recognised need for high-level commitment from PCD senior management (16, 30), financial and staff resources (31), and efforts to improve the capacities of PCD staff (18). Those who subscribe to this perspective are ambivalent about the creation of a new office with expertise on risk communication to support the activities of the bureaus (34).

To design its communication activities, the PCD should listen carefully to what people worry about (5) and then use the best science available (23) to help improve understandings and address their worries. There is a sense that local community residents are capable of understanding pollution and risk problems (2). However, it would be wrong to provide any information local residents want (7) because this could lead to confusion (12) if PCD communications goes beyond the facts.

Perspective 2: PCD risk communication should focus on science

The focus of this perspective is on risk communication that improves people's understandings of the science about risks, pollution control, and pollution mitigation (8, 24). In keeping with the focus on science, it is critically important that the information provided to the public should be based on the best available science (23).

An effective way of improving understandings is to explain information about pollution and risk by comparing levels to standards (20) and to tailor communications to

6 In the following, narrative description numbers in parentheses refer to Q statement numbers in Table 1.

the specific local situation (13). This means that the PCD should strive to understand what local people know (6) and if people make a good argument, PCD should be willing to change a project, programme, or activity (35). However, the PCD's mission should also be limited. The communications of the PCD should focus narrowly on pollution levels and risk. Communication activities should not emphasise education of community residents about environmental threats to health (4), should not give them all the information they want (7), and should not mobilise communities to demand better pollution control and reduction (17).

To achieve the goal of improving understandings about pollution risks and mitigation strategies, PCD risk communication programmes should be closely coordinated with other agencies and the private sector (12, 33). The PCD should be careful not to confuse community residents (and leaders) with communication activities (12, 29). While the PCD can always benefit from more scientific expertise, it already has enough 'in house' to ensure effective communications (32) and there is no need at this time to create an office with expertise on communication to support the activities of the bureaus (34).

Perspective 3: PCD risk communication strives to solve environmental health problems

Those who subscribe to this perspective believe that the PCD and local communities should work together to solve environmental problems in the local areas (1). In keeping with the problem-solving mission, PCD should inform communities about what it is doing (10) and tell people how to protect themselves (15). To improve collaboration, the PCD risk communication programmes should be designed to educate people about environmental threats to health (4) in ways that correct misunderstandings (8).

The focus on environmental health means that risk communication activities should go beyond a focus on pollution levels and risk. This means that PCD must often communicate more than what is required by law and regulation (9). In order to determine what information to communicate, PCD communication activities should include activities designed to help the PCD's officials understand what local people know (6), and communication activities should be tailored to the specific local situation (13). However, while attempting to be responsive to questions, comments, and requests from the public (14, 29), the PCD should not just simply give people any information they want (7).

Those who subscribe to this perspective believe that the PCD has the capacity to achieve these goals. Thus, there is no need for PCD to invest more time, money, and staff for successful communication with the public (31), or develop more scientific expertise (32). There is some feeling that the PCD might benefit from a modest investment in gathering information from the public to help scientists and regulators do a better job (19) and in programmes that help PCD officers communicate better with each other (30). This leads to some ambivalence among those subscribing to this perspective about whether the PCD should create an office with expertise on communication to support the activities of the bureaus (34).

Discussion

Before a more detailed discussion of our results is given, it is prudent to point out the limitations of our study. The chief caveat has to do with the generalisability of our findings. Because of the design of our study, it is not possible to generalise from our research participants to the PCD as a whole. In Q methodology, researchers do not select a random sample of the population but instead they use a purposive sampling approach. In this case, our intent was to select people from different bureaus and different organisational levels who have had experience with risk communication activities. We do not know if this is a representative sample of PCD officers. Consequently, we cannot use these findings to draw conclusions about how other people think within PCD. We can, however, make inferences or develop new hypotheses. In addition, our Q method results are premised on the assumption that we sufficiently identified the bulk of diverse perspectives about risk communication. If we missed one or more important perspectives among the research subjects, then our Q results could be incomplete. Another limitation is that the study does not allow conclusions to be drawn about why particular individuals subscribe to these different ideal types. People may subscribe to different perspectives because of their past experiences, the kinds of problems they work on, or other factors (Tuler & Webler, 2010).

While Q studies have, like all research methods, limitations, it is a technique that makes it an appealing approach for investigating subjective attitudes and beliefs on an issue or topic. First, it allows participants to define their own viewpoints. Second,

it is a technique that forces people to prioritise their preferences in a way that is challenging with interviews or focus groups. Third, Q method can clarify areas of agreement and disagreement by putting people's views in the larger context of their overall viewpoint. Fourth, it summarises the many viewpoints held by individuals into a few shared perspectives. Finally, it is appropriate for situations where the number of people involved is small; surveys are not appropriate for small samples.

With these strengths and limitations of the study design in mind, we now turn to four key observations that emerge from our empirical results.

First, the three perspectives were distinguished by many beliefs in common. Important areas of agreement are that:

- PCD should gather information about potential audiences for external communication activities. This can be to learn about their concerns and understandings to both improve PCD activities and to identify areas of misunderstanding.
- It is important to tailor external communication activities to the context of the situation.
- The PCD should use the best available science to provide information in its communication activities.
- The PCD should not provide any information that is requested by local communities, but rather should only provide information for which there is scientific support (statement 7).
- It would be a mistake for the PCD to focus on local leaders, rather than the whole community when it gives out information or asks for input (statement 29).

Second, perspectives emphasise different goals for risk communication. Perspective 1 represents the view that PCD risk communication should be used to reduce conflict (statement 3). Perspective 2 represents a view that PCD should focus risk communication activities on improving people's understandings of the science about risks, pollution control, and pollution mitigation. Finally, Perspective 3 emphasises collaboration to solve pollution problems.

What is not clear is why different goals are emphasised. Two possible explanations are that 1) different respondents are thinking of different kinds of situations or that

2) there is a lack of consensus within PCD about goals of risk communication. As research and practice in Europe and the United States strongly emphasise that risk communication activities should be tailored to specific situations, if respondents' differences result from varying perceptions of the context, then such differences would be appropriate. However, this study does not provide sufficient data to understand the real reason for these differences.

In spite of our caveats above about limitations, the data do suggest – as shown in Table 3 – that preferences for a perspective are not associated with working duration in a particular bureau or organisational level of the officer (senior, medium, or junior). Practitioners and experienced PCD officers may not be surprised to find that people develop very different ideas about goals and mechanisms for communication with external stakeholders. One interesting observation is the relative absence of senior officers associated with Perspective 3, which represents a more problem solving approach (only 1 out of 8). In addition, we gathered data about years of employment in PCD and the number of cases in which an officer was involved with risk communication. The individuals associated with Perspective 3 have worked somewhat fewer years at PCD, however, the significance of this association is not known.

Third, because they emphasise different goals, the three perspectives suggest different content and ways of communicating messages. Perspective 1 emphasises reduction of conflict, and thus it also highlights the need on occasion to go beyond what is required by law and regulation in communication activities. By focusing on improving understandings, Perspective 2 highlights the need for risk communication messages to focus on pollution levels and risk and to use standards as a basis for comparing what is safe versus what is not safe. In contrast to Perspective 2, Perspective 3 wants to provide information that can inform and empower local communities (statement 15), by, for example, educating people about environmental threats to health (statement 4).

Fourth, the perspectives reflect different beliefs about the PCD's capacity for risk communication, the need to invest more commitment and resources to develop capacity, and whether a new office focusing on external communications should be created. Table 4 summarises the viewpoints expressed by each of the perspectives about these matters. Perspective 1 has the highest rankings for all statements about the need for more commitment and

Table 3: Summary of Results

PERSPECTIVE	*1*	*2*	*3*
Number of individuals loading significantly on factor*	8	7	13
Number from Air Bureau	5	4	5
Number from Water Bureau	1	2	6
Number from Waste Bureau	2	1	2
Average (and median) years worked at PCD	14.75 (16)	14.5 (15)	9.53 (10)
Average (and median) number of projects involving risk communication	16.75** (4.5)	6 (4)	4.46 (3)

** Four individuals loaded on more than one factor. Four individuals did not load significantly on any factor. One individual had only a significant negative loading on one factor (which means significant disagreement with the factor).*

*** The average for Perspective 1 is skewed because one individual responded with '100+' projects. Eliminating this outlier, the average # of projects involving risk communication is comparable across all three perspectives.*

Source: Authors' Questionnaire

resources to develop more capacity. Both Perspectives 2 and 3 represent views that the PCD already has the capacity to design and implement successful risk communications with external stakeholders. It is not surprising then that they also represent a view that there is no need for substantial new resources devoted to helping PCD develop more scientific expertise (about risk communication).

Perspectives 1 and 3 suggest some ambivalence about whether the PCD should create a new office with expertise on risk communication to support the activities of the bureaus (statement 34). Those who subscribe to Perspective 3 have the fewest years working for the PCD and have participated in the fewest number of projects involving risk communication. The problem solving perspective also consists of mainly middle managers and staff. While these associations should be treated with caution, they may suggest that those with less experience believe in a need for more training and support. Perspective 2 is more strongly opposed to the idea of creating a new office, even though it also has the most negative view about the effectiveness of PCD communications with other groups. Perspective 2 also represents the weakest support for having PCD managers who make communication with communities an important priority (statement 16).

Table 4: Suggestions about PCD Capacity for Risk Communication

	FACTOR	A	B	C
Need to develop capacity				
18.	*The PCD staff should learn to communicate better with community residents.*	4	-1	0
19.	*The PCD should gather information from the public that will help scientists and regulators do a better job.*	-1	0	-2
32.	*The PCD should have more scientific expertise*	0	-2	-3
Invest more commitment and resources				
16.	*The PCD managers should make communication with the community an important priority.*	3	0	2
30.	*A commitment to programmes should be made that help PCD officers communicate better with each other.*	2	0	-2
31.	*PCD should invest the time, money, and staff needed for successful communication with the public.*	3	-1	-3
Create new office?				
34.	*PCD should create an office with expertise on communication to support the activities of the Bureaus.*	1	-3	-1

Source: Authors' Questionnaire

Insights and Recommendations About Risk Communication Practice in Thailand

The purpose of this study was to investigate the range of views among PCD officers about 1) the important goals that should be achieved in communication activities with external stakeholders, 2) who the external stakeholders are, and 3) what kinds of information should be provided. This study contributes to a small literature investigating the organisations responsible for risk communication (e.g. Chess & Clarke, 2007; Chess & Johnson, 2006; O'Neill, Calia, Chess, & Clarke, 2007; Shaw & Johnson, 1990; Shen, 2010) and provides insight into the views of agency officers and staff in Thailand about health and environmental risk communication.

We focused on the people responsible for managing and carrying out activities involving risk communication. In the PCD and more widely among Thai government agencies with responsibilities for public and occupational health, there is little explicit focus on risk communication as a core responsibility. Yet, officers and staff

are frequently called upon to be risk communicators and design risk communication activities. They bear the responsibility of determining what is needed in particular contexts to achieve communication goals. Even without explicit rules and procedures, staff and officers are likely to act in ways that are significantly influenced by their job descriptions, organisational incentives, and cultural values and social norms (Chess & Johnson, 2006; O'Neill et al., 2007). In this case we mean cultural values and social norms in both organisational and national contexts. Such values and norms may promote certain behaviours, such as overly reassuring messages that observers identify in Thai crisis communications, which are contrary to guidance about risk communication practice (Lanard & Sandman, 2011). They may also foretell why advice based on European and US experience may go unheeded. For example, advice to apologise and explain past mistakes (as recommended by Lanard & Sandman, 2011) may be difficult for government officers to follow in a culture where saving face and avoiding conflict are important values.

While there are many points of agreement among the respondents, it is also clear that there are some important areas of difference. In particular, officers at all level lack a consensus on the goals of communication activities with external stakeholders. We are not saying, however, that lack of agreement reflects a problem. Rather, it is important to acknowledge that such differences may be a result of different needs in different communication contexts. In fact, many officers believe that risk communication activities should be tailored to specific situations and audiences.

On the other hand, many PCD officers participating in the study have received no training for risk communication, had relatively little experience with risk communication activities, expressed a strong sentiment that more effort should be placed on developing skills and knowledge among officers and staff, agreed that PCD managers should make risk communication an important activity, and believed that PCD communications with the public and NGOs are not as effective as desired.

To improve practice and congruence between agency missions and communication activities, organisations frequently provide managers and staff with training and resources. The results of this study indicate that many PCD officers and staff believe that training for risk communication would be beneficial. However, there has been little effort to investigate the impact of training efforts on the improvement of organisational risk communication capacities.

> *Although many federal and state agencies have conducted risk communication training, there are no peer-reviewed assessments. Anecdotal reports focus on participant satisfaction, rather than changes in knowledge, let alone changes in agency practice. Thus, despite consultants' promotion of the importance of training, there is no evidence about its value. (Chess, 2011, p. 199)*

Effective health and environmental risk communication will continue to be a critical task of government agencies at all levels within Thailand – just as it has emerged within Europe and the United States. Experience has shown that good risk communication can clarify and reduce risk-related disputes, public health risks, and individuals' fears, while poor risk communication can exacerbate them (Foster, Pless-Mulloli, & Busch, 2003; Pidgeon, Henwood, & Maguire, 1999). As government agencies in Thailand seek to develop the capacities for health and environmental risk communication, they will confront many challenges. As this study shows, it cannot be assumed that there will be consensus about goals, perceived needs etc. relating to risk communication within a single bureau, let alone a department/agency. Furthermore, the relevance of existing research from Europe and the United States is unclear within such a different socio-cultural context. Guidance must be tested and developed through experience and systematic learning.

References

Academy for Educational Development (AED). (2010). *Mekong Infectious Disease Behaviour Change & Communication (MID-BCC) Project Summary.* Retrieved 11 February 2012 from http://mekong.aed.org/docs/AEDRDMA_Mekong_FY09_Workplan_Summary_Document.pdf

Bevir, M., & Rhodes, R. (2006). *Governance Stories*. London: Routledge.

Brown, S. (1996). Q Methodology and qualitative research. *Qualitative Health Research, 6*(4), 561-567.

Bumbudsanpharoke, W., Moran, D., & Hall, C. (2009). Exploring perspectives of environmental best management practices in Thai agriculture: an application of Q-methodology. *Environmental Conservation, 36*(3), 225-234.

Chalermphol, J., & Shivakoti, G. P. (2009). Pesticide use and prevention practices of tangerine growers in northern Thailand. *Journal of Agricultural Education and Extension, 15*(1), 21-38.

Chamratrithirong, A., & Boonchalaksi, W. (2009). *Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT): The Impact Survey 2008.* Retrieved 11 February 2012 from http://www.ipsr.mahidol.ac.th/ipsr/Contents/Books/FullText/2009/398-Prevention-HIV-AIDS-Migrant-Thailand.pdf

Chess, C. (2011). Inside the Organization. In B. Fischhoff, N. T. Brewer, & J. S. Downs (Eds.), *Communicating risks and benefits: An evidence-based user's guide* (pp. 195-203). Silver Spring, MD: US Department of Health and Human Services.

Chess, C., & Clarke, L. (2007). Facilitation of risk communication during the anthrax attacks of 2001: The organizational backstory. *American Journal of Public Health, 97*(9), 1578-1582.

Chess, C., & Johnson, B.B. (2006). Organizational learning about public participation: "Tiggers" and "Eeyores". *Human Ecology Review, 13*(2), 182-192.

Foster, K., Pless-Mulloli, T., & Busch, J. (2003). Barriers to effective risk communication: Study of the role of a local public health department in a controversial environmental investigation. *Epidemiology, 14*(5), 132-133.

Heddini A. (2009). *Rapid Communications: Increased number of dengue cases in Swedish travellers to Thailand.* Retrieved 11 February 2012 from http://www.eurosurveillance.org/images/dynamic/EE/V14N05/art19111.pdf

Ichikawa M., Chadbunchachai W., & Marui, E. (2003). Effect of the helmet act for motorcyclists in Thailand. *Accident Analysis & Prevention, 35*(2), 183-189.

Jindawatthana, A., Sukkumnoed, D., Pengkam, S., Chuenchit, W., & Mathurapote, N. (2009). *HIA for HPP, towards health nations: Thailand's recent experiences.* Nonthaburi, Thailand: National Health Commission Office. Retrieved 11 February 2012 from http://en.nationalhealth.or.th/sites/default/files/fromNHC-Thailand/data/HIA%20for%20HPP_Final%20Version_.pdf

Kalof, L. (1998). Understanding the social construction of environmental concern. *Human Ecology Review, 4*(2), 101-105.

Kasperson, R. E., & Stallen, P. J. M. (Eds.) (1991). *Communicating risks to the public.* The Hague, Netherlands: Kluwer.

Krueger, R., & Gibbs, D. (2010). Competitive global city regions and 'sustainable development': An interpretive institutionalist account in the South East of England. *Environment and Planning A, 42*(4), 821–837.

Lanard, J., & Sandman, P. (2011). *Over-Reassuring Thai Crisis Communication about the Great Flood: When "Restoring Trust" Is Too Much to Expect.* Retrieved 11 February 2012 from http://www.psandman.com/col/Thai-flood.htm

Langkulsen U., Vichit-Vadakan N., & Taptagaporn S. (2011). Safety and health in the petrochemical industry in Map Ta Phut, Thailand. *Journal of Occupational Health, 53*(5), 384-392.

Langkulsen, U. (2011). Climate change and occupational health in Thailand. *Asian-Pacific Newsletter on Occupational Health and Safety, 18*(1), 12-13.

Langkulsen, U., Vichit-Vadakan, N., & Taptagaporn, S. (2010). Health impact of climate change on occupational health and productivity in Thailand. *Global Health Action (Online), 3*, doi:10.3402/gha.v3i0.5607. Retrieved 15 May 2012 from http://www.globalhealthaction.net/index.php/gha/article/view/5607/6474

Morgan, M. G., Fischhoff, B., & Bostrom, A. (2001). *Risk communication: The mental models approach.* New York: Cambridge University Press.

Niemeyer, S., Petts, J., & Hobson, K. (2005). Rapid climate change and society: Assessing responses and thresholds. *Risk Analysis, 25*(6), 1443-1456.

O'Neill, K., Calia, J., Chess, C., & Clarke, L. (2007). Miscommunication during the anthrax attacks: How events reveal organizational failures. *Human Ecology Review, 14*(2), 119-129.

Phoolcharoen W., Sukkumnoed, D., & Kessomboom, P. (2003). Development of health impact assessment in Thailand: recent experiences and challenges. Bulletin . *Bulletin World Health Organization, 81*(6), 465-467.

Pidgeon, N., Henwood, K., & Maguire, B. (1999). Public health communication and the social amplification of risks: present knowledge and future prospects. In P. Bennett & K. Calman (Eds.), R*isk communication and public health* (pp. 65-77). Oxford, UK: Oxford University Press.

Rao, N. (1998). Effective HIV/AIDS prevention communication strategies to reach culturally unique populations: Lessons learned in San Francisco, USA and Bangkok, Thailand. *International Journal of Intercultural Relations 22*(1), 85-105.

Regional Forum on Environment and Health in Southeast and East Asian Countries. (2009). *Policy brief: sustainable chemicals management*. Retrieved 11 February 2012 from http://www.environment-health.asia/userfiles/file/HL5_5_4PB_Toxic%20Chemicals%20TWG.pdf

Renn, O. (1992). Risk communication: Towards a rational discourse with the public. *Journal of Hazardous Materials, 29*(3), 465-519.

Shaw, J., & Johnson, B. (1990). *A look inside: Risk communication and public participation within the new jersey department of environmental protection*. Trenton, NJ: NJDEP, Department of Science and Research.

Shen, X. (2010). *Flood risk perception and communication within risk management in different cultural contexts: a comparative case study between Wuhan, China, and Cologne, Germany*. Graduate Research Series, Ph.D. Dissertation. Bonn, Germany: United Nations University, Institute for Environment and Human Security.

Svenkerud, P., & Singhal, A. (1998). Enhancing the effectiveness of HIV/AIDS prevention programs targeted to unique population groups in Thailand: Lessons learned from applying concepts of diffusion of innovation and social marketing. *Journal of Health Communication: International Perspectives, 3*(3), 193-216.

Takeuchi, M. T. (2006). Avian influenza risk communication, Thailand. *Emerging Infectious Diseases, 12*(7), 1172-1173.

Tawatsupa, B., Lim, L., Kjellstrom, T., Seubsman, S., Sleigh, A., & Thai Cohort Study Team. (2010). The association between overall health, psychological distress, and occupational heat stress among a large national cohort of 40,913 Thai workers. *Global Health Action (Online), 3*, doi:10.3402/gha.v3i0.5034. Retrieved 15 May 2012 from http://www.globalhealthaction.net/index.php/gha/article/view/5034

Tuler, S., & Webler, T. (2008). Q methodology. In L. Kalof, A. Dan, & T. Dietz (Eds.), *Essentials of Social Research* (pp. 137-138). Berkshire, UK: Open University Press & McGraw Hill Publishers.

Tuler, S., & Webler T. (2010). How preferences for public participation are linked to perceptions of the context, preferences for outcomes, and individual characteristics. *Environmental Management, 46*(2), 254-267.

Tuler, S., Webler, T., & Finson, R. (2005). Competing perspectives on public involvement: Planning for risk characterization and risk communication about radiological contamination from a national laboratory. *Health, Risk, and Society, 7*(3), 247-266.

US Food and Drug Administration (USFDA). (2011). *Communicating Risks and Benefits: An Evidence-Based User's Guide*. Silver Spring, MD: US Department of Health and Human Services. Retrieved 11 February 2012 from http://www.fda.gov/ScienceResearch/SpecialTopics/RiskCommunication/ default.htm

US National Research Council (USNRC). (1989). *Improving risk communication*. Washington, DC: National Academy Press.

Combating SARS and H1N1: Insights and Lessons From Singapore's Public Health Control Measures

Allen Yu-Hung Lai[1] & Teck Boon Tan[2]

Citation Lai, A. Y.-H., & Tan, T. B. (2012). Combating SARS and H1N1: Insights and Lessons From Singapore's Public Health Control Measures. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 74-101.

Combating the outbreak of infectious diseases is a major public health imperative for the small island-state of Singapore. In this paper we discuss and assess the public health measures taken by the Singaporean government to combat the outbreak of SARS in 2003 and H1N1 in 2009. Most notably, the state introduced a clear line of command and control to monitor the effectiveness and efficacy of public health control measures as well as to oversee their implementation. Meanwhile, it has also employed moral suasion to ensure compliance with draconian health control measures by the population. At the same time, the Singapore government also established a close partnership with the population to ensure the acquiescence of the general public to these measures. Finally, this paper draws on the insights and lessons learned from the two outbreaks to develop a conceptual model for pandemic management.

Keywords: *SARS; H1N1; Public Health Control Measures; Infectious Disease; Singapore*

Die Bekämpfung des Ausbruchs ansteckender Krankheiten ist ein zentrales Gesundheitsgebot für den Inselstaat Singapur. Im vorliegenden Artikel erörtern und bewerten wir die Maßnahmen, welche die Regierung Singapurs im Bereich der öffentlichen Gesundheitsversorgung traf, um den Ausbruch von SARS im Jahr 2003 und von H1N1 im Jahr 2009 zu bekämpfen. Besonders bemerkenswert ist in diesem Zusammenhang die Einführung einer klaren Weisungs- und Kontrollstrategie, um die Wirksamkeit und Wirkungen der Maßnahmen zu überprüfen sowie ihre Implementierung beaufsichtigen zu können. Zudem wurden moralische Appelle angewendet, um die Einhaltung von drakonischen Maßnahmen zur Gesundheitskontrolle durch die Bevölkerung zu gewährleisten. Gleichzeitig etablierte die singapurische Regierung eine enge Partnerschaft mit der Bevölkerung, die das Einverständnis der Öffentlichkeit zu diesen Maßnahmen sicherstellte. Zum Schluss wird im vorliegenden Aufsatz ein konzeptionelles Modell, das auf Einsichten und Lehren aus den beiden Ausbrüchen beruft, ausgearbeitet.

Schlagworte: *SARS; H1N1; Maßnahmen zur öffentlichen Gesundheitskontrolle; Infektionen; Singapur*

1 Lai Yu-Hung Allen is a PhD candidate at Lee Kuan Yew School of Public Policy, National University of Singapore. He is also a senior medical consultant for the Health Promotion Bureau and for the Taiwan Association of Andrology. His current research interests include collaborative capacity, network governance, and organisational learning in public health crises. Contact: allen@nus.edu.sg (Corresponding author)

2 Tan Teck Boon is a PhD candidate at the Lee Kuan Yew School of Public Policy, National University of Singapore, with expertise in intelligence coordination and information synthesis.

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-5

creative commons BY-NC-ND

Introduction

Situated in South-East Asia, Singapore is fortunate enough to be spared from major natural disasters such as typhoons, earthquakes, and tsunamis. However, as the small city-state is one of the most densely populated countries in the world, Singapore is especially prone to transnational health threats such as pandemics. Indeed, during the last decade, Singapore has been struck by two major pandemics. In 2003, Singapore experienced the outbreak of the Severe Acute Respiratory Syndrome (SARS) (Cutter, 2008; Goh et al., 2006; James, Shindo, Cutter, Ma, & Chew, 2006; Pereira, 2008; Tan, 2003). Then, in 2009, the state had to take additional measures against the novel influenza A (H1N1), which put major parts of its population at risk (Cutter et al., 2010; Ministry of Health, 2009; Tay, Cutter, & James, 2010).

Even though the two major outbreaks were eventually contained through an array of public health control measures instituted by the Ministry of Health (MoH) of Singapore, SARS and H1N1 brought about severe public health and economic consequences for the country as a whole (Leo, 2011). As it turned out, the population's receptiveness to draconian measures was enhanced to a large extent through moral suasion and close partnership between the government and people. Indeed, the efficacy of these public health control measures was profoundly related to these two crucial elements. Meanwhile, it is important to note that these public health control measures were swiftly adjusted to meet contingencies that arose – for example when additional epidemiological cases were uncovered and when a better understanding of the viruses was developed. This happened through the introduction of a clear line of command and control. In terms of capacity building in the design and implementation of health control policies, the insights drawn from these two episodes of disease outbreak are invaluable both from a practical as well as a research perspective. Indeed, beyond adding to the body of knowledge on this subject, these insights also serve to guide the planning of health control policies on a broader level.

In this paper, we discuss the health control measures introduced as well as the insights drawn from the Singapore experience with specific references to SARS and H1N1. To achieve our research objective, we utilised a combination of widely-accepted qualitative methodologies. Firstly, we performed a careful examination of official documents released by key institutions such as the Singaporean Ministry of

Health and the *World Health Organisation* (WHO). Secondly, we also examined relevant literature on public control measures against communicable diseases to establish our conclusions. Thirdly, we evaluated public speeches given by senior leaders in the Singapore government and WHO officials on this particular subject-matter. This broad-based methodological approach ensures that our conclusions are both valid and reliable.

The research contribution of this paper is significant because it offers a fresh perspective on the role of the state in pandemic management. Our research also adds to the body of knowledge on epidemic policy design specific to the region of South-East Asia. Indeed, the dominant perspective in this field holds that the state must be able to exercise brute force and impose its will on the population (Lai, He, Tan, & Phua, 2009). However, as shown in our paper, this dominant perspective is at least incomplete because the exercise of authority and power from the government is not a sufficient condition to contain the transmission of virulent diseases. Success in fighting epidemics is also contingent on a concerted effort of partnership between health authorities and the population at large. Beyond this key finding, this paper also contributes to the health policy field by elucidating a conceptual model for pandemic management that is applicable to a broader context.

This paper contains five main sections. Following this introduction, we provide an overview of the epidemiology of SARS and H1N1 in Singapore to familiarise readers with the chain of events surrounding these two outbreaks. This is then followed by a critical discussion of the command and control structures put in place by the Singapore government to combat SARS and H1N1. In the third section, we evaluate the public health control measures that were implemented in key healthcare sectors during the outbreak of SARS and H1N1. Then, we present the conceptual model for pandemic management that we have constructed from our findings. In the final section, we discuss the implications for pandemic control and management in South-East Asia as well as our conclusions.

Epidemiology of SARS and H1N1 in Singapore

The first case of SARS in Singapore was a 22-year-old female Singaporean, who was detected by clinicians at Tan Tock Seng Hospital (TTSH) in March 2003 (Centers for

Disease Control and Prevention, 2003). But what began as a few isolated cases swiftly turned into a major epidemic within a short period of time. The first Singaporean to contract SARS was hospitalised at TTSH in early March 2003 upon her returning from Hong Kong. As it happened, she had been infected by a super-spreader while staying on the same floor of the Metropole Hotel with the latter. The super-spreader, a Chinese physician named Dr. Liu, was later identified by the WHO to be the primary source of infection for multiple cases of SARS (Yeoh, 2003). Back in Singapore, this Singaporean quickly infected 21 others. Although this individual eventually recovered, a number of those infected by her were not as fortunate and finally succumbed to their illness (Ministry of Health, 2003). In late July 2003, Singapore reported 238 probable cases of SARS and by the time the country was removed from the WHO advisory list, 205 (86%) had recovered while 33 (14%) had died. A further breakdown reveals that 8 cases (3%) were infected while staying

Table 1: Comparison of Characteristics of SARS and H1N1

	SARS EPIDEMICS	H1N1 PANDEMICS
Outbreak period	November 2002 to July 2003	April 2009 to August 2010 (WHO declared a pandemic on 11 June 2010)
First reported case in Singapore	1 March 2003	26 May 2009
Pathogen	SARS Coronavirus (identified on 16 April 2003)	Novel Influenza A virus (identified on 24 April 2009)
Outbreak origin	Hong Kong, China	Mexico and the US
Transmitting pathway	Human respiratory droplets, contagious when with fever	Human respiratory droplets, contagious even when without fever
Total cases in Singapore	238	1,348*
Death toll in Singapore (mortality rate)	33 cases (14%)	18 cases (1.3%)
Rapid diagnostics	Available (RT-PCR/reverse transcription polymerase chain reaction)	Available (RT-PCR/reverse transcription polymerase chain reaction)
Medical treatment	Limited (only supportive)	Available (antivirals)
Medical prevention	Not available	Available (antivirals, vaccines)

* Refers to confirmed cases admitted to hospitals, representing about 0.6% of the estimated number of H1N1 infections in polyclinics and general practitioner clinics.

Source: Authors' Compilation From Various Formal Reports

abroad whereas 97 cases (41%) were healthcare workers (WHO, 2003).

H1N1, on the other hand, presented a different set of challenges altogether, as its main epidemiological characteristic was radically different from that of SARS (see Table 1). Crucially, a H1N1 carrier is contagious even when he or she had mild symptoms. SARS, meanwhile, can only be transmitted by the carrier after he or she had developed a fever. For H1N1, viral shedding begins shortly after infection and before the onset of symptoms. In other words, the H1N1 carrier would begin infecting others at a preliminary stage without even realising that he or she was stricken. Therefore, it is apparent that health control measures to combat SARS and H1N1 had to be customised according to their unique epidemiological characteristics (Leung & Nicoll, 2010).

On 26 May 2009, the first case of H1N1 – also a 22-year-old female Singaporean – was detected at a local clinic and subsequently sent to a local hospital designated to treat H1N1 cases (Ministry of Health, 2009). About three weeks after this case was reported, community transmissions (with no links to the first case) broke out at an alarming rate. Health authorities in Singapore immediately introduced rigorous containment measures which eventually brought down the rate of community transmission. Most notably, at the peak of the H1N1 pandemic (from 26 July to 1 August 2009), community outpatient clinics attended to nearly 24,477 cases for acute respiratory illness. In the week between 2 August and 8 August 2009, 65.5% of influenza-like cases were confirmed to be H1N1. By 9 July 2009, there were 1,301 confirmed cases of H1N1 in Singapore (Ministry of Health, 2009). Although the WHO later categorised the H1N1 pandemic as one of moderate severity, the public health control measures introduced to mitigate the severity of this pandemic undoubtedly contributed in no small part to contain this highly contagious pandemic. We will now examine in detail the command and control structure implemented by the health authorities in Singapore to mitigate the severity of the H1N1 pandemic.

Command and Control Structure

One of the most important lessons the Singapore government learned from the SARS epidemic was the significance of the role of the bureaucracy in crisis management. As it turned out, the bureaucratic structure in place prior to the outbreak in 2003

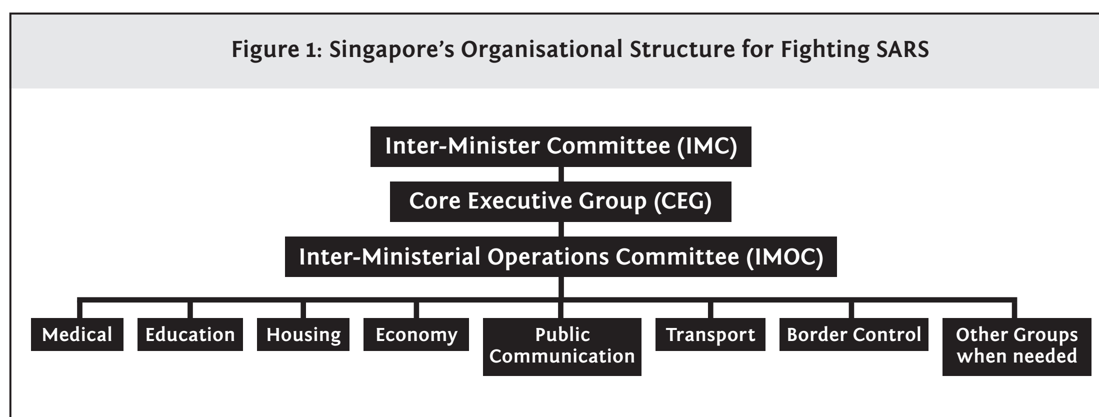
was wholly inadequate in terms of dealing with a crisis situation that was both fluid and unprecedented (Ansell, Boin, & Keller, 2010; Menon & Goh, 2005; Pereira, 2008); consequently, fighting SARS called for more than a medical approach since resources had to be drawn from a number of government agencies that did not fall under the rubric of the MoH.

On 15 March 2003, when the epidemiological nature of SARS was still unclear, the MoH initiated a SARS taskforce to look into the mysterious strain. Only two days later, after more SARS cases were uncovered and a better epidemiological understanding of the strain was developed, the Singaporean government swiftly declared SARS a notifiable disease under the IDA (Ministry of Health, 2003). In the event of a widespread outbreak, IDA made it legally permissible to enforce mandatory health examination and treatment, exchange of medical information and cooperation between healthcare providers and MoH, and quarantine and isolation of SARS patients (Infectious Disease Act, 2003, chapter 137). On 24 March 2003, the MoH was authorised by the IDA to implement compulsory home quarantine for those who had been exposed to the SARS virus. On 7 April 2003 (approximately five weeks after the first case of SARS was reported), a three-tiered national control structure was created in response to SARS. These tiers were individually represented by the Inter-Ministerial Committee (IMC), the Core Executive Group (CEG), and the Inter-Ministry SARS Operations Committee (IMOC) (Tay & Mui, 2004).

The nine-member IMC[3] was chaired by the Minister of Home Affairs (MHA) and fulfilled three major functions: 1) to develop strategic plans, 2) to approve major decisions, and 3) to implement infection countermeasures. Notably, the IMC also played the role of interagency coordinator overseeing the activities of other ministries and their subsidiaries. The CEG was chaired by the Permanent Secretary of Home Affairs and consisted of elements from three other ministries: the MoH, the Ministry of Defence (MoD), and the Ministry of Foreign Affairs (MFA). In particular, the role of the CEG was to manage the SARS epidemic by directing valuable resources to key areas. The IMOC, meanwhile, was seminal in carrying out health control measures issued by the IMC and served as the main operational linkage between the MoH and all healthcare providers (see Figure 1).

3 Besides the Ministries of Home Affairs and Health, the Inter-Ministerial Committee comprised eight more ministries: Foreign Affairs, Defence, Education, National Development, Manpower, Environment, Transport, and Information, Communications and the Arts.

Figure 1: Singapore's Organisational Structure for Fighting SARS



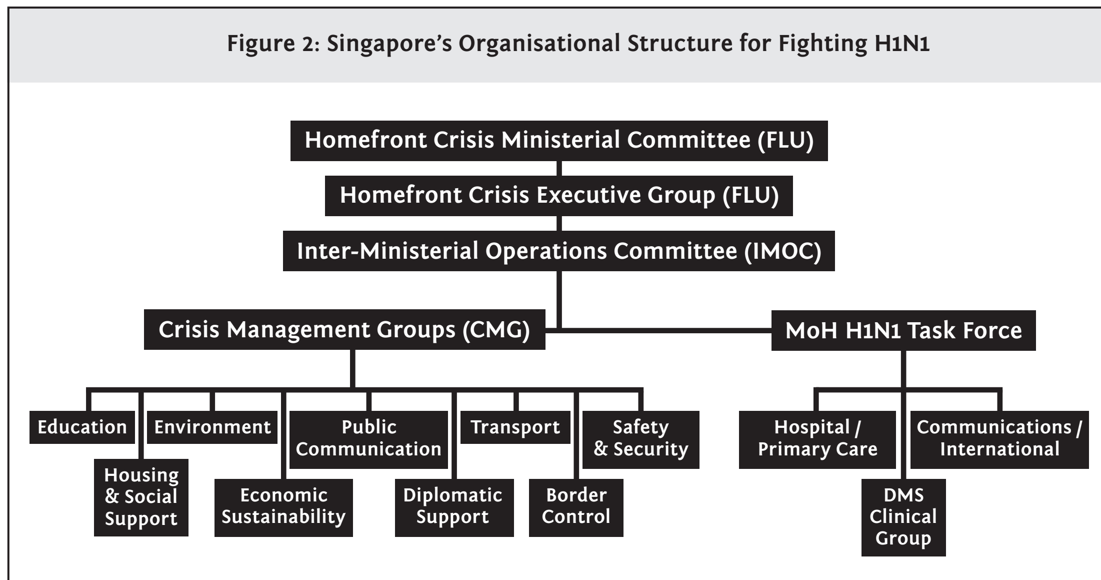
Source: Adapted from Tay & Mui (2004, p. 35)

Following the SARS epidemic, the above command and control structure was revised to adequately reflect the need to create a multi-faceted and robust management approach – one that would be more suited to a fast changing health crisis situation that was both volatile and unheralded. The outcome was the establishment of a Home-front Crisis Management System (HCMS) (Pereira, 2008). Heading this new command and control structure was the Home-front Crisis Ministerial Committee (HCMC). Identical to the IMC, the HCMC served to provide strategic and political directions during health crises. Meanwhile, the functions of the CEG and IMOC were consolidated into the Home-front Crisis Executive Group (HCEG) in order to shorten the time it might take to respond to a health crisis (Pereira, 2008).

During the 2009 H1N1 outbreak, the HCMC for Influenza (HCMC-FLU) was formed and it was supported by the HCEG-FLU (see Figure 2). Various ministries and agencies also formed interagency working groups called Crisis Management Groups (CMGs). Each CMG was in turn headed by a ministry.[4] Then in each CMG, a senior MOH representative was assigned to bring that ministry's expertise to the group. Unlike during the 2003 SARS outbreak, the 2009 H1N1 outbreak saw the MoH (and not the MHA) taking charge of the fight. Among other notable moves, the MoH established a special taskforce – a joint effort made up of key policy makers, public health practitioners, senior clinicians, and infectious disease specialists – headed by the Permanent Secretary of Health to implement all public health control measures and oversee the provision of medical services (Tay, Ng, Cutter, & James, 2010).

4 It is important to point out that during the 2009 H1N1 outbreak various ministries were assigned specific responsibilities such as border screening, vaccination, domestic surveillance, and public education.

Figure 2: Singapore's Organisational Structure for Fighting H1N1



Source: Adapted from Tay et al. (2010, p. 316)

The main benefit of this abridged command and control structure was that it dramatically shortened response time and facilitated the implementation of health control measures across various healthcare sectors during the 2009 H1N1 pandemic. Noting this, we now turn our discussion to the ways in which these health control measures were implemented.

Health Control Measures

Case Management

The manner in which SARS cases were managed clearly illustrates the significance of good governance at all levels. In particular, Singapore's command and control structure to combat SARS was modelled after an *All-in-One* approach toward the management of SARS patients. Specifically, all suspected cases of SARS were confined to a single hospital designated by the MoH – Tan Tock Seng Hospital (TTSH) in this case (James et al., 2006; Tan, 2003). This *All-in-One* approach was unique to Singapore and was not found in other SARS-affected countries. Notably, a crucial element of this All-in-One approach to case management was that it required close partnership between three core groups of constituencies: TTSH, the general public, and healthcare

providers (both in public and private practices).
The mechanics of this unique approach can be delineated into three key steps. Firstly, once the government secured full cooperation from TTSH designating it a SARS specific health institution, it made an unambiguous announcement to medical professionals and the general public as to where SARS patients can be treated. In practice, once a suspected SARS patient was detected at a local clinic or emergency department, he or she would be transferred to TTSH immediately for further evaluation and monitoring. Secondly, the government also had to divert non-flu patients away from TTSH so that the sudden surge in the number of flu cases at TTSH would not paralyze its service delivery. As it happened, through the government's relentless public communication and education, this ad hoc measure ended up receiving strong cooperation and support from the general public. Indeed, by seeking medical treatment from other public hospitals for non-flu illnesses, the general public made it possible for TTSH to concentrate its scarce resources on SARS-related cases. Lastly, the government sought the cooperation of other healthcare providers (such as public hospitals and local clinics) so that they would absorb additional cases of non-flu illnesses. There is no doubt that by concentrating all SARS patients in one facility, Singapore's health authority was able to achieve disease containment more rapidly (Centers for Disease Control and Prevention, 2003).

As opposed to the *All-in-One* approach in 2003, the strategy to combat H1N1 in 2009 took the form of a so-called *One-in-All* approach. As its name suggests, this entailed a single all-encompassing strategy to counter H1N1, which was necessary since the characteristic of H1N1 virus was different (Tay et al., 2010). Unlike SARS carriers, H1N1 carriers could be contagious even when they were in the asymptomatic phase of the illness (in other words, not showing any visible signs of illness). To minimise the risk of transmission, MoH imposed *one* standardised infection control measure on *all* healthcare settings (such as primary care clinics, long-term care facilities, and community renal dialysis centres). Given this imperative, the MoH again needed strong compliance from health professionals and the general public. In practice, one triage system was implemented in all frontline settings to streamline the treatment of H1N1 patients. Once patients were laboratory-confirmed to be stricken with H1N1, mandatory isolation orders were issued and quarantine became compulsory. This was in accordance with the IDA, which, it must be pointed out, was amended in a

timely manner to reflect this imperative (Tay et al., 2010). Furthermore, the MoH also established a specific contact tracing centre to track down all laboratory-confirmed cases. This meant that those who came into close contact with H1N1 patients were swiftly tracked down, ordered to undergo mandatory Quarantine Orders (QOs), and were given *Oseltamivir* as a precaution.[5] However, mandatory isolation in a setting that was external to the traditional healthcare provider did end up raising a wide range of legal, political, and ethical issues that could potentially result in a public backlash at that policy. Indeed, even though the policy of mandatory isolation was arguably quite effective in terms of limiting transmission, such a draconian measure did challenge the public's acceptance of it, especially those who were isolated since that presented an abrupt disruption in their lives and work (Duncanson, 2003). To mitigate such public displeasures, the Singapore government endeavoured to provide the affected a comprehensive livelihood support by enlisting the assistance of non-governmental organisations. At the same time, the population was encouraged to adopt responsible social behaviours (James et al., 2006). We shall discuss this aspect in greater detail in the sections on physical distancing and isolation/quarantine.

Surveillance

Disease surveillance is central to combating pandemics because it can serve three critical functions. Firstly, surveillance helps to identify patterns of disease progression; secondly, it provides advance warning and detection of impending outbreaks; and thirdly, surveillance can even indirectly lower the mortality rate through better understanding of the pandemic on hand (Aledort, Lurie, Wasserman, & Bozzette, 2007; Briand, Mounts, & Chamberland, 2011). At the moment, the surveillance process is predominantly carried out by health authorities at major border-crossings (Ansell, Boin, & Keller, 2010; Briand, Mounts, & Chamberland, 2011; Jebara, 2004; Bhatia & Narain, 2010; WHO, 2009; WHO Writing Group, 2006). Yet, a functional surveillance system must also count on timely and accurate disease identification and reporting. It is also imperative that the surveillance process can be extended beyond border-crossings to that of the community-level and this invariably requires close partner-

5 Quarantine orders were served for a period of seven days from the date of last contact with the index case.

ship between the health authorities and healthcare professionals (such as general practitioners at the community level, infectious disease specialists, and laboratory scientists at hospitals).

When SARS first emerged, the nature of the virus was largely unknown (Tan, 2006). As a consequence, health authorities worldwide were mostly ill-equipped to detect suspected cases, let alone monitor them. Similarly, health authorities in Singapore encountered this problem. But with the aid of WHO technical advisors, Singapore managed to establish identification and reporting procedures in a timely manner. Furthermore, the MoH also swiftly expanded on the definitions used by the WHO to identify suspected cases of SARS (to include any healthcare workers with fever and/or respiratory symptoms) in order to widen the surveillance net (Goh et al., 2006; Tan, 2006).

It is important to note that in order to cast a wide surveillance net, the MoH needed the cooperation of various targeted groups, such as healthcare workers with fever, patients with atypical pneumonia, clusters of three or more healthcare workers in the same work area and so forth. As a result, sick leaves of healthcare workers were closely monitored and as the pace of SARS transmission quickened, the Singaporean Parliament even amended the IDA on 24 April 2003, requiring all suspected SARS cases to be reported to the health authority (MoH) within 24 hours from the time of diagnosis (Centers for Disease Control and Prevention, 2003). While these control measures were laudable, SARS also exposed the weakness of the fragmented epidemiological surveillance and healthcare system Singapore had in place at the time (Goh et al., 2006). For example, surveillance of healthcare-associated infections was not fully instituted in all healthcare facilities in Singapore before SARS. As a result, atypical clinical presentation of SARS cases, for example, immunocompromised patients, managed to evade detection by the surveillance net in place at the time (Tan, 2006).

Therefore, when the SARS epidemic was finally put under control, MoH quickly introduced a number of novel surveillance measures to integrate epidemiological data and to identify the emergence of a new virulent strain faster. For example, a rigorous measure of thrice-daily temperature surveillance of all healthcare workers was introduced by MoH in every institution as well as active surveillance for clusters of febrile patients (Goh et al., 2006). Another of MoH's notable innovations was the es-

tablishment of an Infectious Disease Alert and Clinical Database system to integrate critical clinical, laboratory, and contact tracing information with a new information technology infrastructure developed to support the surveillance and management of SARS. Drawing heavily on its experience with SARS's wide-net surveillance, the MoH also introduced an enhanced process that consisted of five major formal operational components – community surveillance, laboratory surveillance, veterinary surveillance, external surveillance and lastly, hospital surveillance (see Table 2). However, it is important to point out that relying exclusively on this formal surveillance system might not be judicious from an operational standpoint. Indeed, in the fight against H1N1, MoH's external surveillance system did not play a significant role in providing early warning of that outbreak. As it turned out, it was through private partnership with health professionals – an informal global network – that MoH was able to obtain valuable information on H1N1 (Tay et al., 2010). The formal surveillance process in place at the time of the outbreak of H1N1 only fulfilled an ancillary function.

Table 2: Singapore's Integrative Surveillance System

TYPE OF SURVEILLANCE	OPERATIONAL COMPONENT
Community surveillance	Community-based reporting of acute respiratory infections
Laboratory surveillance	Laboratory testing of influenza viruses to detect new strains
Veterinary surveillance	Poultry or the wild bird populations
External surveillance	Infectious diseases in the region and globally
Hospital surveillance	Cases of atypical pneumonia, prolonged unexplained fever and sudden death of respiratory infection in all Singapore hospitals

Source: Authors' Compilation From Various Formal Reports

Physical Distancing

Physical distancing refers to those measures that sought to limit physical contacts at public locations such as workplaces, places of worship, entertainment spots, and schools. Accordingly, MoH advocated the practice of physical distancing during the outbreak of SARS as well as H1N1. The sole intention of physical distancing was of course to limit physical interactions and close contacts in public areas to slow the

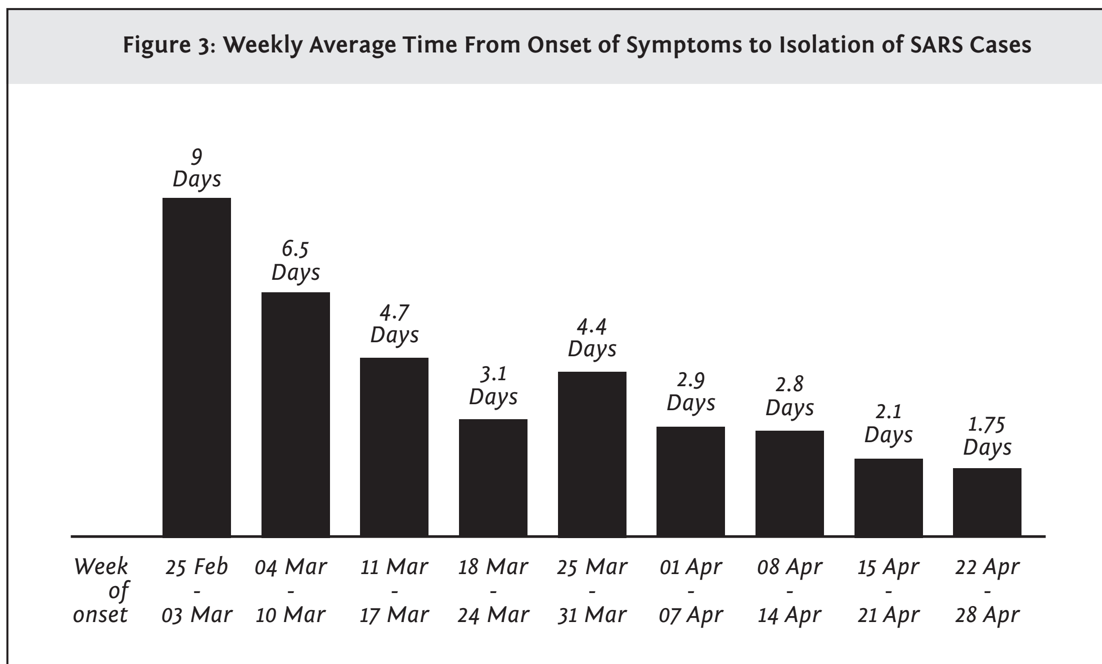
rate of disease transmission. During SARS, all kindergartens, after-school centres, primary and secondary schools, and junior colleges were closed for two weeks from 26 March to 6 April 2003. In addition, school children who had stricken siblings were advised to stay home for at least 10 days. Beyond that, students who showed flu-like symptoms or had travelled to other affected countries were automatically granted a seven-day Leave of Absence (Goh et al., 2006). To mitigate the side-effects caused by these disruptions, the Ministry of Education (MoE) instituted a number of home-based learning programmes for those affected. Schools meanwhile were also advised to scale down their extracurricular activities in order to minimise physical contacts. In all, during the outbreak of H1N1, there were 148 class closures (66 at the primary and secondary, 82 in kindergartens) between 28 June and 31 August 2009 (Tay et al., 2010).

During the mitigation period, the MoH also advised businesses within the service sector to adopt physical distancing countermeasures such as split-team arrangements and allowing staff to work from home (Tay et al., 2010). Those who were at higher risk of developing complications if stricken were also removed from frontline work to other areas where they were less likely to contract the viruses. The practice of physical distancing, however, also drew strong criticisms from businesses that suffered economic losses as a result (Duncanson, 2003). It is therefore important to point out that the effectiveness of physical distancing remains controversial and the practice itself relies heavily on the judgement passed by a selected few (see for example, Aledort et al., 2007; Briand, Mounts, & Chamberland, 2006; Gostin, 2006; WHO, 2006). Indeed, few studies have been conducted since the SARS outbreak in 2003 to establish the effectiveness of this control measure. Despite the absence of solid empirical data, the WHO nevertheless established a set of general guidelines for countries that sought to institute physical distancing to follow, and recommended that it should be introduced only in accordance with the severity of the epidemic, risk groups affected, and epidemiology of transmission (WHO, 2005). In other words, physical distancing should only be introduced when it is supplemented by other measures to compensate those who suffered economic losses as a result. Only then will physical distancing, as a public health control measure, receive the broad-based buy-in that is necessary for it to be effective.

Isolation and Quarantine

On 24 March 2003, the MoH invoked the IDA to isolate all those who had been exposed to SARS patients (Ministry of Health, 2003). These "contacts" were quarantined for 10 days either at home or at specific centres and were told to take their body temperatures twice a day. During the quarantine period, contacts who developed a fever (defined as a body temperature higher than 38°C) would automatically be referred to TTSH for further monitoring and investigation. Meanwhile, the MoH also uncovered an old law that granted that ministry the authority to mandate quarantines. As a result, it was able to serve quarantine orders in thousands of suspected cases. Harsh penalties, such as hefty fines of more than USD 4,000 or imprisonment, were imposed on those who defied quarantine orders ("Singapore Imposes", 2003). In a drastic move reminiscent of a police state, closed circuit cameras were installed in the houses of those ordered to stay home to monitor their compliance with the quarantine order ("Singapore Imposes", 2003). At the height of SARS, 12,194 suspected cases were ordered to stay home, all of whom were monitored either by cameras or in less severe cases, by telephone calls. Initially, when little was known of the epidemiology of SARS, the average quarantine period for suspected cases was six to eight days. However, as the MoH came to understand the disease better, that was significantly reduced to just one to three days (see Figure 3).

Figure 3: Weekly Average Time From Onset of Symptoms to Isolation of SARS Cases



Source: Adapted from Tan (2003)

During the H1N1 pandemic, quarantine and isolation were also mandated as part of the overall containment strategy (Tay et al., 2010). Similar to the approach taken during SARS, patients who demonstrated mild symptoms were ordered by their doctors to stay at home as part of the QO. On the other hand, close contacts of index cases were issued QOs and quickly admitted to public hospitals for isolation. Contacts who were Singaporeans were generally quarantined in their own homes while foreigners were assigned to Government Quarantine Facilities. At the same time, experienced clinicians were elevated to the status of Health Officers under the IDA and given broad authority to issue mandatory isolation orders.

It is important to point out that empirical evidence based on mathematical modelling demonstrated a direct correlation between early quarantine and the number of secondary cases generated in subsequent time periods (Lipsitch et al., 2003). In other words, the sooner an index case was isolated, the fewer subsequent infections could be linked to it. Yet, quarantine, regardless of its effectiveness, received strong criticisms from the general public during the outbreak of SARS and H1N1 due to the invasive nature of that measure (Duncanson, 2003; Menon, 2011). Therefore, it remains an ongoing debate in the public policy realm as to where the balance between the requirement for disease containment and privacy can be struck when quarantine is introduced.

In response to the public complaints, authorities in Singapore provided economic assistance to those individuals and businesses who had been affected by home quarantine orders through a *Home Quarantine Order Allowance Scheme* (Tay & Mui, 2004; Teo, Yeoh, & Ong, 2005). At the same time, the MoH worked together with various ministerial authorities to provide essential social services to those affected by the quarantine order. For example, housing was offered to those who were unable to stay in their own homes (because of the presence of family members) during their quarantine, ambulance services were provided to those undergoing quarantine at home to visit their doctors as well as high-tech communication gadgets (such as webcams) for those undergoing quarantine to stay in touch with relatives and friends.

Healthcare Sector Infection Control Measures

The view that infection control measures implemented in the healthcare sector can

limit the transmission of infectious diseases is widely supported in extant literature on this subject (see for example, Aledort et al., 2007; Jeffries, 1995; Pittet, 2001). Indeed, it is not a matter of dispute that measures that discourage hospital visits in non-essential cases while encouraging better personal hygiene and respiratory etiquette can help to lower the rate of infection. Therefore, to limit the risk of transmission in healthcare institutions, the MoH decided to implement a series of stringent infection countermeasures that called for the cooperation of all healthcare workers (HCWs) and visitors to hospitals during the outbreak of SARS. At the same time, the MoH instructed all HCWs to wear appropriate personal protective equipment[6] when treating patients. Visitors to public hospitals were also advised not to enter areas where transmission and contraction were most likely. The movements of HCWs in public hospitals were also heavily proscribed during the outbreak. As a result, many physicians and nurses were restricted to working in one specific medical facility at any time (James et al., 2006; Teo, Yeoh, & Ong, 2005). Unfortunately, except for TTSH, these critical measures were not enforced in a number of healthcare sectors until 8 April 2003, and this oversight led to a number of intra-hospital infections (Goh et al., 2006). This oversight taught the MoH an important lesson; consequently, stringent infection control measures were implemented in all healthcare settings during the outbreak of H1N1.

It is important to point out that when H1N1 broke out in 2009, the MoH utilised a combination of *soft* and *hard* tactics to combat that outbreak. As an example, the ministry was *soft-handed* when it simply reminded all healthcare sectors of their social responsibility to limit the transmission of the H1N1 virus (Menon, 2011). It is somewhat unfortunate that this form of moral suasion has been given little emphasis in extant literature even though there is a growing body of evidence which underscores the significance of cooperation between the general populace and the government. Meanwhile, the MoH also introduced *heavy-handed* measures such as restricting the movements of HCWs and visitors to hospitals. Even more drastic than the measure that was taken during the outbreak of SARS in 2003, the movements of HCWs and patients *between* hospitals were restricted during the outbreak of H1N1 in 2009. As a matter of fact, only HCWs who provided essential services were permitted

6 Personal protective equipment includes N95 masks, disposable gloves, gowns, and goggles or visors.

to move freely from one hospital to another. At the same time, patient movement between hospitals was strictly restricted to medical transfers. Moreover, the number of visitors to hospitals was also tightly controlled and their particulars were recorded during each visit (Leo, 2011). Ultimately, it was not a single infection control measure that defeated H1N1 but rather a novel combination of soft-handed and heavy-handed measures that ultimately brought the virulent outbreak under control.

Public Education and Communication

During the SARS and H1N1 outbreaks, the MoH practised a high degree of transparency and forthrightness when it shared information with the general public (Menon, 2011). Information was communicated to the public through every conceivable channel and medium to educate the domestic populace while reassuring the international community. For example, a government information channel dedicated to providing timely updates was created on the same day – 13 March 2003 – when the WHO issued a global alert. A dedicated TV Channel called the SARS Channel[7] was also launched to broadcast information on the symptoms and transmission mechanisms of the viruses (James et al., 2006). As to reach out to a wider audience, the MoH even advertised epidemic-related information in local newspapers. National TV stations Channel 8 and Channel U even made the rare move of using a range of local dialects such as Hokkien and Teochew to host live call-in SARS forums.[8] As it happened, the outbreak of SARS prompted the state media in Singapore to permit such broadcasts underscoring the severity of the situation as well as the will of the state. In addition to mass media (for example TV and radio), information pamphlets were distributed to every households in the country via the postal service and the MoH website provided constant updates and health advisories to the general public (Menon, 2011).

Throughout the SARS crisis, a single MoH spokesperson acted as the state's mouthpiece to the media (James et al., 2006). In stark contrast to how the Taiwanese government handled the SARS outbreak – by allowing numerous medical experts and

7 As the health crisis deepened in May 2003, television broadcast competitors *Singapore Press Holdings* (SPH), *Media Corporation of Singapore* (MediaCorp), and StarHub Cable TV joined forces to establish a dedicated SARS Channel, which transmitted from noon to midnight each day.

8 It is noteworthy that Singapore stopped broadcasting TV programs in local dialects since the early 1980s (Menon & Goh, 2005). The temporary reversal of this government policy was the result of initial media criticism that the campaigns needed to be more effectively targeted by reaching out to those people who only understood dialects.

local health professionals to voice their opinions and provide fodder for the local media on a daily basis – the Singaporean government's strategy of presenting one monolithic voice to the media was indeed sensible and commendable (Ho, 2003). At the same time, the media in Singapore also acted in a sound manner by assuming a social responsible role, which, among others, saw the media establishing a close working partnership with the state to help manage the national crisis.[9] For instance, the local newspaper, The *Straits Times*, published articles that were largely supportive of the health control measures introduced by the government (Menon & Goh, 2005). In addition to news and articles that supported the state's actions, news headlines also called on members of the public to change their attitudes and behaviours toward personal hygiene. Unquestionably, these unambiguous messages from the state contributed in no small part towards lowering the risk of public panic. Singapore's open and responsive risk communication even earned the small nation-state praises from Dr. Osman David Mansoor, a Senior Health Advisor for the UNICEF. Underscoring the efficient and almost mechanical manner in which Singapore had handled the SARS outbreak, Mansoor commented in particular that "if Singapore cannot get it under control, it is going to be very hard to get it under control anywhere else" (Fung, 2003).

It is important to note that during the H1N1 outbreak in 2009, this monolithic strategy of public education was also pursued rigorously. Similar to the strategy adopted during the outbreak of SARS, the MoH worked closely with the media to provide regular and timely updates and health advisories to the general populace (Menon, 2011). The public was educated on how to minimise the risk of contraction and transmission as well as on how to identify symptoms of influenza. Many public and private organisations also displayed prominent signs in front of their building entrances that reminded their staff as well as visitors to be socially responsible. School children were instructed to wash their hands and take their body temperature regularly. The public was told to wear masks and postpone non-essential travels to other countries. Once the H1N1 vaccine became available, the MoH also pushed for the general public to be immunised.[10] However, the vaccination coverage rate in the general public was less than 20 percent, that is lower than the level of herd immu-

9 Criticisms come in as a self-censored mechanism exists in Singapore's media coverage. However, the authors argue that the government's concerted communication serves as a necessary, effective policy instrument to mitigate the public panic at the response stage of fighting pandemics.

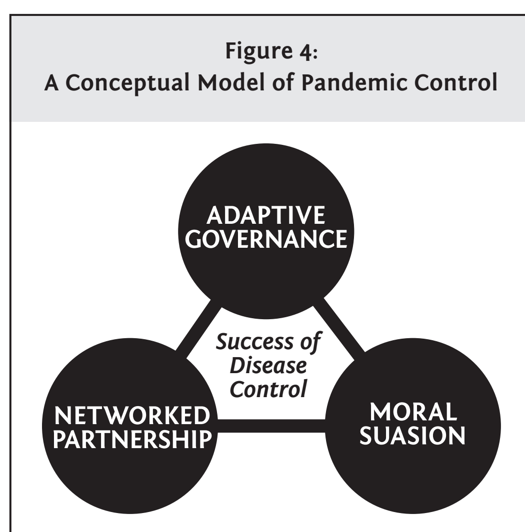
10 To be fair, concerns over the vaccines' safety tempered the general public's receptiveness toward immunisation.

nity. A survey conducted in November 2009 among Singapore's healthcare workers (HCWs) revealed fewer than 40 percent of HCWs expressed willingness to receive the H1N1 vaccination. The top two concerns preventing vaccination were "fear of side effects" and "unsure of effectiveness" (Toh et al., 2012). When concerns arose regarding the safety of the vaccines, key politicians and ministers took the lead to assuage such concerns by getting vaccinated themselves (Menon, 2011).

Conceptual Model and Implications for Pandemic Management

The draconian health control measures imposed by authorities in Singapore to defeat SARS and H1N1 have received heavy criticism both from the West and from within Singapore itself ("Singapore Imposes", 2003; Menon, 2011). Indeed, the use of quarantine orders during the outbreaks is reminiscent of the kind of measures used only by police states. It is conceivable that few countries in the West would have resorted to the use of CCTVs to ensure compliance with home quarantine orders. However, the evidence presented in this paper strongly suggests that such a perspective is incomplete at best. For one, the Singapore government did employ gentler approaches in the form of moral suasion and public-private partnerships to combat SARS and H1N1. Guided by this insight, we hereby delineate a comprehensive model that is better able to capture the essence of Singapore's success in combating SARS and H1N1 (see Figure 4). Crucially, this model is composed of three critical components – adaptive governance, networked partnership, and moral suasion – all of which are implicitly or explicitly revealed in the measures that had been discussed so far in this paper. More importantly, this conceptual model offers a valuable framework into the kind of approach needed to combat future pandemics especially in South-East Asia. We will now discuss the significance of each element and its implications.

Figure 4:
A Conceptual Model of Pandemic Control



Source: Authors' Compilation

Adaptive Governance

Adaptive governance, in this context, refers to a clear but flexible command and control structure that can be swiftly adapted to changing circumstances. Among other things, the flexibility endemic to this command and control structure facilitates the building of trust between the state and its people (Lai, 2009). This in turn ensures that government measures are quickly accepted by the general public.

As shown in this paper, the Singapore government practised adaptive governance during the outbreak of SARS and H1N1 by establishing a command and control structure that was able to adapt to rapidly changing circumstances. Indeed, this command and control structure was reorganised swiftly to deal with the uncertainties that stemmed from the outbreaks. When SARS broke out in 2003, the MoH set up a taskforce within that ministry even when the definition of SARS remained unclear. As more SARS cases were uncovered and better epidemiological information became available, the government quickly created the Inter-Ministerial Committee (IMC) and Core Executive Group (CEG) – both of which were instrumental in the design and implementation of all public health control measures – to coordinate the operation to combat the outbreak. While this overarching governance structure is more or less standard worldwide (LaPorte, 2007; 't Hart, Rosenthal, & Kouzmin, 1993), the case of Singapore is unique in that the nation-state was able to overcome bureaucratic inertia and adapt this governance structure to deal with the subsequent outbreak of H1N1 in 2009. Indeed, MoH officials swung into action once they realised that the IMC–CEG structure was inadequate in terms of facilitating close cooperation between various key government agencies to tackle the health crisis on hand (Pereira, 2008). Accordingly, in the post-SARS period, the IMC–CEG structure quickly evolved into an influenza-focused Home-front Crisis Ministerial Committee (HCMC-FLU) and the Home-front Crisis Executive Group (HCEG-FLU). On top of facilitating close inter-agency coordination, the strength of this revamped structure was its ability to ensure swift response to a pandemic outbreak by implementing health control measures more effectively and efficiently.

Singapore's legal framework also played an adaptive role in terms of facilitating a swift response to the outbreak of pandemics. A legacy of Singapore's British colonial past, the Singaporean legislature is well known for passing laws in a swift and ef-

ficient manner. Using the IDA, MoH declared SARS a notifiable disease on 17 March 2003 – a mere two weeks after the first imported case. H1N1 was declared a notifiable disease on 28 April 2009 – just one day after the WHO raised the alert from phase 3 to 4 – even when there were no reported cases of H1N1 in Singapore then. More importantly, Singapore was able to swiftly amend the IDA during the health crises to suit volatile conditions such as when more epidemiological cases were uncovered and the viruses were better understood. In particular, the government amended the IDA on 24 April 2003 requiring all those who had come into contact with SARS patients to remain indoors or report immediately to designate medical institutions for quarantine. Though vitally important, an adaptive governance structure was not the only reason behind the successful defeat of SARS and H1N1 – individual values and the interests of different stakeholders were crucial as well (Teo, Yeoh, & Ong, 2005). This brings us to the second element of our conceptual model: a networked partnership.

Networked Partnership

Combating pandemics requires multiple government agencies and private organisations to work together in close partnership – not unlike that of a network (Lai, 2012; Shalala, 1997; Webby & Webster, 2003). While the health authorities of a country typically lead such efforts, the inclusion of other departments, agencies, and organisations (including non-governmental ones) is necessary and ultimately, inevitable. Indeed, major countermeasures such as public education and surveillance are often made possible with the aid of non-health agencies such as the media and schools. In Singapore, healthcare delivery is carried out through a variety of providers in the public, private, and voluntary welfare organisation sectors. For example, the national vaccination program against H1N1 in 2009 involved not only the MoH but also a number of other ministries such as the MoE, MoD, MFA as well as entities such as the media, public hospitals, and private clinics. Therefore, it is clear that the ability to synergise the capacity of various organisations is central to the fight against infectious diseases (Lai, 2012; Leung & Nicoll, 2010; Voo & Capps, 2010).

In general, every public health control measure introduced by the MoH was well-received by the public for two main reasons: Firstly, the level of trust Singaporeans had for their government was relatively high and support for the party in office was

strong. The general sense was that the government needed *carte blanche* in order to combat the pandemics effectively and this in turn allowed various government agencies and departments to push through a series of draconian measures to contain the outbreaks. Secondly, the government's eagerness to enter into a partnership with various organisations to combat SARS and H1N1 was also a key reason. One dramatic example of this was a joint decision made by both the health and education ministries on 25 March 2003 to close all institutions of learning in Singapore. The decision was not made on medical grounds but because principals and general practitioners have reported that parents continued to be concerned about the risk to their children in schools (Lanard, 2004). Then-education minister Teo Chee Hean assured four groups of stakeholders that they were being heard and taken seriously: principals, general practitioners, parents, and the general public. "The ministers can't do everything the public wants – but the public knows its wishes will be considered," Teo said (Fung, 2003). A shared control with its public not only works for partnership but also for moral suasion.

Moral Suasion

Moral suasion means the use of a persuasion tactic by an authority to influence and pressure but not to force individuals or groups into complicity with a policy (Aimone, 2010; Barrett, 2007). Public education and risk communication are two indispensable components in health crisis management (Reddy et al. 2009; Reynolds & Seeger, 2005). The evidence suggests that draconian government measures, such as quarantine and travel restrictions, are less effective than voluntary measures (such as good personal hygiene and voluntarily wearing of respiratory masks), especially over the long term (Bruine, Fischhoff, Brilliant, & Caruso, 2007). Therefore promoting social responsibility is crucial in terms of slowing the pace of infection through good personal hygiene and respiratory etiquette in all settings (Aledort et al., 2007). This, in large part, has to rely on public education and risk communication. Indeed, getting the right message across to the general public can often be a major challenge, especially when no established and respected organisation can act as the central authority for information collection and dissemination. Hence, it is absolutely necessary to disseminate essential information to the targeted population in a transparent manner.

Moral suasion is best illustrated in the Singaporean government's communication strategy during the outbreak of SARS and H1N1. The lack of knowledge on the epidemiology of SARS and H1N1 at the beginning of the outbreaks inevitably led to public fear and panic. Throughout the pandemic, the Singaporean government relentlessly raised the level of public awareness on social responsibility and personal hygiene. Singapore's approach to manage public fear and panic was through ensuring transparency and building trust (Menon & Goh, 2005). Since earning the trust of the public was not a given, political leaders had to be seen as doing and initiating a series of countermeasures to reassure the public. One good example was demonstrated by Singapore's Senior Minister Lee Kuan Yew who told the media how he never left home without his thermometer while Prime Minister Goh Chok Tong lunched with local media editors at a hotel restaurant to show Singaporeans that it was safe to be in public places ("PM Goh Says", 2003). Goh deliberately used the story of people's sacrifices during SARS to further indicate the type of character that all Singaporeans should embrace:

> *I believe, however, that Singaporeans are made of sterner stuff. I believe they have fighting spirit. Otherwise, Singapore would have collapsed by now...Take for instance our doctors, nurses and other personnel working to help SARS-infected patients. They have conducted themselves magnificently throughout the crises. They have displayed great resolve, and a noble sense of professional responsibility. They have chosen courage over their fear of SARS...This is the kind of steel in our character that will see Singapore through hard times. We should honour them. (Goh, 2003)*

All these stories illustrated to the Singapore public the 'moral virtue' of political leaders setting an example. By showing the people that government leaders practised what they preached, the examples served to 'naturalise' and 'legitimise' the public discourse of 'social responsibility' and 'sacrifice' for all Singaporean citizens.

Conclusion

The world today is more inter-connected than ever before. International travel, transnational trade, and cross-border migration have drastically increased as a consequence of globalisation. In response to these developments, the approach needed to combat a pandemic must also be standardised. Public health control measures such

as case management, surveillance, physical distancing, and school closures require wide-spread support from the general public for them to be effective. Meanwhile, Singapore's experiences with SARS and H1N1 also strongly suggest that a control measure can be effective only when a range of partners and stakeholders (such as government ministries, non-profit organisations, and grass-roots communities) become adequately involved. Unilateral actions are simply insufficient and ineffectual.

This article discussed the health control measures introduced as well as the insights drawn from the Singaporean experience in response to SARS and H1N1. In our study of two public health emergencies, we have shown that there was fairly widespread public support for control measures that other countries were unwilling to adopt (such as social distancing and quarantine order). The two health crises revealed that public compliance is particularly effective and necessary to limit the spread of infectious diseases, especially at the early stage of disease containment. As it turned out, the population's receptiveness to these draconian measures was enhanced to a large extent through moral suasion and networked partnership between the government and the people; indeed, the efficacy of these public health control measures was profoundly related to these two crucial elements. While Singapore may be unique in many aspects, its experience highlighted the critical importance of adaptive governance, networked partnership, and moral suasion in ensuring transparency and public trust when confronting the outbreaks.

Epidemic control in Singapore can therefore lend itself to other countries in the region and beyond: a strong command and control governance structure that imposes clear and transparent orders to shape the crisis mentality of the people. The presence of such a governance structure and the extent to which it is utilised explains and predicts how well an epidemic can be successfully contained. Whether all of these aspects are transferrable elsewhere needs to be assessed in future analysis. Nonetheless, this unique discipline certainly has helped Singapore come out of public health crises on a regular basis.

References

Aimone, F. (2010). The 1918 Influenza Epidemic in New York City: A Review of Public Health Response. *Public Health Reports, 125*(Suppl 3), 71-79.

Aledort, J. E., Lurie, N., Wasserman, J., & Bozzette, S. A. (2007). Non-pharmaceutical Public Health Interventions for Pandemic Influenza: an evaluation of the evidence base. *BMC Public Health, 7*, 208. Retrieved 3 April 2012 from http://www.biomedcentral.com/1471-2458/7/208

Ansell, C., Boin, A., & Keller, A. (2010). Managing Transboundary Crises: Identifying the Building Blocks of an Effective Response System. *Journal of Contingencies and Crisis Management, 18*(4), 195-207.

Barrett, S. (2007). The Smallpox Eradication Game. *Public Choice, 130*(1-2), 179-207.

Bhatia, R., & Narain, J.P. (2010). The challenge of emerging zoonoses in Asia Pacific. *Asia Pacific Journal of Public Health, 22*(4), 388-394.

Briand, S., Mounts, A., & Chamberland, M. (2011). Challenges of global surveillance during an influenza pandemic. *Public Health, 125*, 247-256.

Bruine, de B. W., Fischhoff, B., Brilliant, L., & Caruso, D. (2006). Expert judgments of pandemic risks. *Global Public Health, 1*(2), 1-16.

Centers for Disease Control and Prevention. (2003, 9 May). Editorial Note to: Y. S. Leo et al., Severe Acute Respiratory Syndrome – Singapore, 2003. *Morbidity and Mortality Weekly Report, 52*(18), 411. Retrieved 8 May 2012 from http://www.cdc.gov/mmwr/PDF/wk/mm5218.pdf

Cutter, J. (2008). Preparing for an influenza pandemic in Singapore. *Annals, Academy of Medicine, Singapore, 37*, 497-503.

Cutter, J. L., Ang, L. W., Lai, F. Y. L., Subramony, H., Ma, S., & James, L. (2010). Outbreak of pandemic influenza A (H1N1-2009) in Singapore, May to September 2009. *Annals, Academy of Medicine, Singapore, 39*, 273-382.

Duncanson, J. (2003, 25 April). How Singapore Avoided WHO Advisory. *Toronto Star*. Retrieved 8 May 2012 from http://www.singapore-window.org/sw03/030425ts.htm

Fung, A. (2003, 9 April). SARS: How Singapore outmanaged the others. *Asia Times Online*. Retrieved 8 May 2012 from http://www.atimes.com/atimes/China/ED09Ad03.html

Goh, C. T. (2003, 29 April). Speech by Prime Minister's May Day message 2003. Retrieved 8 May 2012 from https://gpxsvr3.np.edu.sg/apps5/lib/reference/refenq.nsf/c0ccd7b5848a4643c8256686000eea16/8bafeea05e4180a148256fdb000481f5/$FILE/GCTMayDay2003.doc

Goh, K. T., Cutter, J., Heng, B. H., Ma, S, Koh, B. K. W., Kwok, C., et al. (2006). Epidemiology and Control of SARS in Singapore. *Annals, Academy of Medicine, Singapore, 35*, 301-316.

Gostin, L. (2006). Public health strategies for pandemic influenza: ethics and the law. *The Journal of the American Medical Association, 295*(14), 1700-1704.

Ho, K. L. (2003). SARS, Policy-making and Lesson-drawing. In T. Koh, A. Plant, & E. H. Lee (Eds), *The New Global Threat: Severe Acute Respiratory Syndrome and Its Impacts* (pp. 195-206). Singapore: World Scientific Publishing.

't Hart, P., Rosenthal, U. & Kouzmin, A. (1993). Crisis Decision Making: The Centralization Thesis Revisited. *Administration and Society, 25*(1), 12-45.

Infectious Disease Act. (2003). *Singapore Government – Attorney-General's Chambers*. Retrieved 23 April 2012 from http://statutes.agc.gov.sg/aol/search/display/view.w3p;page=0;query=CompId%3A36018f92-ded1-4567-96aa-4c192da67e58;rec=0

James, L., Shindo, N., Cutter, J., Ma, S., & Chew, S. K. (2006). Public health measures implemented during the SARS outbreak in Singapore, 2003. *Public Health, 120*, 20-26.

Jeffries, D. J. (1995). Viral hazards to and from health care workers. *Journal Hospital Infection, 30*(Supplement), 140-155.

Lai, A. Y., He, A. J., Tan, T. B., & Phua, K. H. (2009). A Proposed ASEAN Disaster Response, Training and Logistic Centre: Enhancing Regional Governance in Disaster Management. *Transition Studies Reviews, 16*(2), 299-315.

Lai, A. Y. (2009). Shaping the Crisis Perception of Decision Makers and Its Application of Singapore's Voluntary Contribution to Post-Tsunami Reconstruction Efforts. *Journal of Administration and Governance, 4*(2), 1-12.

Lai, A. Y. (2012). Organizational Collaborative Capacity in Fighting Pandemic Crises: A Literature Review from the Public Management Perspective. *Asia-Pacific Journal of Public Health, 24*(1), 1-14.

Lanard, J. (2004). WHO Expert Consultation on Outbreak Communications – Singapore's SARS Outbreak Communications. Retrieved 8 May 2012 from http://www.psandman.com/articles/sarscomm.htm

LaPorte, T. R. (2007). Critical Infrastructure in the Face of a Predatory Future: Preparing for Untoward Surprise. *Journal of Contingencies and Crisis Management, 15*(1), 60-64.

Leo, Y. S. (2011). *Pandemic Preparedness and Responses: Lessons from Singapore's Immediate Past Experiences*. Presentation at the International Pandemic Preparedness and Response Conference, Singapore, 18-19 April 2011.

Lipsitch, M., Cohen, T., Cooper, B., Robins, J. M., Ma, S., James, L. et al. (2003). Transmission dynamics and control of severe acute respiratory syndrome. *Science, 300*, 1966-1970.

Leung, G. M., & Nicoll, A. (2010). Reflections on Pandemic (H1N1) 2009 and the International Response. *PLoS Medicine, 7*(10). Retrieved 18 May 2012, from http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000346

Menon, K. U., & Goh, K. T. (2005). Transparency and trust: risk communications and the Singapore experience in managing SARS. *Journal of Communication Management, 9*(4), 375-383.

Menon, K. U. (2011). *Pigs, People and a Pandemic: Communicating Risk in a City-state* (NTS Working Paper Series No. 6). Singapore: RSIS Centre for Non-Traditional Security (NTS) Studies.

Ministry of Health. (2003). Chronology of SARS Events in Singapore. Retrieved 3 April 2012 from http://www.moh.gov.sg/corp/sars/news/chronology.html

Ministry of Health. (2009). Outbreak of pandemic influenza A (H1N1-2009) in Singapore, May-September 2009. *Epidemiological News Bulletin, 35*, 39-48.

Pereira, D. (2008). *Crisis Management in the Homefront*. Presentation at Network Government and Homeland Security Workshop, Singapore, 7 January 2008.

Pittet, D. (2001). Improving adherence to hand hygiene practice: a multidisciplinary approach. *Emerging Infectious Disease, 7*(2), 234-240.

PM Goh Says IMH Suspects 99% All SARS Free, Super Good News. (2003, 17 May). *Channel News Asia*. Retrieved 13 May 2012 from http://www.sgcollect.com/forum/index.php?showtopic=4914

Reddy, M. C., Paul, S. A., Abraham, J., McNeese, M., DeFitch, C., & Yen, J. (2009). Challenges to Effective Crisis Management: Using Information and Communication Technologies to Coordinate Emergency Medical Services and Emergency Department Teams. *International Journal of Medical Informatics, 78*, 259-269.

Reynolds, B., & Seeger, M. W. (2005). Crisis and Emergency Risk Communication as an Integrative Model. *Journal of Health Communication, 10*, 43-55.

Singapore Imposes Quarantine to Stop SARS Spreading. (2003, 25 March). *ABC News Online*. Retrieved 8 May 2012 from http://www.abc.net.au/news/2003-03-25/singapore-imposes-quarantine-to-stop-sars-spreading/1823362

Shalala, D. E. (1998). Collaboration in the Fight against Infectious Diseases. *Emerging Infectious Diseases, 4*(3), 355-358.

Tan, C. C. (2003). *National Responses to SARS: Singapore*. Presentation at WHO Global Conference on Severe Acute Respiratory Syndrome (SARS), 17-18 June 2003. Retrieved 24 April 2012 from http://www.who.int/csr/sars/conference/june_2003/materials/presentations/sarssingapore170603.pdf

Tan, C. C. (2006). SARS in Singapore – key lessons from an epidemic. *Annals, Academy of Medicine, Singapore, 35*, 345-349.

Tay, J., Ng, Y. F., Cutter, J., & James, L. (2010). Influenza A (H1N1-2009) Pandemic in Singapore – Public Health Control Measures Implemented and Lessons Learnt. *Annals, Academy of Medicine, Singapore, 39*, 313-324.

Tay, C. B., & Mui, W. K. (2004). *An Architecture for Network Centric Operations in Unconventional Crisis: Lessons Learnt from Singapore's SARS Experience*. Thesis of Naval Postgraduate School, California, USA.

Teo, P., Yeoh, B. S. A., & Ong, S. N. (2005). SARS in Singapore: surveillance strategies in a globalizing city. *Health Policy, 72*(3), 279-291.

Toh, M. P. H., Kannan, P., Chen, Y., Chng, F. L. C., & Tang, W. E. (2012). Healthcare Workers and H1N1 Vaccination: Does Having a Chronic Disease Make a Difference? *Vaccine, 30*(6), 1064-1070.

Voo, T. C., & Capps, B. (2010). Influenza Pandemic and the Duties of Healthcare Professionals. *Singapore Medical Journal, 51*(4), 275-281.

Webby, R. J., & Webster, R. G. (2003). Are We Ready for Pandemic Influenza? *Science, 302*, 1519-1522

World Health Organization. (2003). Summary of probable SARS cases with onset of illness from; 1 November 2002 to 31 July 2003 (based on data as of the 31 December; 2003). Retrieved 3 April 2012 from http://www.who.int/csr/sars/country/table2004_04_21/en/index.html

World Health Organization. (2005). *WHO guidelines on the use of vaccines and antivirals during influenza pandemics*. Geneva, Switzerland: Word Health Organization. Retrieved 23 March 2012 from http://www.who.int/csr/resources/publications/influenza/11_29_01_A.pdf

World Health Organization. (2009). *Global Outbreak Alert & Response Network' Global alert and response*. Retrieved 1 April 2012 from http://www.who.int/csr/outbreaknetwork/en/

World Health Organization Writing Group. (2006). Nonpharmaceutical interventions for pandemic flu. *Emerging Infectious Disease, 12*(1), 81-87.

Yeoh, E. L. (2003, 9 April). Singapore Woman Linked to 100 SARS Cases. *Associated Press*. Retrieved 13 May 2012 from http://www.ph.ucla.edu/epi/bioter/singaporewomanSARS.html

On the Edge of Crisis: Contending Perspectives on Development, Tourism, and Community Participation on Rote Island, Indonesia

Cassandra Wright[1] & Belinda Lewis[2]

Citation Wright, C., Lewis, B. (2012). On the Edge of Crisis: Contending Perspectives on Development, Tourism, and Community Participation on Rote Island, Indonesia. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 102-127.

The eastern Indonesian province of Nusa Tenggara Timur (NTT) is struggling to overcome the burden of widespread poverty, illness, and illiteracy. Within the context of globalisation and Indonesia's ongoing transitions in governance, people on Rote Island, NTT, are experiencing rapid socio-cultural change. The increasing arrival of tourists and foreign business interests add further complexity to these processes of transition. The direction forward for Rote is a topic of considerable debate amongst community members, development workers, businesses, and other stakeholders. This qualitative pilot study explores key community stakeholders' perspectives on development, tourism, and community sustainability in Delha, Rote. It has revealed conflicting perspectives about future development and tourism on Rote, with particular concern regarding social, cultural, and environmental impacts, and loss of autonomy and community control. Important 'dynamics of exclusion' between stakeholders are identified. More equitable participation in planning and decision-making is needed to ensure that the benefits of tourism and development are not concentrated with a privileged few.

Keywords: *Nusa Tenggara Timur; Social Change; Culture; Globalisation; Tourism*

Die indonesische Provinz Nusa Tenggara Timur (NTT) ist mit weitverbreiteter Armut, Krankheiten und Analphabetismus konfrontiert. Im Kontext der Globalisierung und Indonesiens politischer Transformation vollzieht sich ein rascher soziokultureller Wandel auf der Insel Rote, NTT. Eine steigende Zahl an TouristInnen sowie ausländische Unternehmensinteressen verschärfen die komplexe Übergangssituation. Der weitere Entwicklungsweg für Rote ist Gegenstand zahlreicher Debatten zwischen Community-Mitgliedern, EntwicklungshelferInnen, Unternehmen und anderen AkteurInnen. Die vorliegende qualitative Vorstudie untersucht zentrale Perspektiven unterschiedlicher AkteurInnen in Bezug auf die zukünftige Entwicklung Rotes und legt besonderes Augenmerk auf soziale, kulturelle und ökologische Auswirkungen sowie den Verlust von Autonomie und gemeinschaftlicher Kontrolle. "Ausschlussdynamiken" zwischen den AkteurInnen werden identifiziert. Gleichberechtigte Partizipation in der Planung und Entscheidungsfindung ist entscheidend um sicherzustellen, dass die Vorteile von Tourismus und Entwicklung nicht nur auf wenige Privilegierte beschränkt bleiben.

Schlagworte: *Nusa Tenggara Timur; sozialer Wandel; Kultur; Globalisierung; Tourismus*

www.seas.at SEAS doi 10.4232/10.ASEAS-5.1-6

creative commons BY-NC-ND

1 Cassandra Wright holds an Honours degree of the Bachelor of Health Science (Health Promotion) from Monash University, Australia. Her main research interest area is health promotion in both local and international contexts, and her current research is focused on the evaluation of a major Australian government health promotion initiative. Contact: cassandra.wright@monash.edu

Introduction

This paper reports on research exploring key community stakeholders' perspectives on the relationships between development and community sustainability in the Delha community of Rote Island, Nusa Tenggara Timur (NTT) province, Indonesia. As in most of eastern Indonesia, NTT is geographically isolated from the rapid industrialisation of the western side of the nation, where the majority of the country's economic activity takes place (Barlow & Gondowarsito, 2007; Carnegie, 2008). The province has been of little interest to commercial investors, and there has been inadequate government investment in basic infrastructure essential for health (water, sanitation, power), healthcare, and education services. Therefore, many communities continue to experience inflated transport costs, widespread illiteracy, and illness (Barlow & Gondowarsito, 2007).

Rote is the southern-most inhabited island of Indonesia (see Figure 1), and lies only 500 kilometres from mainland Australia. Despite its geographic proximity to Australia, Rote is extremely isolated in terms of access. There are no direct commercial flights from any international airport into Rote, including from Australia. Access to

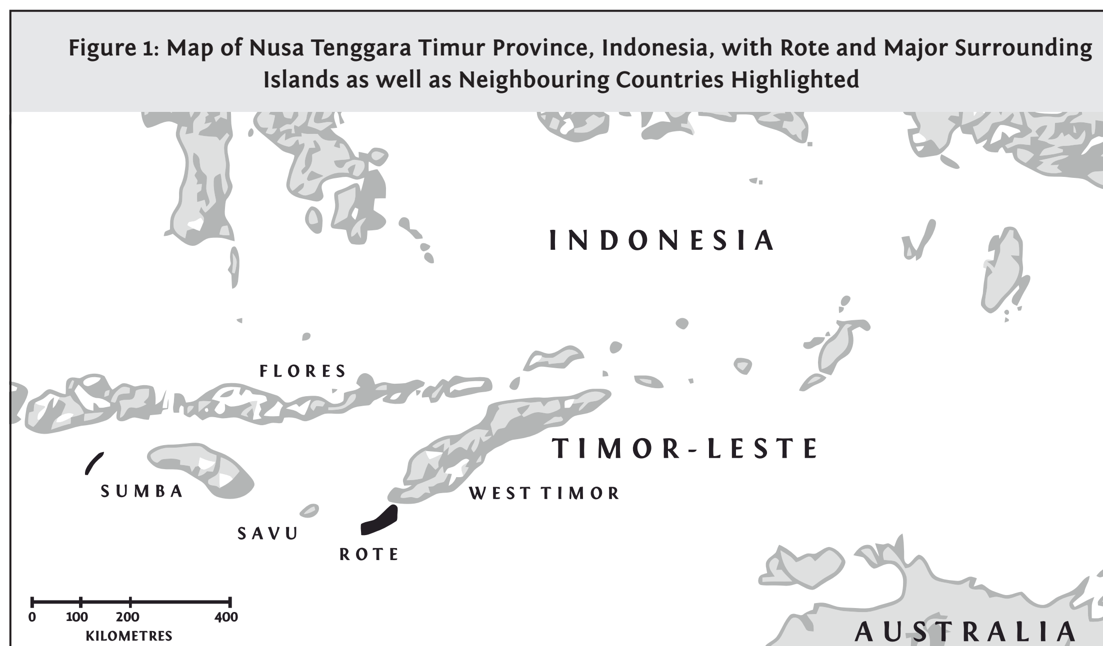


Figure 1: Map of Nusa Tenggara Timur Province, Indonesia, with Rote and Major Surrounding Islands as well as Neighbouring Countries Highlighted

Source: Adapted from Carnegie, 2008

2 Belinda Lewis has a PhD in Health Promotion, and has worked as a practitioner, researcher, and health promotion consultant. Her most recent book is *Bali's Silent Crisis: Desire, tragedy and transition*. Her forthcoming book is *Health Communication: a media and cultural studies approach*.

the closest international airports in Kupang, West Timor, or Dili, Timor-Leste, require an overland bus trip followed by a two-hour ferry transport to the island. The population of Rote is 119,711 (Badan Pusat Statistik Republik Indonesia, 2010).

Despite its geographic isolation, Rote has a complex history, blending the development of local custom and distinctive community practices with ongoing interactions through trade and cultural exchange (Carnegie, 2010; Fox, 1977). Rote's maritime context has ensured continued contact with other peoples, particularly through religious missions, commerce, and colonisation. Traditionally, social hierarchies have been organised around the harvest of the lontar palm (*Borassus flabellifer*) (Barlow & Gondowarsito, 2007; Fox, 1977). The functional significance of the lontar palm is related to the difficult climatic conditions endured by islanders (Fox, 1977); the area suffers a long dry season, with sporadic rainfall inadequate for sustainable agricultural yield (Barlow & Gondowarsito, 2007). The lontar palm juice, tree, and oil have provided sustenance during famine, material for building housing, and means of income for the Rotinese through history (Carnegie, 2010; Fox, 1977). In addition, the Rotinese currently rely on subsistent agriculture, fishing and more recently, a seaweed farming industry initiated by the Australian Agency for International Development (AusAID) in 2001 as their means of survival and income (Barlow & Gondowarsito, 2007; Carnegie, 2008).

Living conditions are basic as there is no reticulated water supply or waste management, and most of the population do not have access to electricity and other infrastructure. Recent statistics highlight the extent of poverty, showing that residents of NTT live on one-third of the average income of Indonesians (Resosudarmo & Jotzo, 2009, p. 4). Recent literature states that poverty is concentrated in rural areas where the majority of people live and highlights that most people are in fact living on less than USD 1 per day (Carnegie, 2008; Resosudarmo & Jotzo, 2009).

Indonesia is still considered to be undergoing transition to democratic decentralisation, with several reforms taking place since the dismantling of Suharto's military dictatorship, the New Order Regime, in 1998. The *reformasi* represented the end of a highly autocratic and nepotistic leadership with hopes of bringing power closer to the people. Extensive Indonesian Studies literature has been written to analyse the associated economic, political, and socio-cultural transitions at a broader level (Erb, 2011; Furqan & Som, 2010; Kristiansen & Santoso, 2006; Phelps, 2004), but relatively

little attention has been paid to the practical implications for specific provinces such as NTT (Cole, 2008; Sahin, Lewis, & Lewis, 2012). For remote and impoverished regions including NTT, investments in infrastructure, health, and education can have visible and life-changing outcomes for communities. There are currently concerns that the benefits of decentralisation have been offset by corruption (Erb, 2011; Furqan & Som, 2010; Sahin et al., 2012), and the limited publications capturing local perspectives indicate that regional needs are still felt to be largely ignored and not well-served by the new government structures (Fointuna, 2008; Kristiansen & Santoso, 2006; Resosudarmo & Jotzo, 2009; Sahin et al., 2012).

Rote has not been impervious to the ripple of wider political and economic changes in Indonesia and globally. Although structural development has thus-far been slow, people in particular areas such as the Delha region of West Rote are experiencing rapid socio-cultural changes associated with global communication technologies (TV, radio, Internet, mobile phones) and the increasing arrival of foreigners purchasing land and engaging in the local economy (Carnegie, 2008; Indigo Foundation, 2011). However, the current (lack of) infrastructure continues to profoundly affect people's health. Major issues include inadequacies of the health care system, difficulties with transportation and roads, and the aforementioned lack of basic necessities such as clean water provision and sanitation management. Furthermore, little work has been done to ensure the protection and sustainability of the environment for further development in NTT (Resosudarmo & Jotzo, 2009).

While improvements to the socio-economic conditions and infrastructure (which might accompany development and increased tourism) are welcomed by members of the Delha community, the specific direction forward for Rote is a topic of contentious debate (Indigo Foundation, 2011; van Sebille, 2001) and one worthy of documentation due to the potential implications for the local community. Of particular concern to the Rotinese in Delha is the potential for loss of autonomy and decision-making regarding the development of their community, loss of cultural traditions, and economic and environmental sustainability (Indigo Foundation, 2011).

There is a wealth of literature describing the effects of rapid development and change on developing regions of Indonesia (Barlow & Gondowarsito, 2007; Cole, 2008; Lewis & Lewis, 2009; Sahin et al., 2012). A key learning from this literature is that not all development is positive, and the model of development undertaken will determine

many outcomes for communities. Most studies of tourism-related development in Indonesia have focused on Bali, capturing the environmental, social, and cultural destruction which have accompanied growth in wealth and development (Hitchcock & Darma Putra, 2007; Howe, 2005; Lewis & Lewis, 2009). Conversely, there have been several studies which highlight the wide benefits of community-driven development, and participation in tourism (Cole, 2006; Timur & Getz, 2009). While there is only scant literature about Rote specifically (Carnegie, 2010; Fox, 1977), a number of studies have examined the dynamics of development and rapid socio-cultural change in other areas of eastern Indonesia (Cole, 2006; 2008; Sahin et al., 2012). Several of these studies highlight the complex impacts on health, well-being, and sustainability of communities (Cole, 2008; Kristiansen & Santoso, 2006).

For the people of Delha, prospects of development present great potential to improve living conditions but also loom with threats to the community. Given the critical importance of considering community perspectives about development, and the lack of published literature focused on Rote, there is a need for research to explore the perspectives of multiple community stakeholders around the issue of development, tourism, community sustainability, and their roles within this process. Preliminary consultations (conducted by the secondary researcher and *Indigo Foundation*) have exposed the need for further research and have identified key issues of community concern regarding the process of development and its relationship with health in Delha. In-depth research into people's lived experience of development, and perspectives on the links between tourism and development on Rote would yield valuable findings to inform future development practice.

This study therefore aims to explore community perspectives on the relationships between development, tourism, and community sustainability in Delha. In the light of existing gaps in the literature, the research will provide insights into people's perspectives and experiences of the development and rapid social change currently taking place on Rote. Of priority is the identification of key issues of concern to different stakeholders, outlining the differences and commonalities in stakeholder groups. Given the small scope of this study, these will be preliminary findings that will provide the basis for more in-depth exploration in a larger qualitative research project.

Theoretical Underpinnings

The research was guided by two theoretical paradigms: Development Theory and Cultural Studies.

Firstly, theories of participatory, community-driven development (Bebbington, Dharmawan, Fahmi, & Guggenheim, 2004; Haslam et al., 2009), and sustainable tourism development (Cole, 2006; Graci & Dodds, 2010) provide an alternative to traditional top-down development models (Haslam et al., 2009) and were utilised to inform the development of research questions and data analysis. This literature also provided a framework for identifying the key players in development.

Secondly, a Cultural Studies paradigm allowed for reflection on the social and cultural context of rapid social and cultural transition in Rote. Key theoretical perspectives include “transculturalism” (Lewis, 2008, pp. 10-18 & p. 107) and cultural transition in the context of globalisation (Lewis, 2008, pp. 288-322). Cultural Studies is particularly interested in the cultural politics of ‘meaning-making’. It is concerned with the ways that discourse and everyday practice are related to knowledge, power, culture, and processes of change (Lewis, 2008; Lewis & Ridge, 2005). This theoretical framing provided a useful lens through which to understand the heterogeneity of local views and the interactions and disputes over meaning associated with social, economic, and cultural transition.

Methodology

Study Design

The research consisted of a small, qualitative pilot study, analysing in-depth interviews with 11 key stakeholders in development in Delha. For pragmatic reasons relating to the short time frame, lack of funding, and limited scope of this study, all research was conducted from Australia. Stakeholders were identified by the research team in a preliminary study on Rote, which enabled the current research to be conducted from a distance. All identified stakeholders were contactable on Rote via phone or were in Australia at the time of the study.

The project feeds into an Action Research Cycle, which involves the work of two aid organisations: *Indigo Foundation*, an Australian development organisation, and their local partner *Lua Lemba Community Development and Education Organisation*, a Rotinese community initiative. Ethics approval was granted by the Monash University Human Research Ethics Committee, and the study was approved and supported by Indigo Foundation and Lua Lemba. All participants' names have been replaced with pseudonyms in order to protect confidentiality.[3]

Qualitative methods can be used to gain a deeper understanding of phenomena, rather than simply identifying patterns and trends (Liamputtong, 2009). They have an emphasis on meaning and interpretation from the perspective of the participants (Denzin & Lincoln, 2008 in Liamputtong, 2009, p.xi). Individual interviews were chosen as an appropriate method for data collection, in part because the study was conducted at a distance from the research setting but also largely because formative research indicated that development is a strongly contested issue and there are substantial differentials in power and social status between stakeholders in Delha. Liamputtong (2009) suggests that participants are more likely to provide richer and full data in individual interviews when researching areas which are sensitive or contentious. A second strength of qualitative research is its capacity to uncover and understand phenomena, particularly where there is little existing knowledge (Corbin & Strauss, 2008). This is particularly relevant for Rote, where development processes and people's perspectives about these processes have not been formally studied and documented.

Sampling Strategies

The study utilised purposive sampling, a non-probability sampling technique common to qualitative research (Patton, 2002). Purposive sampling involves the deliberate selection of specific individuals because of the crucial information that they can provide that cannot be obtained adequately through other channels (Carpenter & Suto, 2008 in Liamputtong, 2009, p. 11). Patton (2002) discusses the power of this

3 Because Delha is a very small community, it was important to further protect respondents' confidentiality in reporting the findings. Any descriptive information about participants would make it extremely easy for readers to identify the source of specific quotes. Thus, in order to minimise potential stress and further community division, the researchers have provided only minimal descriptive information.

method to lie in accessing information-rich cases, which offer in-depth understanding and insights into the findings. The sample size consisted of 11 participants. Sample size was determined according to two priorities. The first was to fill all sections of the sampling frame (see Table 1). The second was to achieve data saturation in relation to the themes arising from the preliminary analysis. Sampling was also guided by principles of equitable gender representation.

Stratified, maximum variation sampling technique was conducted, which involves the purposeful selection of participants with variation in a characteristic of interest (Patton, 2002). According to Minichello, Sullivan, Greenwood, and Axford (2004), this is a particularly useful technique for research where little is known as it can provide a wide scope for understanding the issues.

Contemporary Development Theory acknowledges that there are four key groups of actors in development. Given the importance of this theory in understanding development processes, stratification was based on the framework of 'actors in development' provided by Haslam et al. (2009) to explore stakeholder groups. Participants were then recruited from each of these groups in order to ensure that multiple perspectives were represented – while bearing in mind the limited size and scope possible within this preliminary pilot study. Sampling aimed to include key community stakeholders, both local and non-local, with a broad range of 'interests' in development of Rote (see Table 1).

This pilot study seeks to complement the existing more general, local-centred need analyses conducted by Indigo Foundation with specific and detailed data about

Table 1: Sampling Frame

	LOCAL	NON-LOCAL
GOVERNMENT	Doctor (F) University academic (F)	Dentist (F)
CIVIL SOCIETY / NGOs	Lua Lemba rep and teacher (F) Lua Lemba rep and teacher (M)	Indigo Foundation rep (F) Indigo Foundation rep (M)
COMMUNITY MEMBERS	(overlap of all other local categories here)	Foreign resident (M)
PRIVATE SECTOR	Land agent/business owner (M) Tourism operator (M)	Business owner (M)

Authors' compilation, based on Haslam et al. (2009)

the perspectives of additional stakeholders. The study includes key informants of local and non-local origin for two main reasons: 1) these perspectives are potentially competing and it is important to draw out the main areas of contention and contradiction, and 2) it is important to ensure that all stakeholder groups in development are represented so that pathways and structures for collaborative development practice can be negotiated.

As the primary researcher does not speak Indonesian, and most Rotinese have poor English speaking skills and literacy, it was therefore appropriate to only access stakeholders who could competently speak English and were available either to meet in Australia or be interviewed by phone from Rote. No other exclusion criteria applied.

Data Analysis

This study used modified Grounded Theory to identify themes which emerged from the data during the analysis process (Corbin & Strauss, 2008). The thematic analysis then proceeded as an iterative process (Corbin & Strauss, 2008; Minichello et al., 2004).

As discussed earlier, this study was further informed by the theoretical perspectives of Development Theory and Cultural Studies. These theoretical frameworks were used to extend the Grounded Theory approach. The emergent themes were examined in relation to these theories in a cyclical and reflexive manner. This enabled the researchers to adopt a more theoretically informed, critical, and holistic perspective when reporting the findings (Minichello et al., 2004). Preliminary data analysis began after the first three interviews were conducted and continued concurrently with ongoing data collection.

Findings and Discussion

This section presents a synthesis of key findings and their discussion in relation to existing literature and relevant theories of development and community sustainability. Of the many themes which emerged from the data, four themes were selected

for detailed analysis and discussion based on their relevance to the research question. These themes also provide insights into several key areas of contention between stakeholders. The first theme focuses on overarching notions of inclusion and exclusion that permeated throughout each of the other themes. Three other significant themes are then discussed, which explore issues of tourism, development, and socio-cultural changes. These include: unfettered development, contending perspectives on tourism, and negotiating cultural transitions.

Exclusion and Power Asymmetries: 'Insiders' and 'Outsiders'

As the research unfolded, it became apparent that there were forces of exclusion and power differentials operating between different groups within the community of Delha. The interviews were threaded with notions of who fits 'inside' or 'outside' the community and many comparisons were made between particular groups (or individuals) who did or did not 'belong'. Short-term tourists were, for many local informants, explicitly seen as outsiders. Foreign residents and business owners were similarly seen as outsiders by informants from all other groups, though some felt they had built networks with particular groups that granted them 'insider' status. Development workers were labelled as outsiders by several local residents but commented that from their own perspective, they felt they had a 'special' (inside) role in the community. Indonesian migrants were granted 'local' status by other outsider groups (such as foreign land-owners, tourists, and development workers) but were often themselves seen as outsiders to Rotinese locals, who were seen as the ultimate insiders by everyone. Each of these comparisons involves a sense that the 'other' is an outsider to the community and/or culture and therefore does not have as legitimate a claim to being a 'stakeholder'.

While this insider/outsider discourse is potentially a way of creating cohesion and cultural stability within a community, it can also give rise to practices of exclusion which marginalises 'others' (Reid, 1999). It reflects a struggle for power; while 'outsiders' have more economic power and access to decision-makers, locals use operations of exclusion to establish their own mechanisms for community control (Reid, 1999). This process of 'othering' (Riggins, 1997) can also obstruct progress towards collaborative approaches to development and problem-solving (Reid, 1999). This dy-

namic is common within communities experiencing rapid social change associated with development while at the same time becoming more culturally hybridised (Connor & Vickers, 2003; Lewis & Lewis, 2009). Exclusion of individuals or groups from participation in society undermines social cohesion; it can also give rise to stigma, discrimination, and conflict within communities (Keleher & MacDougall, 2011). The practical implications of this finding for community development and sustainability will be discussed further in the following themes.

Unfettered Development: Crisis and Opportunity

> *The development is unfettered . . . They're making the same mistakes that everybody in the world ever made. We can't condemn them for that but it's happening. (Cathy, foreign, personal communication, 23 April 2011)*

Informants, both local and foreign, shared concerns about the pace and control of development on Rote, especially as none knew of any current formal planning. Locals and development workers in this study were particularly concerned about the implications of this for local ownership of land and access to beaches, which hold significance for the livelihoods of local fishermen and seaweed farmers. Many saw existing resources and infrastructure (such as water, electricity, and land space) as 'natural' limiting factors for development and tourism on the island. Several local informants felt this would prevent tourism from becoming 'Bali style', referring to both the magnitude of tourism in Bali and the negative consequences seen there. Foreign informants tended to disagree, viewing development and tourism as a 'juggernaut' requiring careful management. There was a consistent view that the responsibility of managing development lay primarily in the hands of the government and it was common to hear that this role was being neglected or improperly managed. Several foreign informants spoke with a wariness of the government's pro-development stance.

> *They came to me and said they're prepared to waive any tax, give me any permits if I wanted to encourage tourism . . . But you just can't go along the coast willy-nilly without thinking of the consequences – the sewerage, the water and everything else. They're not thinking about that, they just want more bums on seats. (John, foreign, personal communication, 8 May 2011)*

> *The local governments . . . typically want to take it [development] as fast and furious as they can . . . They have all the tools in place to control it, they just don't [control it]. (Jim, foreign, personal communication, 13 July 2011)*

All stakeholders agreed that improvement to infrastructure and services were necessary and important for the living conditions of people on Rote, however, foreign stakeholders felt that there were also benefits of Rote's 'under-developed state'. The basic conditions were viewed as the main barrier to increased tourism. Foreign informants saw this as a protective factor as they felt the island was underprepared for the 'wrath' of development. All local informants believed that infrastructure should be a top priority, to improve community health, for community amenity, and to facilitate increased tourism. Health promotion literature emphasises the importance of environmental conditions in determining health outcomes (Commission on the Social Determinants of Health, 2008). Improvements to infrastructure in Delha would likely lead to improved community health. However, if as predicted, the improved infrastructure also leads to increased tourism this becomes a paradoxical solution for the Rotinese.

Tourism development literature warns of the environmental destruction associated with rapid and uncontrolled increases in tourism numbers in the absence of planning for longer-term sustainability (Graci & Dodds, 2010; Muhanna, 2006). As demonstrated in other provinces, such as Bali and Lombok, this can also have profound impacts on the livelihoods, health, and security of local people (Lewis & Lewis, 2009). In the current study, development workers commented that foreign visitors and residents could potentially play an important role in creating demand and lobbying for increased infrastructure, especially considering their privileged relationships with government. Locals further pointed out that while happy to donate funds to education and health services, tourists and foreign residents did not donate to infrastructure despite requests. This was commonly attributed to vested interests in keeping the destination 'quiet' for themselves to enjoy: "The tourists here don't want to give money for infrastructure here. . . . They don't want too many other foreign people" (Aaliyah, local, personal communication, 10 August 2011).

However several locals did also identify an alternative reason, citing that foreign people felt that infrastructure was a "responsibility from the government" and that "they don't want to involve because the government here is so very *korupsi* [corrupt]" (Aaliyah, local, personal communication, 10 August 2011).

This disjuncture between foreign stakeholders' 'good intentions' and how they are perceived by the local stakeholders was a common theme. As mentioned, many

local informants were concerned about decreasing beach access due to foreign land control along the coast. One foreign land-owner provided a contrasting explanation for the foreign land uptake, saying that investors were making a concerted attempt to protect the local community by developing their own methods of regulating development where government was lacking.

> *There was a conscious decision by the Westerners to buy and lease as much land along the coast to prevent it [rapid development]. It's not a selfish outlook. It's to give them time and space because these people are being fed information by the government of Rote . . . that they need development quick, to make it look like Bali. We just know from . . . the very, very many experiences from across the globe that it's not going to work there. Because of the scarcity of water, scarcity of food, and the infrastructure . . . I'm a firm believer in what we're doing is a good thing. (John, foreign, personal communication, 8 May 2011)*

A frequently mentioned example of this 'misunderstood' protective behaviour was of the sand-mining on local beaches. A foreign investor explained:

> *We were told by the local government that sand-mining was illegal . . . We didn't want to invest in a place where people could come and just start taking all the sand . . . As foreign investment money was coming in, all of a sudden the locals had a little bit more money . . . So instead of living in a grass roof thatch wall home, they started building houses with cinder blocks and pinned roots. But to build those houses they needed to have cement. To make the cement they need sand. So they started going down to the beaches and taking sand. It starts off as a few truckloads, the next thing you know it's hundreds and hundreds of truckloads of sand being taken off the beach. And they have no education as to how sand and erosion works, they just see a lot of sand – What's the big problem? It took me five years of complaining to the government – 'Hey this sand-mining's going on, you have to stop this!' He told us he would . . . Nothing happened until enough land had been leased across the front of West Rote here. Access for the trucks to get to the beach got blocked by the foreign investors who didn't want trucks being driven across the land or sand-mining going on. . . . Well, the villagers got all angry because they thought the Westerners were trying to take over their village. When all we were really trying to do is preserve the beach. (Jim, foreign, personal communication, 13 July 2011)*

In this case, it took many years of disagreement before changes were made to preserve the natural environment. One foreign informant felt that residents and investors toe "a fine line between vested interest and convincing them [the local community] of what they really need for their future" (Jim, foreign, personal communication, 13 July 2011). Some locals talked about a change in their attitudes, whereby they now agree that foreign stakeholders were acting with good intent with regards to beach conservation.

> *We had the bad habits of collecting the sand from the beach to make buildings. That has been stopped because the land from the beach-front was taken over by the foreigners and now they protect it. (Ari, local, personal communication, 12 August 2011)*

Despite this apparent approval, there was a common local perception that there needs to be greater communication between foreign and local stakeholders and more equitable distribution of assistance.

> *We're needing more communication between the local people and the foreigners there. There's no communication . . . The foreigners, they have the mind to protect the local people but they have to have the same ideas for everybody, of what they can do to help the local people. (Ari, local, personal communication, 12 August 2011)*

A successful example of local and foreign stakeholders openly negotiating to achieve community protection is illustrated in the recent move toward local people leasing rather than selling their land. This initiative was driven by a local land agent, who explained that it was received well by the foreign investors, but initially more difficult to gain support of the locals.

> *In Nemberala from the beginning when people start to lose the land, I told the people in town, don't sell because if you sell your land, you'll be gone. You'll be moved from Nemberala so you don't have any place to stay for your kids . . . So just lease for 20 years . . . Even if they lease for 40 years but the land is still yours . . . The people didn't really understand that. (Paulus, local, personal communication, 29 July 2011)*

Many stakeholders noted that leasing land rather than selling was now the accepted standard practice in Delha. While some local informants were concerned about the sale and lease of land, most acknowledged this negotiation as being important for maintaining community control.

> *The land is not going to be taken over forever but only like a lease contract . . . I don't think the Chinese or anyone from other parts of Indonesia would come and only lease the land. But the foreigners here, Australians and Americans, they're there to lease the land, that is good. It will go back to us later, after 40 years. (Ari, local, personal communication, 12 August 2011)*

Many informants, both local and foreign, additionally agreed that there also needed to be greater communication between the local community and NGOs for assistance to be useful in the medium to long term. Examples were cited of aid organisations sporadically donating infrastructure, which quickly fell into disrepair due to inadequate engagement with the community to teach them how to properly use or maintain the equipment. NGOs with a long-term commitment and focus on empowerment approaches to development assistance such as Indigo Foundation were

more widely accepted because "the programs come from the community" (Martha, local, personal communication, 2 August 2011). However, one foreign informant was critical of the slow pace of this approach, noting that "they're going to need to do it for about 10 to 20 years at the rate they're doing it now" (Jim, foreign, personal communication, 13 July 2011).

Both local informants and development workers agree that a plan needs to be developed which actively engages 'the community'. However, this implies that the community is a homogeneous entity and denies the varied range of perspectives, interests, and power differentials of stakeholders on Rote, all of whom have an important role in development (Haslam et al., 2009). Current approaches of development organisations have thus far had a primary focus on building local capacity. Contemporary development literature endorses this approach but additionally emphasises the value of building partnerships between stakeholders to enhance the effectiveness and sustainability of practices.

In the setting of Delha, the 'outsider' status of foreigners currently presents a barrier to potentially valuable collaborations and hinders planning required for sustainable development and equitable health outcomes (Muhanna, 2006; Timur & Getz, 2009). According to Graci and Dodds (2010), plans need to be agreed on by all stakeholders involved, and communication and aligned vision between stakeholders is essential for this process. Whilst these suggestions are theoretically appealing, the current findings suggest that stakeholders in the Delha community see considerable barriers to collaboration and planning in practice. There are strongly conflicting perspectives about both the direction forward for Delha and how best to proceed. Without effective mediation of these conflicts, the possibilities for equitable and genuinely participatory development appear unlikely.

Contending Perspectives on Tourism

> *There are lots of tourists. That helps increase the community's income – although it's not everybody who benefits . . . There are also not just good things that affect people . . . but some don't see this. (Martha, local, personal communication, 2 August 2011)*

In general, there are very positive views of tourism across the community, however, there are also growing concerns that this confidence might be misplaced. Some

stakeholders talked about a 'dark side' of tourism-related development, which locals are not anticipating. Rote has recently seen a steady increase in foreign visitors, including both short and long-term tourists, foreign investors, and aid/development workers, largely concentrated in coastal areas around Delha. Stakeholders consistently viewed tourism as being an important source of income generation for local people, offering previously unavailable opportunities to young people for education and skill building: "When the tourists come here, they help people here to make some jobs and they give the people money . . . To help us to have a new chance to life" (Yuli, local, personal communication, 30 July 2011).

It was commonly reported that visitors to Delha have thus far showed generosity to the community by making substantial donations to the health centre and schools. This is encouraged by a donation system set up at the main resort in Nemberala. Both local and non-locals also viewed tourism as an exciting opportunity for cultural exchange and learning.

> *Most tourists have come to visit our school . . . and then give some help for us for the toys and books. And they help us to giving better information to the student about education. (Yuli, local, personal communication, 30 July 2011)*

> *Tourists give donations to the community, which is a very good thing. The community can improve their English by interacting with the tourists too. (Peni, local, personal communication, 21 July 2011)*

Most locals in this study said that they would like to see tourism increase in order to improve local livelihoods and there was an expressed expectation from many that the generosity and goodwill from visitors would continue. Interestingly, several local informants described Indigo Foundation representatives as 'good-natured tourists', and this would likely contribute to the positive impressions of tourism. However, in sharp contrast to this perspective, other locals articulated serious concerns that the community more broadly is unaware of the potential implications of larger scale tourism and was encouraging tourism based on naivety. This makes Delha extremely vulnerable to the potential harm caused by unregulated development and tourism.

> *It's trying to educate the stakeholders on the island that Bali's not the Holy Grail . . . You've got to remember that you're dealing with people who've got limited travel experience, limited knowledge, limited education. (John, foreign, personal communication, 8 May 2011)*

Some foreign investors attributed local naivety to the fact that currently, most tourists to Rote are 'low-impact' visitors. One foreign informant explained that the demographics and mentality of tourists are currently quite different to other tourism destinations such as Bali: "We have not had that young Westerner population that's coming here and wanting to party or do drugs . . . For now anyway" (Jim, foreign, personal communication, 13 July 2011).

This is seen to be a protective factor for the community. However, many informants showed great concern for what might happen 'if the flood-gates open' for tourism, expecting it to attract the 'wrong crowd'. Although this was primarily reported by foreign informants, all locals who had travelled to Bali showed equal concern.

> *If the place is changed, you never know, it might be that criminals come out too. And the prostitutes. I'm really expecting Nemberala is be the same as Bali . . . Bali right now is really bad . . . Criminals and prostitutes are everywhere. For me personally, I don't want Nemberala to be like Bali. (Paulus, local, personal communication, 29 July 2011)*

It was widely acknowledged by local community members that there were both positive and negative implications of tourism, but the negatives were seen as a reasonable trade-off for the increased income and opportunities: "They don't necessarily like everything tourism brings, but they feel that on balance, there's a benefit" (James, foreign, personal communication, 20 April 2011).

Several local stakeholders felt that this view was short-sighted and described a broad range of 'fears' they had for the medium/long-term future of Rote. Table 2 lists the current and potential impacts of tourism as perceived by local community stakeholders.

Another concern of local informants was whether community members had opportunities to actively engage in future tourism and development rather than act as passive bystanders. Tourism has been widely viewed as presenting great new opportunities to Rotinese young people, and the main tourism operators have explicitly taken an ethical approach to train and employ local people first. However, there are still concerns that foreign investors will continue to disproportionately benefit as there have been few observable opportunities for local control: "I'd like to see that local people also take part in the development and not just people from outside" (Martha, local, personal communication, 2 August 2011). Another stakeholder added:

Table 2: Current and Potential Impacts of Tourism in Delha, Rote Island

CURRENT POSITIVE IMPACTS OF TOURISM	**CURRENT NEGATIVE** IMPACTS OF TOURISM	**POTENTIAL FURTHER NEGATIVE** IMPACTS OF TOURISM
Opportunity for jobs and wealth generation	Loss of control over land/beach access	Foreigners reaping all benefits of development
Donations from visitors	Some beach pollution	Environmental degradation
Environmental protection initiatives	Pressure on natural resources	Loss of cultural traditions
Potential to improve infrastructure	Display of taboo behaviour	Cultural 'corruption' of young people
Learning opportunities		Sexual exploitation of youth
		Crime
		Drug use

Authors' own compilation based on interview findings

"I want the younger generations to be able to work and to have the job but I want them to be able to create their own work" (Ari, local, personal communication, 12 August 2011).

Development workers showed similar concerns for the power asymmetries between foreign landowners and local community members.

> *They [foreign landowners] kind of sit on top of the community, but there's no vertical unity to it. They might have local people cook for them or clean their house . . . They feel that they're benefitting the community by paying their housekeepers a very generous wage. It's not working in a lot of ways. It's leading to inflation in the markets and a distorted view of Westerners. (Cathy, local, personal communication, 23 April 2011)*

The findings suggest that the flow of benefits from development and tourism into the community has been largely inequitable, with the majority of the benefits reaped by people not originally from Rote. The tourism operators' decision to train local young people has the potential to empower those involved by enhancing their skills and self-efficacy, however, leaves others remaining impoverished and without livelihoods or economic security. The difference between this approach and a true community-driven approach is the opportunity to participate in decision-making and therefore take some control, which is not currently well established. Sustainable tourism literature indicates that for tourism and development to benefit the local community in a long-term and sustainable manner, there is also a need for support of local

enterprises (Cole, 2006; Muhanna, 2006). This would assist in extending the reach of tourism-related benefits across the local community in a more equitable manner.

Literature documenting other tourism developments in Indonesia indicates that continuation of the current 'open slather' development may potentially have disastrous implications for the natural environment and the livelihoods of the local community (Hitchcock & Darma Putra, 2007; Nutbeam, 1996). Considering the widespread concerns about local comprehension of these negative consequences, the foreign stakeholders feel that they are playing an important role in protecting the community from tourism mismanagement. However, their current approach perpetuates the exclusion of locals from playing a fuller role in participating in tourism development. This further supports the need for integrated planning and communication between various stakeholders.

Negotiating Cultural and Socio-economic Transitions

> *Lots of tourists from different cultures are coming . . . The kids, they're shocked with the different culture. They're comparing the culture with which one is good or which one is better. (Martha, local, personal communication, 2 August 2011)*

While Rote has its own distinctive cultural modes and practices (Fox, 1977), the island has a long history of interaction with other social groups, religions, and cultural frames. According to Carnegie (2010), the Rotinese have over many decades successfully mediated the interaction of ethnicities and religions through *adat* (customary law) to produce low-conflict communities. More recently, in Delha the community has seen rapid cultural shifts arising from increased global and local interconnectivity and new opportunities for education, work, and travel. Our findings suggest that these transitions are viewed to have both positive and negative implications. Both local informants and development workers showed concern for the social and cultural implications of changes to local livelihoods and lifestyles.

> *Parents here now always give attention to working the seaweed . . . for the money. So they ignore their children . . . They're busy, they work in the sea and come home late and go to bed and don't see their children. (Aaliyah, local, personal communication, 10 August 2011)*

> *The [villages] that are experiencing it [development] first and benefiting the most from it, they're losing some of their traditions . . . really quickly. The weaving's disappearing because it's a really time-intensive way to earn money. People can go out and farm seaweed and earn money much more quickly and a much more regular return than from weaving. The dancing and things, I'm not quite sure why they seemed to*

> *be disappearing . . . but clearly it is those communities most impacted by development that are losing those traditions the fastest. (James, foreign, personal communication, 20 April 2011)*

> *The community used to work together to do things occasionally, like they would work together to build the church. But now people don't have so much time to do that . . . Those old support systems have fallen into disrepair once people started working doing farming for the seaweed . . . There are definite changes in the structure in the community. (Cathy, foreign, personal communication, 23 April 2011)*

Interactions between the local and foreign people are widely regarded amongst informants as opportunities for the exchange of knowledge systems. Outsiders are seen to have valuable knowledge to share on concepts such as environmental conservation, management of development, health, and education: "The tourists teach the community how to be on time in doing their job, how to put garbages on the right place in order to keep clean environments" (Peni, local, personal communication, 21 July 2011).

However, not all ideas have been so easily accepted. Conflicting cultural ideas are also emerging through exposure to (predominantly Western) outside values and ideas, especially regarding modesty and sexuality.

> *We have a tradition about our clothes . . . but some tourists come here with clothes not the same as our tradition. Some of us think that is not good for our tradition, for our development, for the young people here. (Yuli, local, personal communication, 30 July 2011)*

> *The tourists also teach bad things to the community such as just wearing underwear at the public area, kissing, sensual kissing at public areas. These two things are taboo to the local people. Drugs also is not good things for the youth local people. (Peni, local, personal communication, 21 July 2011)*

Cultural conflict surrounding sexuality and modesty have been common across tourism destinations in Indonesia (Hitchcock & Darma Putra, 2007; Lewis & Lewis, 2009). Interestingly, development workers observed that locals are developing some mechanisms for negotiating these cultural exchanges.

> *We were talking with kids in the schools [and] they said 'Well, we see these people acting really badly . . . We've seen that they have free sex. They don't cover themselves. They don't work. They don't get married… But we spoke about this and our parents say . . . they're having their holidays . . . They do that because they're from that country but we have our own values and that's not how we behave and we don't copy their behaviour'. So they've got a very strong kind of sense of identity and of their own community and their own values. (Cathy, foreign, personal communication, 23 April 2011)*

There are also contending views amongst locals with regard to the arrival of new

technologies. Locals conveyed a sense of excitement about emerging technologies within the community, although there were differing opinions on whether this was positive or negative: "The phone is pretty good because you can communicate to your friends anywhere in the world. It's very good for us" (Paulus, local, personal communication, 29 July 2011).

> *It's like, you never have TV and then suddenly . . . you have access to all those things. There are lots of kids that watch TV all night. It's a big problem. (Martha, local, personal communication, 2 August 2011)*

Many locals have consequently expressed a desire for the community to have wide access to 'social education', so that they can better understand the cultural differences and make informed choices about the consequences of their behaviour.

> *People can get access from the Internet, from the television but it's just a matter of social education for young kids. Sex education. This is not a normal thing for us in Nemberala . . . We have now a lot of problems with teenagers, they are pregnant at school. Don't you think that's the saddest one? I'm concerned about it . . . A family with money, they buy television and they get their kids to watch all the programs . . . It brings all the problems. (Ari, local, personal communication, 12 August 2011)*

Some changes have sparked a broad local desire to preserve expressions of traditional culture such as weaving, art, dancing, and dress. This has been assisted by a Lua Lemba and Indigo Foundation initiative for a 'cultural festival'.

> *People start to realise that they should keep their culture – things like traditional dances – they get the kids to learn. I think it's a good thing that people want to preserve their culture. (Martha, local, personal communication, 2 August 2011)*

Cole (2008) describes tourism as a driver for the process of 'localisation', suggesting that tourism encourages the construction of cultural or ethnic identities which can then be used as a resource and commodity for communities to participate in tourism. Despite many questioning the authenticity of cultural identities created through tourism (Allerton, 2003; Cole, 2008; Howe, 2005; Picard, 1996), Cole observed villagers in Ngadha, NTT, gaining pride in their cultural heritage and political empowerment in this process (Cole, 2006; 2008). Aitchison (2001) similarly states that using culture in tourism can empower host communities and help to equalise the power differentials between them and outsiders. However, the discourse of 'inside' and 'outside' ideas can facilitate exclusion and hinder broader community cohesion (Riggins, 1997).

Studies of the *Ajeg Bali* cultural movement in Bali demonstrate the double-edged nature of strategies for cultural revivification, including their potential for exclusion of ethnic minorities (Lewis & Lewis, 2009). In the current study, both local and foreign informants expressed the view that the cultural festival in Delha is an exciting mechanism for the local community to build solidarity, share new cultural forms, and strengthen their sense of cultural identity as an 'anchor' for more productive cultural interactions with others.

> *It's the first time I've seen so many people doing so many different traditional things. That was a wonderful thing to see. The way they participate – you can see there's a strong community. (John, foreign, personal communication, 8 May 2011)*

Several local informants claimed that conservative traditional practices could also have negative consequences and suggested that some transitions associated with greater cultural interaction may benefit the economic and social well-being of the community.

> *For a man to marry a woman they have to save [money] all their lives to be able to pay for the marriage price . . . Also for family occasions – weddings, funerals – people like partying. They spend so much on the occasions. It is really not good for the economics. They don't spend that money on education. (Ari, local, personal communication, 12 August 2011)*

Informants not originally from Rote also discussed culture as a barrier to the health of locals, especially related to understandings of health. Western medical models of health are still seen as 'alternative treatments', second to spiritual and superstitious beliefs about health and well-being. Health workers voiced great frustration as they feel there are missed opportunities when medical treatment is seen as a last resort.

> *It's like competition with doctor and medicine and prayer . . . they more believe the prayer than me . . . As long as I work here, I have already lost for competition with the prayer . . . Maybe if they don't believe that the prayer is the most important then they believe me as well. Maybe it will not happen. But you know my person's already dead! . . . Because they need maybe four hours just for praying. (Aaliyah, local, personal communication, 10 August 2011)*

> *They have a very strong aversion to medical science . . . Black magic kind of rules the day around here so unfortunately we see a fair amount of deaths. (Jim, foreign, personal communication, 13 July 2011)*

However, some locals had mediated these contradictory beliefs, saying that there were merits of both health belief systems.

> *It is the Christianity way, it's good . . . A lot of them get cured from [prayer]. . . . But people have a low understanding of medication and check-ups and this is not really a good thing. Maybe both is good. (Jim, foreign, personal communication, 13 July 2011)*

Consistent with the globalisation literature (Huynen, Martens, & Hilderink, 2005), these findings suggest that within Delha, rapid cultural shifts are taking place through the exchange and hybridisation of beliefs and practices. According to Lewis (2008), 'culture' is a convergence of meaning systems that operates through social groupings and practices and "culture is always transitional, open and unstable" (p. 13).

A Cultural Studies approach helps to explain the phenomena on Rote as the negotiation of knowledge systems as people come to and from the island, each sharing their beliefs and meanings. This is intensified by the gradually increasing presence of the mass media in the everyday lives of locals, which brings into closer proximity the products, practices, and values of other cultures (Lewis, 2008). Some locals in Delha see this as extremely problematic, while others see merits of outside ideas, new technologies, and transitions. Studies of development and tourism in other areas of Indonesia have likewise highlighted cultural tensions regarding the influence of Western cultural practices, particularly around gender roles, sexuality, and the body (Howe, 2005; Lewis & Lewis, 2009).

Within the context of globalisation and increasing levels of social, economic, and cultural interaction between people across the globe, contemporary societies are constantly exposed to alternative ways of living, acting, and making meaning. Thus, they are becoming more complex, mixed, and heterogeneous, rendering them vulnerable to an infinite array of external and internal disputes of meaning (Lewis, 2008). While cultural transition is an inevitable consequence of globalisation, there is clearly a negotiation process by which the Rotinese are both challenging and selectively integrating new ideas and practices into their everyday lives. According to the informants in this study, these disputes of meaning, along with struggles around traditional structures of power and influence, have the potential for positive outcomes but they are also creating threats to social cohesion and new forms of exclusion. This dynamic poses a threat to the health, well-being, and sustainability of local communities. It is also undermining opportunities for building the collaborations that are required for development to be managed in an equitable and genuinely participatory manner (Cole, 2006; Reid, 2000).

Conclusion

The findings of this study demonstrate that in the Delha community, development is a passionately disputed issue. The political and economic context for development in Rote is complex, with processes of globalisation and governance transition simultaneously shaping local outcomes from afar. Further complications arise at the community level, where a lack of planning and regulation has left Delha on the brink of crisis, particularly with regard to increasing tourism and local control of development. Furthermore, while many stakeholders share common views about the need for planning and collaboration, there are contrasting perspectives about who should be involved in this process and the best way for development to proceed. The findings from this small, preliminary study suggest these disputes and power differentials are excluding important perspectives and undermining people's sense of control over the health, well-being, and future sustainability of their communities.

In the midst of these debates are complex cultural interactions between locals and outsiders. These exchanges of ideas, practices, and economies are seen to have both positive and negative ramifications for community well-being in Delha. Undermining people's sense of social cohesion, community sustainability, and control over their health are struggles arising from power differentials, inequities, and deeply entrenched notions of exclusion. The current study has begun to draw out and analyse selected key issues to demonstrate the diverse and contested perspectives surrounding development, tourism, and community sustainability in Delha, Rote.

References

Aitchison, C. (2001). Theorizing Other discourses of tourism, gender and culture. *Tourist studies, 1*(2), 133-147.

Badan Pusat Statistik Republik Indonesia. (2010). *Hasil Sensus Penduduk 2010: Kabupaten Rote Ndao Data Agregat per Kecamatan*. Retrieved 14 April 2011 from http://www.bps.go.id/hasilSP2010/ntt/5314.pdf

Barlow, C., & Gondowarsito, R. (2007). *Socio-economic Conditions and Poverty Alleviation in Nusa Tenggara Timur*. Canberra, Australia: Australian National University.

Bebbington, A., Dharmawan, L., Fahmi, E., & Guggenheim, S. (2004). Village politics, culture and community-driven development: insights from Indonesia. *Progress in Development Studies, 4*(3), 187-205.

Carnegie, M. (2008). Development prospects in Eastern Indonesia: Learning from Oelua's diverse economy. *Asia Pacific Viewpoint, 29*(3), 354-369.

Carnegie, M. (2010). Living with difference in rural Indonesia: What can be learned for national and regional political agendas? *Journal of Southeast Asian Studies, 41*(3), 449-481.

Cole, S. (2006). Information and Empowerment: The Keys to Achieving Sustainable Tourism. *Journal of Sustainable Tourism, 14*(6), 629-644.

Cole, S. (2008). *Tourism, Culture and Development: Hopes, Dreams and Realities in East Indonesia*. Clevedon, UK: Channel View Publications.

Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization.

Connor, L., & Vickers, A. (2003). Crisis, citizenship, and cosmopolitanism: Living in a local and global risk society in Bali. *Indonesia, 75*, 153-180.

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research.* Los Angeles: SAGE Publications.

Erb, M. (2011). Talk of Corruption in Eastern Indonesian Communities: Reactions to Local Government in the Post-Suharto Reform Era. *Asian Journal of Social Science, 39*(2), 171-195.

Fointuna, Y. (2008, 16 March). Rote Ndao faces poverty, climate change and apathy. *The Jakarta Post*. Retrieved 16 February 2011 from http://www.thejakartapost.com/news/2008/03/16/rote-ndao-faces-poverty-climate-change-and-apathy.html

Fox, J. (1977). *Harvest of the Palm: Ecological Change in Eastern Indonesia*. London: Harvard University Press.

Furqan, A., & Som, A. P. M. (2010). Effects of Decentralization Policy on Island Destination in Indonesia. *World Applied Sciences Journal, 10*, 63-70.

Graci, S., & Dodds, R. (2010). *Sustainable Tourism in Island Destinations*. London: Earthscan.

Haslam, P., Schafer, J., & Beaudet, P. (2009). *Introduction to International Development: Approaches, Actors and Issues*. South Melbourne, Australia: Oxford University Press.

Hitchcock, M., & Darma Putra, I. N. (2007). *Tourism, development and terrorism in Bali.* Hampshire, UK: Ashgate Publishing.

Howe, L. (2005). *The changing world of Bali: religion, society and tourism*. London: Routledge.

Huynen, M., Martens, P., & Hilderink, H. (2005). The health impacts of globalisation: a conceptual framework. *Globalization and Health, 1*(14).

Indigo Foundation. (2011). Rote, Indonesia. Retrieved 11 December 2010 from http://www.indigofoundation.org/rote.php

Keleher, H., & MacDougall, C. (Eds.). (2009). *Understanding Health: A Determinants Approach* (Second ed.). South Melbourne, Australia: Oxford University Press.

Keleher, H., & MacDougall, C. (Eds.). (2011). *Understanding Health* (Third ed.). South Melbourne, Australia: Oxford University Press.

Kristiansen, S., & Santoso, P. (2006). Surviving decentralisation? Impacts of regional autonomy on health service provision in Indonesia. *Health Policy, 77*(3), 247-259.

Lewis, B., & Ridge, D. (2005). Mothers reframing physical activity: family oriented politicism, transgression and contested expertise in Australia. *Social Science and Medicine, 60*(10), 2295-2306.

Lewis, J. (2008). *Cultural Studies: The Basics* (Second ed.). London: SAGE Publications.

Lewis, J., & Lewis, B. (2009). *Bali's Silent Crisis: Desire, tragedy, and transition*. Lanham, MD: Lexington Books.

Liamputtong, P. (2009). *Qualitative Research Methods*. South Melbourne, Australia: Oxford University Press.

Minichello, V., Sullivan, G., Greenwood, K., & Axford, R. (2004). *Handbook of Research Methods for Nursing and Health Science*. Frenchs Forest, Australia: Pearson Education Australia.

Muhanna, E. (2006). Sustainable Tourism Development and Environmental Management for Developing Countries. *Problems and Perspectives in Management, 4*(2), 14-30.

Nutbeam, D. (1996). Healthy Islands - a truly ecological model of health. *Health Promotion International, 11*(4), 263-264.

Patton, M. (2002). Qualitative research and evaluation methods. London: SAGE Publications.

Phelps, N. A. (2004). Archetype for an archipelago? Batam as anti-model and model of industrialization in reformasi Indonesia. *Progress in Development Studies, 4*(3), 206-229.

Reid, J. N. (2000). *How People Power Brings Sustainable Benefits to Communities*. USDA Rural Development: Office of Community Development.

Reid, S. A. (1999). Language, power, and intergroup relations. *Journal of social issues, 55*(1), 119-139.

Resosudarmo, B. P., & Jotzo, F. (2009). *Working With Nature Against Poverty*. Singapore: Institute of Southeast Asian Studies.

Riggins, S. H. (1997). *The Language and Politics of Exclusion: Others in Discourse*. Thousand Oaks, CA: Sage Publications.

Sahin, S., Lewis, B., & Lewis, J. (2012). Fractured futures: Indonesian political reform and West Timorese manganese mining. *Global Change, Peace & Security, 24*(2), 289-304.

Timur, S., & Getz, D. (2009). Sustainable Tourism Development: How Do Destination Stakeholders Perceive Sustainable Urban Tourism? *Sustainable Development, 17*(4), 220-232.

van Sebille, T. (2001). *Rote, Indonesia: An Indigo Foundation Community Development Partnership*. Retrieved 10 December 2010 from http://www.indigofoundation.org/pdfs/newsletters/July2001_Newsletter.pdf

Pro- oder Anti-Life? Die katholische Kirche in der Debatte um reprodukive Gesundheit auf den Philippinen

Marina Wetzlmaier[1]

Citation Wetzlmaier, M. (2012). Pro- oder Anti-Life? Die katholische Kirche in der Debatte um reproduktive Gesundheit auf den Philippinen. *ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften, 5*(1), 128-138.

Einleitung

Im September 2010 drohte die Katholische Bischofskonferenz der Philippinen (*Catholic Bishops' Conference of the Philippines*, CBCP) Präsident Benigno Aquino mit der Exkommunizierung, also der höchsten Strafe, die die Kirche aussprechen kann. Aquinos „Vergehen" war die Ankündigung, armen Familien künstliche Verhütungsmittel zur Verfügung zu stellen, wenn diese es wünschten. In den Augen der Kirche galt dies jedoch als „unmoralisch" und nicht mit dem Katholizismus vereinbar, und der damalige Vorsitzende der CBCP, Bischof Nereo Odchimar aus Surigao del Sur, Mindanao, sah in Empfängnisverhütung sogar einen Verstoß gegen die zehn Gebote (Tubeza, 2010a).

Seit über zehn Jahren wird auf den Philippinen ein Gesetz zur reproduktiven Gesundheit[2], die Reproductive Health (RH) Bill, debattiert, das die Förderung von allen Formen der „natürlichen" und „künstlichen"[3] Familienplanung sowie Maßnahmen zur Müttergesundheit vorsieht. Im Februar 2011 flammte die Diskussion wieder auf, als dem Kongress ein neuer Entwurf vorgelegt wurde. Dafür, dass es bisher zu

1 Marina Wetzlmaier schloss Ende 2011 das Studium der Internationalen Entwicklung an der Universität Wien ab. In ihrer Diplomarbeit behandelte sie die Landrechtsbewegung auf den Philippinen. Derzeit arbeitet sie bei FIAN (FoodFirst Information and Action Network) Philippines, Quezon City. Kontakt: marina.wetzlmaier@gmx.at

2 Die Weltgesundheitsorganisation (*World Health Organisation*, WHO) definiert reproduktive Gesundheit folgendermaßen: „Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (WHO, 2012). Das Recht auf reproduktive Gesundheit beinhaltet Informationen über und Zugang zu sicheren, effektiven und leistbaren Methoden der Empfängnisverhütung. Frauen haben außerdem das Recht auf eine angemessene Gesundheitsversorgung, die eine sichere Schwangerschaft und Geburt garantieren soll.

3 Mit „künstlicher" Verhütung sind Methoden gemeint, die die Befruchtung der Eizelle verhindern, oder verhindern, dass Samenzellen in die Gebärmutter gelangen, wie zum Beispiel Kondom, Pessar, Spirale oder hormonelle Methoden wie die Pille oder Injektionen (Likhaan, 2010).

creative commons BY-NC-ND

doi 10.4232/10.ASEAS-5.1-7 www.seas.at SEAS

keiner Verabschiedung kam, machen BefürworterInnen der RH Bill die katholische Kirche verantwortlich, deren Vertreter in öffentlichen Kampagnen, durch Fernsehinterviews, Pastoralbriefe, während Messen und im Internet unmissverständlich ihren Widerstand gegen eine „anti-life, anti-natal and contraceptive mentality" (CBCP, 2011) äußern. Im Folgenden wird daher genauer auf die kontroverse Debatte rund um das Thema reproduktive Gesundheit eingegangen. Der Beitrag soll dabei einen Überblick über zentrale Argumente der unterschiedlichen AkteurInnen geben und die Bevölkerungspolitik auf den Philippinen skizzieren.

Emotionale Debatte

Medien nahmen die Spannungen zwischen Präsident Aquino und der CBCP zum Anlass, um von einem Konflikt zwischen Staat und katholischer Kirche zu sprechen, bei dem Regierung und Kirche anhand der RH Bill um Einflusssphären in der Gesellschaft konkurrierten (David, 2011; Doronila, 2010). Die Debatte rund um die RH Bill stellt sich jedoch nicht primär als Auseinandersetzung zwischen Kirche und Regierung dar, sondern geht über diese beiden Akteurinnen hinaus. Sinnvoller ist es daher, zwischen zwei gegensätzlichen Lagern zu unterscheiden – auf der einen Seite AnhängerInnen einer *pro-life*-Haltung, die eine RH Bill klar ablehnen, und auf der anderen Seite die BefürworterInnen eines *pro-choice*-Ansatzes (Umali, 2010, S. 92). Letztere vertreten die Position, dass alle Eltern das Recht haben, frei zu entscheiden, ob und welche Art von Familienplanung sie durchführen wollen. Die katholische Kirche, mit der CBCP als ihrem offiziellen Sprachrohr, wirkt in der Debatte so dominant, weil sie die stärkste Akteurin der *pro-life*-Fraktion ist, zu der auch mehrere katholische Organisationen zählen (Umali, 2010, S. 103).

Eine dieser Organisationen ist *Pro-Life Philippines*, deren Mitglieder in den vergangenen Jahren immer wieder in emotionale Auseinandersetzungen mit BefürworterInnen der RH Bill involviert waren. Ein Beispiel dafür ist der Konflikt mit AktivistInnen der NGO *FilipinoFreethinkers*, die für die Verabschiedung des Gesetzesentwurfs eintreten. Im November 2010 wollten die *FilipinoFreethinkers* eine Messe in der Manila Cathedral besuchen, wo über das kontroverse Thema gesprochen werden sollte. *Pro-Life Philippines* hinderte sie jedoch daran und reagierte mit verbalen Attacken, wie:

„Satan, get away from us! You should have asked your mother to abort you" (Santos, 2011). Ein aufgeheiztes Klima wie dieses lässt neutrale Diskussionen kaum zu und lenkt von zentralen Inhalten der RH Bill ab.

Inhalte der RH Bill

Seit 21. Februar 2011 liegt dem philippinischen Kongress die *House Bill 4244* unter dem Titel *An Act Providing for a Comprehensive Policy on Responsible Parenthood, Reproductive Health, and Population and Development, and for Other Purposes* vor. Abgesehen vom oft vorgebrachten Argument, dass Bevölkerungswachstum zugunsten der wirtschaftlichen Entwicklung und Armutsbekämpfung eingeschränkt werden müsse, betonen die AutorInnen auch den menschenrechtlichen Aspekt reproduktiver Gesundheit: „The State recognizes and guarantees the exercise of the universal basic human right to reproductive health by all persons, particularly of parents, couples and women, consistent with their religious convictions, cultural beliefs and the demand of responsible parenthood" (Republic of the Philippines House of Representatives, 2011, S. 2). Konkreter noch wird reproduktive Gesundheit als Frauenrecht definiert und als Mittel zur Förderung von Gendergerechtigkeit und *Empowerment* (House of Representatives, 2011, S. 4). Die „Guiding Principles" berücksichtigen außerdem das universelle Recht auf Gesundheit, das vor allem für marginalisierte Bevölkerungsgruppen gesichert werden muss (House of Representatives, 2011, S. 2). Daher sieht die RH Bill neben Methoden der Familienplanung auch Maßnahmen zur allgmeinen Förderung der Kinder- und Müttergesundheit vor. So soll es pro 500.000 EinwohnerInnen mindestens ein Krankenhaus geben, das eine Notfallversorgung und grundlegende Geburtshilfe anbietet (House of Representatives, 2011, S. 10). Während über diese Aspekte Konsens besteht, sorgen andere Forderungen für Kontroversen, unter anderem der Anspruch auf ein flächendeckendes Angebot an effektiven Methoden zur Familienplanung: „The State shall promote, without bias, all effective natural and modern methods of family planning that are medically safe and legal" (House of Representatives, 2011, S. 3). Der Entwurf sieht vor, Verhütungsmittel und Informationen zu deren effektiven Verwendung staatlich zu fördern und sowohl in staatlichen Krankenhäusern als auch in kleineren Gesundheitskliniken zur Verfügung zu stellen. Für ärmere Bevölkerungsgruppen soll die staatliche Gesundheitsversicherung, *Philippine*

Health Insurance Corporation (PhilHealth), die Kosten abdecken (House of Representatives, 2011, S. 10). Dagegen wehren sich Vertreter der CBCP, in deren Augen künstliche Empfängnisverhütung unmoralisch sei, da sie das menschliche Leben – „the most sacred physical gift" (CBCP, 2011) – nicht respektiere.

Die Bedeutung der katholischen Kirche

Die Äußerungen der Bischöfe der CBCP prägen unter anderem deshalb die öffentlichen Debatten, da der Katholizismus gesellschaftlich, kulturell und politisch eine zentrale Rolle auf den Philippinen spielt. Über 80 Prozent der etwa 100 Millionen EinwohnerInnen sind katholisch, wobei die weite Verbreitung des Katholizismus auf die Missionierung während drei Jahrhunderten spanischer Kolonialherrschaft zurückgeht (Zabel, 2007, S. 325). Politische Legitimität erlangte die katholische Kirche während der *People Power Revolution* von 1986, als KirchenrepräsentantInnen wie der damalige Erzbischof von Manila, Jaime Kardinal Sin, jene Massenproteste anführten, die den Diktator Ferdinand Marcos zu Fall brachten. Seither bewahrte sich die Kirche ihren Ruf als „Hüterin der Demokratie" und bezieht immer wieder Stellung zu aktuellen Themen, wie Wahlen, Korruption oder Landreform (Zabel, 2007, S. 328; siehe auch Carcamo, 2009). Während sich die Kirche als „moralisches Gewissen" der Nation versteht, argumentieren ihre KritikerInnen, dass sie sich zu sehr in politische Angelegenheiten einmische (Santos, 2011) und betonen dabei, dass Kirche und Staat laut Verfassung getrennt sein sollten. Laut Medienberichten spaltet die Kontroverse um die RH Bill allerdings auch die katholische Gemeinschaft selbst, denn die Kirchenführung würde sich durch ihre orthodoxe Haltung immer mehr von den Menschen entfernen, während ein Großteil der katholischen Bevölkerung die RH Bill unterstützt (Balana & Burgonio, 2011).

Die Debatte rund um die RH Bill zeigt außerdem, dass es auch innerhalb der Kirchenführung divergierende Positionen gibt. Eine der zentralen katholischen Persönlichkeiten, die den öffentlichen Diskurs zur RH Bill beeinflussen, ist der Jesuitenpater Joaquin Bernas. In den vergangenen Jahren plädierte er in den Medien immer wieder für die Verabschiedung des Gesetzes, weshalb ihn einzelne Bischöfe sogar als „Ketzer" bezeichneten. Dabei lehnt Bernas künstliche Empfängnisverhütung ebenso ab

wie die meisten katholischen Bischöfe. Aus Respekt vor Religionsfreiheit und Pluralismus hält er die RH Bill jedoch für richtig und betont, der Staat müsse die Bedürfnisse aller BürgerInnen berücksichtigen (Bernas, 2011). Wie eine Studie der *Social Weather Stations* (SWS) zeigt, befürworten 71 Prozent der Bevölkerung die RH Bill, wobei der Glaube keinen Einfluss auf die Haltung zu reproduktiver Gesundheit hat. Ebenso wären sie mit Aufklärungsunterricht an den Schulen einverstanden, wie er im Gesetzesentwurf auf optionaler Basis vorgesehen ist. Zudem befürworten Menschen aller sozialen Schichten[4] gleichermaßen die RH Bill, unabhängig von Geschlechterzugehörigkeit und Beziehungsstatus der Befragten (SWS, 2008).

Unterschiedliche lokale Gesetze

Die RH Bill soll vor allem einen national einheitlichen gesetzlichen Rahmen schaffen, der bisher fehlte. Stattdessen liegt Gesundheitspolitik in der Verantwortung der Lokalregierungen[5] (*Local Government Units*, LGU), die entscheiden können, wieviel Budget sie für welche Art von Familienplanung ausgeben. Dies führte zu einem ungleichen Zugang der Bevölkerung zu effektiven Verhütungsmitteln und anderen Leistungen reproduktiver Gesundheit, wie in den zwei folgenden Fällen sichtbar wird. In Manila City verhängte im Jahr 2000 der damalige Bürgermeister Jose „Lito" Atienza ein komplettes Verbot von künstlicher Empfängnisverhütung und argumentierte, dass seine Stadt eine „Kultur des Lebens" fördern wolle:

> *The City promotes responsible parenthood and upholds natural family planning not just as a method but as a way of self-awareness in promoting the culture of life while discouraging the use of artificial methods of contraception like condoms, pills, intrauterine devices, surgical sterilization, and other. (Atienza zit. nach Demeterio-Melgar, Pacete, Aguiling-Pangalangan, Lu, & Sabundayo, 2007, S. 9)*

In der Praxis bedeutete dies, dass Krankenhäuser und Gesundheitszentren keine Verhütungsmittel ausgeben durften. Frauenorganisationen warfen Atienza vor, gegen nationale Gesetze zu verstoßen, denn im *Local Government Code* von 1991 heißt es, dass grundlegende Gesundheitsdienstleistungen angeboten werden müssen, wozu

4 Die SWS kategorisiert die sozioökonomischen Schichten nach den Einkommensklassen A, B, C, D und E, wobei die letzten beiden die ärmsten Bevölkerungsgruppen darstellen.

5 LGU bezeichnet allgemein die administrativen Einheiten auf Provinz-, Stadt- und Gemeindeebene.

auch alle Methoden der Familienplanung gehören (Demeterio-Melgar et al., 2007, S. 38). Mittlerweile sind andere BürgermeisterInnen dem Beispiel Manilas gefolgt und verbieten hormonelle Verhütung, beispielsweise mit dem Argument, dass es sich um Abtreibungsmittel handelt (Austria, 2011, S. 1).

Im Gegensatz dazu verabschiedete die LGU von Quezon City im Norden des Großraums Manila 2008 ein umfassendes Programm zur Förderung reproduktiver Gesundheit und künstlicher Empfängnisverhütung. Der Fall sorgte für Aufmerksamkeit, weil einer der Hauptinitiatoren, Stadtrat Joseph Emile Juico, starken öffentlichen Attacken durch die katholische Kirche ausgesetzt war, seine Familie jedoch enge Beziehungen zu katholischen Persönlichkeiten pflegte. Juico begründete seine Position damit, dass er den Willen der BürgerInnen vertrete (Umali, 2010, S. 192-193). Der Fall zeigt, dass der Einfluss der katholischen Kirche nicht überall gleich stark ist, sondern dass es vor allem vom politischen Willen abhängt, ob BürgermeisterInnen reproduktive Gesundheit, inklusive aller Formen von Verhütung, fördern oder nicht.

Nationale Bevölkerungspolitik

Die Bevölkerungspolitik auf den Philippinen war stets von starken Dynamiken geprägt, die von den jeweiligen Regierungen, ihrer politischen Agenda und ihren Perspektiven auf Familienplanung und reproduktive Gesundheit abhängig waren. Die Politik Corazon Aquinos wurde von VertreterInnen der katholischen Kirche beeinflusst, was unter anderem an Aquinos Bringschuld gegenüber den Bischöfen lag, die sie während der *People Power Revolution* unterstützt hatten (Umali, 2010, S. 60). Aquinos Nachfolger hingegen förderten Familienplanung als Mittel zur Bevölkerungsregulierung, um die wirtschaftliche und soziale Entwicklung des Landes anzukurbeln. Im Jahr 2000 stellte Estradas Regierung PHP 70 Millionen[6] zum Kauf von Verhütungsmitteln zur Verfügung. Allerdings kam es aufgrund der Amtsenthebung Estradas im Jahr 2001 nie zur Ausführung dieses Plans (Umali, 2010, S. 6). Der Amtsenthebung war ein mehrtägiger Protestmarsch vorausgegangen, bei dem die katholische Kirche an vorderster Front vertreten war und damit entscheidend zum Fall Estradas und der

6 Etwa EUR 1,67 Millionen (berechnet nach dem durchschnittlichen Wechselkurs von EUR 1 = PHP 41,8 im Jahr 2000).

anschließenden Amtseinführung Gloria Macapagal-Arroyos beitrug. Laut KritikerInnen begann unter Arroyo eine erneute „Katholifizierung" der Bevölkerungspolitik, da ihre Haltung zu reproduktiver Gesundheit die Prinzipien der CBCP widerspiegelte. Sie kürzte öffentliche Gelder für künstliche Verhütung und förderte stattdessen natürliche Familienplanung, die der „philippinischen Kultur" mehr entspreche: „The government needs to adopt policies that will take into consideration population and reproductive health approaches that respect *our culture and values*" (Arroyo zit. nach Demeterio-Melgar et al., 2007, S. 14).

Barrieren für reproduktive Gesundheit und deren Folgen

Seit den 1970er-Jahren war die amerikanische Entwicklungsagentur *United States Agency for International Development* (USAID) die wichtigste Unterstützerin philippinischer Bevölkerungsprogramme. Im Sinne ihrer Priorität für natürliche Familienplanung stoppte Arroyo diese Geldflüsse und Frauen müssen sich seither am Privatsektor versorgen, was für viele unleistbar ist. 42 Prozent der alleinstehenden Frauen, die 2004 nicht verhüteten, führten finanzielle Gründe dafür an. Von den verheirateten Frauen nannten im Jahr 2003 8 Prozent diesen Grund, fünf Jahre später waren es bereits 15 Prozent. Davon abgesehen meinen 41 Prozent der Frauen, nicht schwanger werden zu können, weil sie nur unregelmäßig Sex hätten. Religiöse Gründe spielen in Bezug auf die Familienplanung eine immer geringere Rolle: Im Jahr 2008 gaben 10 Prozent der Frauen an, aus religiöser Überzeugung nicht zu verhüten, während es 2003 noch 18 Prozent waren (Likhaan, 2010).

Nicht nur die limitierte Verfügbarkeit von Verhütungsmitteln stellt vor allem für Frauen aus ärmeren Bevölkerungsschichten ein Problem dar. Mit dem Wegfall der staatlichen Förderung für künstliche Empfängnisverhütung wurde auch Aufklärungskampagnen weniger Priorität eingeräumt. Frauen aus ärmeren Bevölkerungsschichten, die ohnenhin einen schlechteren Zugang zu Informationen über reproduktive Gesundheit haben, waren von dieser Entwicklung am stärksten betroffen. Dies führte unter anderem dazu, dass die meisten Frauen (44 Prozent) nicht verhüteten, weil sie gesundheitsschädigende Folgen befürchteten (Likhaan, 2010) – eine Angst, die einerseits auf einen generellen Mangel an Informationen und andererseits auf falsche In-

formationen von GegnerInnen der RH Bill zurückgeführt werden kann. So behauptete die CBCP in einem Pastoralbrief[7]: „Scientists have known for a long time that contraceptives may cause cancer. Contraceptives are hazardous to a woman's health" (CBCP, 2011). Bezüglich der RH Bill kam die CBCP zum Schluss, dass sie reproduktive Gesundheit nicht fördern würde. Im Gegenteil, „the very name 'contraceptive' already reveals the anti-life nature of the means that the RH bill promotes. These artificial means are fatal to human life" (CBCP, 2011). Weiters verbreitete die CBCP die Ansicht, dass die RH Bill Abtreibung unterstütze, während sie entgegen dieser Behauptung auch nach der Verabschiedung des Gesetzes verboten bleiben würde.

Jährlich treiben auf den Philippinen über 500.000 Frauen illegal ab, 90.000 Frauen müssen als Folge davon ins Krankenhaus eingeliefert werden und etwa 1.000 sterben dabei (Likhaan, 2011b). Um das Risiko jener Frauen, die illegal abtreiben, zu verringern, sieht die RH Bill eine medizinische Versorgung für sie vor: „The government shall ensure that all women needing care for post-abortion complications shall be treated and counseled in a humane, non-judgmental and compassionate manner" (House of Representatives, 2011, S. 4).

Dass Maßnahmen zur Verbesserung reproduktiver Gesundheit den Bedürfnissen vieler Frauen entsprechen würden, zeigen auch aktuelle Daten der Frauenrechts- und Gesundheits-NGO Likhaan. Frauen bevorzugen demnach allgemein kleinere Familien, in denen sie die Kinder besser versorgen können. Im Idealfall wünschen sie sich zwei Kinder, während eine durchschnittliche Familie auf drei kommt. Ärmere Familien haben im Schnitt zwei Kinder mehr als ursprünglich geplant (Likhaan, 2010). Laut einer Studie des Guttmacher Institute und der University of the Philippines waren 54 Prozent der Schwangerschaften im Jahr 2008 ungewollt (Likhaan, 2011b). 68 Prozent dieser Frauen haben nicht verhütet und 24 Prozent wandten natürliche Verhütungsmethoden an. Die Studie zeigt auch, dass die Mehrheit der Frauen, die nicht verhüten, aus ärmeren Bevölkerungsschichten kommen, da sie einen schlechteren Zugang zu qualifizierter Geburtshilfe und zu medizinischer Versorgung haben (Likhaan, 2011b). Täglich sterben in Folge dieser fehlenden Grundversorgung 11 Frauen während der Geburt, sagen AktivistInnen. Kürzere Geburtenabstände und eine bessere Versorgung der Mütter und Kinder würden außerdem die Säuglingssterblichkeit senken. Ausrei-

7 Pastoralbriefe dienen der öffentlichen Verbreitung von Positionen der CBCP und werden sowohl in Medien publiziert als auch während der Messen vorgetragen (Zabel, 2007, S. 326).

chend Zugang zu reproduktiver Gesundheit rettet Leben, lautet daher ein Hauptargument der RH-Bill-BefürworterInnen (Likhaan, 2011a).

Ausblick: Ein Ende der Debatte?

Ende 2011 erreichte die Debatte rund um die RH Bill ihren Höhepunkt und die Verabschiedung des Gesetzes schien in greifbarer Nähe zu sein. Präsident Benigno Aquino drängte den Kongress, das Gesetz noch vor Jahresende durchzubringen (Balana, 2011) und erklärte es ungeachtet der Exkommunizierungsdrohungen sogar zur Priorität (Montenegro, 2011). Bisher scheiterte die Gesetzesverabschiedung jedoch am langwierigen Entscheidungsprozess im Kongress. PolitikerInnen und Fraktionen, die eine *pro-life* Haltung teilen und von den Bischöfen politisch unterstützt werden, nutzen ihr Vetorecht, um den Prozess zu verzögern. Solange die Debatte in der derzeitigen Emotionalität fortgeführt wird, kommt es zu keiner Abstimmung. Dass sowohl die Mehrheit der Filipinas und Filipinos, von denen sich viele als religiös bezeichnen, als auch einzelne KirchenvertreterInnen die RH Bill befürworten, zeigt, dass sie nicht zwingend im Widerspruch zur katholischen Praxis steht. Einige Lokalregierungen fördern seit Jahren Aufklärungskampagnen und Programme zur reproduktiven Gesundheit. Auf nationaler Ebene scheint eine Einigung allerdings noch fern zu sein. Während über Moral und philippinische Werte debattiert wird, bleiben wichtige Maßnahmen zur sexuellen Selbstbestimmung, Familienplanung sowie Mütter- und Kindergesundheit, die die RH Bill vorsieht, auf der Strecke.

Bibliographie

Austria, C. R. (2011). *The Philippines: Local Ordinance vs Contraceptives*. Zuletzt zugegriffen am 22. Dezember 2011 auf die Homepage der University of Toronto unter http://www.law.utoronto.ca/documents/reprohealth/LS061_Philippine_OrdinanceBansContraceptives.pdf

Balana, C., & Burgonio, T. J. (2011, 28. April). Catholic Church isolated on RH bill now. *Philippine Daily Inquirer*. Zuletzt zugegriffen am 18. März 2012 unter http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20110428-333367/Catholic-Church-isolated-on-RH-bill-row

Balana, C. D. (2011, 9. Dezember). Aquino getting impatient over RH bill passage. *Philippine Daily Inquirer.* Zuletzt zugegriffen am 22. Dezember 2011 unter http://newsinfo.inquirer.net/107789/aquino-getting-impatient-over-rh-bill-passage.

Bernas, J. G. (2011, 23. Mai). My stand on the RH Bill. *Philippine Daily Inquirer.* Zuletzt zugegriffen am 20. Dezember 2011 unter http://opinion.inquirer.net/5340/my-stand-on-the-rh-bill.

Carcamo, D. (2009, 18. Mai). Bishops meet GMA today for CARPER passage. *The Philippine Star.* Zuletzt zugegriffen am 18. März 2012 unter http://www.philstar.com/Article.aspx?articleid=468876

Catholic Bishops' Conference of the Philippines [CBCP]. (2011, 30. Januar). *Choosing Life, Rejecting the RH Bill. A Pastoral Letter of the Catholic Bishops' Conference of the Philippines.* Zuletzt zugegriffen am 16. Dezember 2011 auf die Homepage der Loyola School of Theology unter http://www.lst.edu/community/news-a-features/326-cbcp-letter-choosing-life-rejecting-the-rh-bill.

David, R. (2011, 15.Mai). Debating the RH Bill. *Philippine Daily Inquirer.* Zuletzt zugegriffen am 19. März 2012 unter http://opinion.inquirer.net/inquireropinion/columns/view/20110515-336572/Debating-the-RH-bill

Demeterio-Melgar, J. L., Pacete, J. C., Aguiling-Pangalangan, E., Lu, A. V. M., & Sabundayo, M. L. (2007). Imposing Misery. *The Impact of Manila's Ban on Contraception.* Quezon City, Philippines: Likhaan, ReproCen, Center for Reproductive Rights.

Doronila, A. (2010, 4.Oktober). RH bill fight may damage Church. *Philippine Daily Inquirer.* Zuletzt zugegriffen am 18. März 2012 unter http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20101004-295848/RH-bill-fight-may-damage-Church

Republic of the Philippines House of Representatives (2011). *House Bill No. 4244.* Quezon City, Philippines.

Likhaan (2010, 31. Mai). *Facts on Barriers to Contraceptive Use in the Philippines.* Zuletzt zugegriffen am 23. Dezember 2011 unter http://www.likhaan.org/content/facts-barriers-contraceptive-use-philippines

Likhaan (2011a, 5. Februar). *Ten Good Reasons to Pass the RH Bill Now.* Zuletzt zugegriffen am 23. Dezember 2011 unter http://www.likhaan.org/content/ten-good-reasons-pass-rh-bill-now

Likhaan (2011b, 26. August). *Why Investing in Family Planning Makes Sense.* Zuletzt zugegriffen am 23. Dezember 2011 unter http://www.likhaan.org/content/why-investing-family-planning-makes-sense

Montenegro, C. (2011, 31. Januar). CBCP: RH Bill a Form of 'Moral Corruption'. *GMANews.TV.* Zuletzt zugegriffen am 16. Dezember 2011 unter http://www.gmanetwork.com/news/story/211922/news/nation/cbcp-rh-bill-a-form-of-moral-corruption

Santos, K. (2011, 6. Januar). Catholics Risk Excommunication over Reproductive Rights. *Inter Press Service.* Zuletzt zugeriffen am 20. Dezember 2011 unter http://www.ipsnews.net/news.asp?idnews=54045

Social Weather Stations. (2008, 16. Oktober). *Third Quarter 2008 Social Weather Survey: 76 % Want Family Planning Education in Public Schools; 71 % Favor Passage of the Reproductive Health Bill.* Zuletzt zugegriffen am 20. Dezember 2011 unter http://www.sws.org.ph/pr081016.htm

Tubeza, P. (2010a, 30. September). CBCP Reminds Aquino about Excommunication. *Philippine Daily Inquirer.* Zuletzt zugegriffen am 23. Dezember 2011 unter http://newsinfo.inquirer.net/breakingnews/nation/view/20100930-295226/Bishop-threatens-Aquino-with-excommunication-over-birth-control

Tubeza, P. (2010b, 5. März). Aquino Eases up on Reproductive Health Bill. *Philippine Daily Inquirer*. Zuletzt zugegriffen am 23. Dezember 2011 unter http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20100305-256725/Aquino-eases-up-on-reproductive-health-bill

Umali, V. A. (2010). *The Politics of Population Policy-Making in the Philippines: Insights from the Population and Reproductive Health Legislative Proposals*. Dissertation, Institut für Politikwissenschaft, Universität Wien, Österreich.

World Health Organization (WHO). (2012). *Health topics Reproductive health*. Zuletzt zugegriffen am 15. April 2012 unter http://www.who.int/topics/reproductive_health/en/

Zabel, D. (2007). Einmischen aus Überzeugung. Gesellschaftliches Engagement und politischer Einfluss der katholischen Kirche. In N. Reese, & R. Werning (Hrsg.), *Handbuch Philippinen. Gesellschaft, Politik, Wirtschaft, Kultur* (S. 325-329). Bad Honnef, Deutschland: Horlemann Verlag.

Customer Empowerment in Healthcare Organisations Through CRM 2.0: Survey Results from Brunei Tracking a Future Path in E-Health Research

Muhammad Anshari[1], Mohammad N. Almunawar[2], Patrick K. C. Low[3] & Zaw Wint[4]

Citation Anshari, M., Almunawar, M. N., Low, P. K. C., & Wint, Z. (2012). Customer Empowerment in Healthcare Organisations Through CRM 2.0: Survey Results from Brunei Tracking a Future Path in E-Health Research. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 139-151.

Introduction

The idea of customers' empowerment in healthcare emerged in response to the rising concern that customers or patients should be able to play a critical role in improving their own health. In traditional healthcare practices, a patient is the recipient of care as well as medical decisions. However, a paradigm shift has taken place – that is, a change from patients who merely receive care to those who actively participate in their healthcare. This change emerged in the 1960s and has spread throughout the entire healthcare industry as a social movement characterised by the right to act based on informed choice, active participation, a self-help perspective, and full engagement in critical processes (Kieffer, 1984).

Traditionally, healthcare providers have made most of the decisions on treatments. Indeed, the lack of participation of patients in healthcare processes was the main obstacle to the empowerment of patients as customers. Nevertheless, there will always be circumstances in which patients choose to hand over responsibility for

1 Muhammad Anshari is a PhD candidate at the Faculty of Business, Economics, and Policy Studies, Universiti Brunei Darussalam. Contact: anshari@yahoo.com (Corresponding author)

2 Mohammad N. Almunawar is a Senior Lecturer and a Deputy Dean of Faculty of Business, Economics, and Policy Studies, Universiti Brunei Darussalam. Contact: nabil.almunawar@ubd.edu.bn

3 Patrick K. C. Low is is a Professor and an Associate at the University of South Australia. Contact: patrick_low2003@yahoo.com

4 Zaw Wint is a Senior Lecturer at the PAPRSB Institute of Health and the Acting Director of Graduate Studies and Research Office, Universiti Brunei Darussalam, Brunei Darusssalam. Contact: zaw.wint@ubd.edu.bn

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-8

BY-NC-ND creative commons

decisions about their healthcare to providers due to the difficulty in selecting available options or the time needed to understand the health problem and the options. However, this does not undermine the proposition that customers' empowerment will promote efficiency and that decisions should also be made from the perspective of customers (Segal, 1998).

The utilisation of information and communications technology (ICT), especially the Internet, in the healthcare sector is frequently referred to as electronic health or e-health. The main purpose of e-health is to improve healthcare management for the mutual benefit of patients and healthcare providers. One important aspect of e-health is how to manage relationships between a healthcare provider and its customers (patients) in order to create greater mutual understanding, trust, and patient involvement in decision making. Therefore, healthcare organisations are implementing Customer Relationship Management (CRM) as a strategy for managing interactions with their patients (Anshari & Almunawar, 2012). The recent Web technology (Web 2.0) facilitates customers to generate contents to accommodate both patient-health provider and patient-patient interactions. CRM enriched with the Web 2.0 (also called CRM 2.0) provides the capability for the intensive interactions mentioned above (Anshari, Almunawar, & Low, 2012). Besides, it can be considered a technology and strategy at the same time, raising hope for the advancement of e-health initiatives around the world.

The main goal of this paper is to introduce a promising future research direction which may shape the future of e-health systems. In this paper, we examine customers' expectations concerning the process of empowerment through CRM 2.0 to make customers more proficient in dealing with their own healthcare issues. A preliminary survey regarding empowerment in e-health services was conducted in Brunei Darussalam (Brunei). The Internet density in Brunei is high with over 75 percent of the population having access to the Internet, and there is a very narrow digital divide in Brunei (AITI, 2010). Internet literacy in Brunei is high, and so are people's expectations to be empowered through e-health. However, it has to be noted that the development of e-health in Brunei is still in its infancy. The future developments within the scope of e-health services in Brunei should therefore significantly focus on patients' empowerment as one of the important features required by the people. The rest of this paper is organised as follows: the following section presents the background of

the study, followed by the research methodology. We then discuss the results of the study in relation to a CRM 2.0 model we propose based on this investigation.

Study Background

Many researchers have discussed the issue of empowerment in healthcare organisations. For instance, empowerment can be analysed from the perspective of patient-healthcare provider interactions (Dijkstra, Braspenning, & Grol, 2002; Paterson, 2001; Skelton, 1997; van Dam, van der Horst, van den Borne, Ryckman, & Crebolder, 2003), or from the point of view of the patient alone (Anderson et al., 1995; Davison & Degner, 1997;; Desbiens et al., 1998; McCann & Weinman, 1996), or analysis can encompass both above mentioned perspectives (Golant, Altman, & Martin, 2003; Maliski, Clerkin, & Letwin, 2004; McWilliam et al., 1997). However, research that specifically discusses the issue of empowerment through CRM, and particularly CRM 2.0, is still very limited in the domain of e-health. Australia, a pioneer on this matter, has adopted a Personally Controlled Electronic Health Record (PCEHR) system, which stands out as an example for empowerment through e-health services (NEHTA, 2012). A significant element of patients' empowerment was achieved by allowing them to view their medical information electronically. However, PCEHR only enables patients to view their Electronic Health Record (EHR); it has not utilised features of CRM 2.0, which allow collaboration and conversation among patients or between patients and their healthcare providers. Therefore, our research primarily aims to develop a system that utilises features of CRM 2.0 in order to meet significant challenges in patients' empowerment in the domain of healthcare.

Customer Relationship Management

The fact that customer expectations in healthcare services are high poses a serious challenge to healthcare organisations as they have to meet customers' requirements and make an exceptional impression on every customer (Anshari & Almunawar, 2011). CRM can be used by healthcare organisations both as a tool and a strategy to meet their customers' expectations. The terms of Social CRM and CRM 2.0 are used inter-

changeably; both signify a new approach in CRM by allowing intensive interaction between customers and organisations and among customers by utilising Web 2.0. Hence, both share new distinct capabilities of social media and social networks that provide new approaches and potential which surpass the scope of traditional CRM. Cipriani (2008) described the fundamental changes offered by CRM 2.0 in terms of relationship, connection, and generated value.

The most significant feature of CRM 2.0 for e-health is the extensive network among customers and healthcare providers. This network is beneficial for customers as it provides multiple ways of interactive communication that enables sharing experience and knowledge electronically. Furthermore, it accommodates both the interaction between provider and patient, and between patient and patient. It also enables patients to generate contents of their personal health records.

With regard to these new features, Table 1 summarises the difference between CRM 2.0 and the precedent CRM 1.0 based on the type of relationship, connection, and generated value. CRM 1.0 mainly focuses on the individual one-way relationship, either customer to customer (C2C) or customer to business (C2B), whereas CRM 2.0 offers a collaborative relationship and thus supports the engagement in a more complex relationship network. Consequentially, CRM 2.0 enables customers to take a greater role in forming relationships. The connection types in CRM 1.0 present a limited view of the customer which has an adverse effect on their narrow information. On the other hand, CRM 2.0 enables multiple connections which allow customers to gain additional knowledge. In terms of generated value, CRM 1.0 is restricted to targeted messages, whereas CRM 2.0 offers more diverse value generation resulting from informal conversations of customers within social networks. A healthcare provider must consider the essential role of the conversation among patients as recent ICT enables them to share experiences without barriers. For example, the conversation that takes place among patients on a social network on healthcare services may influence the image of the healthcare provider. Shared experience of unprofessional treatments or services to patients can easily lead to distrust (Almunawar et al., 2012).

With all its features and benefits, CRM 2.0 can enhance the sense of control, improve self-care practices, and increase the scope of utilisations of healthcare services. The role of CRM 2.0 in empowering customers within healthcare organisations is further explored in the next section.

Table 1: Comparison CRM 1.0 and CRM 2.0

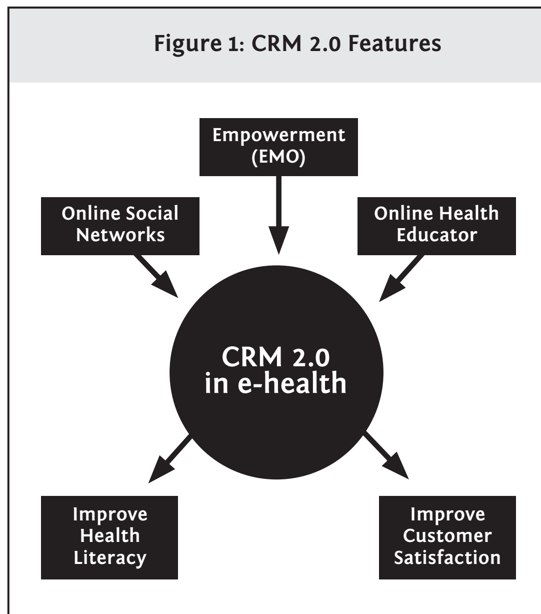
TYPE	CRM 1.0	CRM 2.0
Relationship	Focus on individual relationship (C2C, C2B)	Focus on collaborative relationship (engaging a more complex relationship network)
Connection	Limited view of the customer & his/her community preferences, habits, etc.	Multiple connections allow better understanding of the customer and his/her community
Generated Value	Targeted messages generate value	Conversation generates value

Source: Cipriani, 2008

Empowering Customers

Empowerment is well supported in the healthcare literature and related to customers and healthcare services over the past decade (Dijkstra et al., 2002; Paterson, 2001; Skelton, 1997; van Dam et al., 2003). In the organisation, empowerment implies the provision of necessary tools to staff in order to be able to resolve, on the spot, most problems or questions faced by customers. Besides, staff can deal with customers directly and so reduce the number of dissatisfied customers who would otherwise have complained, but now simply switch brands (Low, 2002).

According to McWilliam et al. (1997), empowerment is a result of both interactive and personal processes, where caring relationships facilitate the emergence of *power* (or potential). Empowerment as an interactive process suggests that *power* is 'transferred' by one person to another, whereas empowerment as a personal process suggests that *power* is 'created' by and within the person. Although the expected outcome is the same, i.e. the gain of more *power* over one's life, the nature of the two processes is very different (Aujoulat et al, 2006). The first case entails that *power* can emerge through active co-creation and collaboration in an empowering relationship. Since CRM 2.0 facilitates interactions and collaborations, it can be used as a tool to implement empowerment. In the second case, when the process of empowerment is perceived from the point of view of the customers, it is considered as a process of personal transformation.



Source: Authors' Compilation

Figure 1 presents three features of CRM 2.0 that can be embedded in e-health systems: online social networks, empowerment of electronic medical object (EMO), and online health educators. Online social networks present a facility for patient to patient interaction; EMO entails the ability of patients to access their specific medical record, which is empowered by healthcare organisations; online health educators are provided by a healthcare provider to facilitate the interaction between healthcare organisations and patients. Details of each component will be highlighted in the model discussion.

Methodology

With all the promises and benefits offered by empowerment, the research attempts to utilise CRM 2.0 as both a tool and a strategy to empower customers in healthcare scenarios. For this purpose we single out potential features offered by CRM 2.0 to support customers' empowerment and prove these features in a survey. We use the purposive sampling methods in which respondents were intentionally selected from patients, patients' family, or medical staff from hospitals and homecare centres across the country. Questionnaires were developed based on the extracted features of CRM 2.0 (see Figure 1).

There were 366 respondents participating in the survey which was conducted from February to March 2011. Attributes of empowerment through CRM 2.0 were interrogated and analysed in order to gain preliminary responds from the potential users in Brunei. Data gathered from the survey was examined, interpreted and eventually converted in requirements to develop a prototype of CRM 2.0 for healthcare as shown in Figure 3. The prototype will be tested for the development of a system and for future recommendations.

Table 2: Demographic Characteristics of Sample

	Employment
42%	Private
58%	Government
	Gender
46%	Male
54%	Female
	Age
13%	20 years or younger
38%	21 - 30
19%	31 - 40
18%	41 - 50
12%	51 years or older
	Education
10%	Did not complete high school
31%	Completed high school only
59%	Completed more than high school
	Internet Usage
63%	At least daily
18%	Daily to weekly
9%	Weekly to monthly

Table 3: Empowerment Features in CRM 2.0

	Empowerment of EMO
83%	Request appointment online
79%	View Electronic Medical Record (EMR)
69%	Update personal medical activities
81%	View health promotion online
76%	Record health activities online
84%	View payment online
	Online Health Educator
77%	Prescription online
78%	Referral online
50%	Paying service online
73%	Consultation online
92%	EMR only for trusted doctors
	Social Networks
62%	Discuss health service in social network
77%	Control of own EMR
72%	Discuss health status in social network
76%	Discuss with patients same condition

Source (Both Tables): Authors' Survey Results

Analysis and Discussion

To analyse the reliability of the questionnaire items used in this study, Cronbach's alpha is used to measure internal consistency (1). Cronbach's Alpha[5] measured 0.80 for 363 items which indicates a relatively high internal consistency and therefore reliability of the study. Table 2 shows the demographic characteristics of the samples. Important to note here is that respondents between the age of 20 to 50 years are the most potential users of CRM 2.0 notably because of their basic Internet literacy which is the critical success factor for the empowerment through CRM 2.0.

$$\alpha = \frac{N.\bar{c}}{\bar{v} + (N - 1).\bar{c}} \quad \textbf{(1)}$$

Table 3 below shows the results of the survey in percentage. Interestingly, the survey reveals that the expectations of customers toward empowerment through CRM 2.0 are very promising.

5 Cronbach's alpha determines the internal consistency or average correlation of items in a survey instrument to gauge its reliability.

The Proposed CRM 2.0 Model

Based on the literature review and the survey results, we propose a CRM 2.0 model to accommodate the features of patients' empowerment. CRM functionalities are composed of Marketing, Sales, and Customer Service, which are operated to achieve the business strategy of a healthcare organisation. For example, a marketing strategy should accommodate social marketing to promote public health and commercial marketing to acquire more customers coming for services. Customer service will offer distinct value for each activity. CRM 2.0 accommodates various features and components of empowerment in healthcare systems, as its central role entails self-managed data and authorisation to encourage customers to provide full information in relation to their health. This is very important to healthcare organisations as it also enables customers to access more information especially on EMO. Organisations will benefit from the strategy of marketing, sales, and customer service, while customers will benefit from an empowerment which promises better customer satisfaction and health literacy.

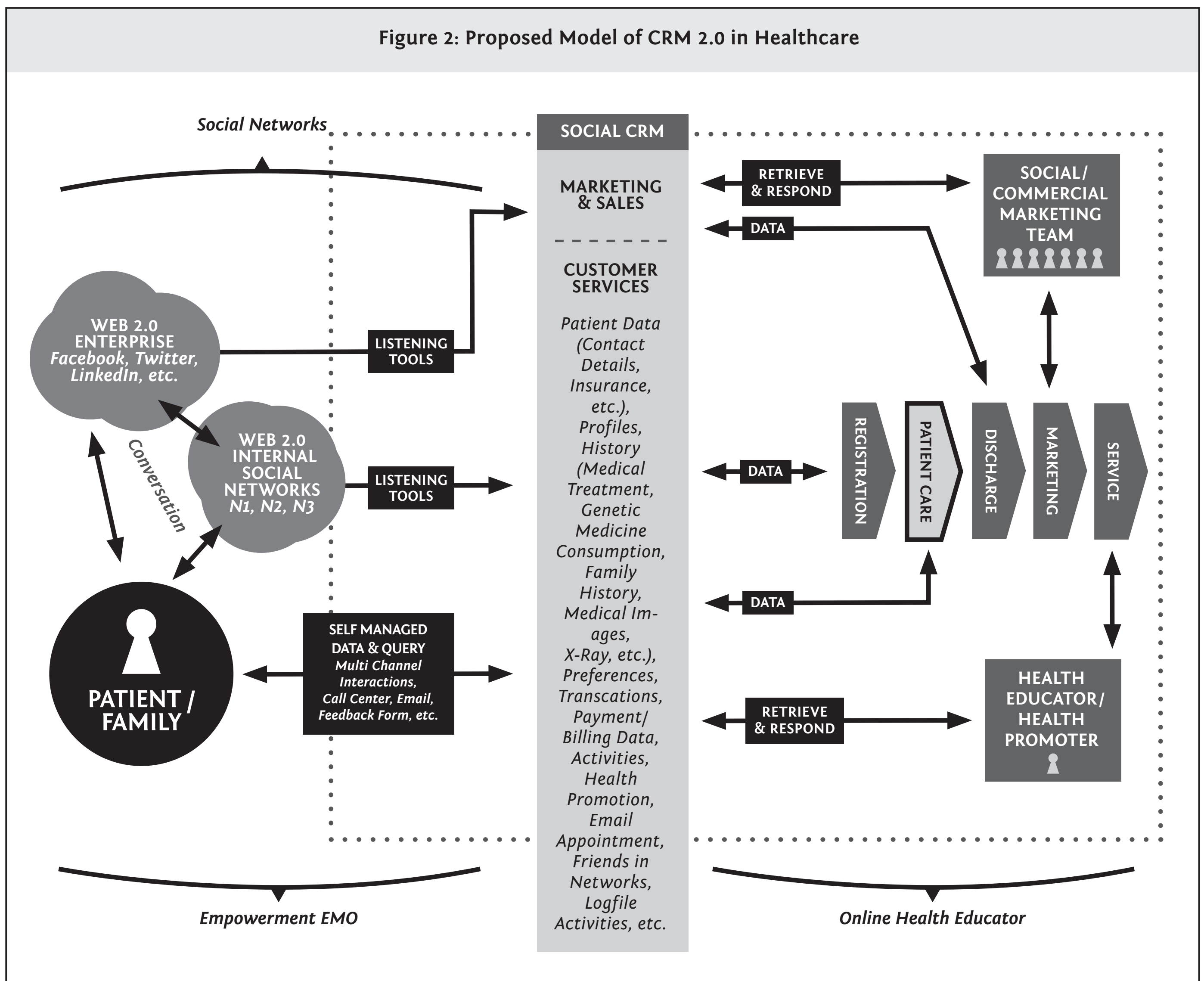
Figure 2 presents a proposed model of CRM 2.0 in healthcare organisations. It offers a starting point for identifying possible theoretical mechanisms that might account for ways in which CRM 2.0 provides one-stop service for building relationships between a healthcare organisation, patients, and community at large. The framework is developed from Enterprise Social Networks, Internal Social Networks, listening tool interfaces, and healthcare value configuration.

The term social networks refers to any Web 2.0 technology accessed by patients or their families. We focus on two different types of interconnection: Enterprises Social Networks and Internal Social Networks. The Enterprises Social Networks refers to external and popular Web 2.0 applications such as *Facebook, Twitter, Linkedln, MySpace, Friendster* etc. which may serve as platforms for interaction between patients. The dashed line connecting Enterprises Social Networks and CRM systems means that none of these networks has control over the other directly. However, constructive conversation and information from Enterprises Social Networks should be captured for creating strategies, innovations, better services and, at the same time, respond accurately to emerging challenges. Furthermore, the model involves Internal Social Networks that are operated, managed, and maintained within the healthcare organi-

sation's infrastructure. The pivotal target is a conversation between internal patients and their families with regard to similar health problems and illness. For example, patients with diabetes will be motivated to share their experience, process of learning, and knowledge with other patients.

In general, the aim for having external and internal social networks is to engage patients and export ideas, foster innovations of new services, and ensure quick response/feedback for existing services and technologies from people inside and outside the organisation. Both provide a range of roles for the patient or his/her family; this is in line with the survey results presented in Table 3.

Figure 2: Proposed Model of CRM 2.0 in Healthcare



Source: Authors' Compilation

CRM 2.0 empowers patients (and their family) to control their own data. Once the patient registers for the service from the healthcare provider, it will enable him/her to enjoy the benefits of a personalised e-health system with CRM 2.0 as the frontline of the system. Authorisation will be provided for each patient. Hence, the authorisation and self-managed account/service grant the access to all applications and data offered by the system. Technical assistance is provided by the manual or by a health informatics officer (just like any other customer service in business/organisation), who is available online and assists patients and their family in utilising the system. Furthermore, since all information (medical record) can be accessed online anywhere and at any time, it can contribute to a collaborative treatment in telemedicine. This feature refers to the empowerment through EMO (see Figure 1 and Table 3).

The model adopts a modular approach; it will assist a healthcare provider to initiate empowerment by stages, and measure the performance gradually. Some of the features available to the users include the update of personal data, access to medical records and history (medical treatment received, medicine consumption history, family illness history, genetic, medical imaging, x-ray and so forth), preference services, transaction, payment/billing data, activities, personal health promotion and education, e-mail, appointment, friend in networks, forums, chatting and so forth.

Finally, a healthcare business scenario is a critical process that affects personal health as much as it affects healthcare organisations. It is important for healthcare organisations to ensure that CRM 2.0 is fully utilised by their customers. Patients need to collaborate with healthcare providers in order to gain sufficient know-how to use electronic and online services effectively. To support this function, we propose an Online Health Educator which enables patients to attain a better knowledge and control over their health data, and yet, contributes to the basic communication between patients and healthcare providers. Additionally, the Online Health Educator determines the success of the implementation as it ensures that there is a group of staff dedicated to guarantee that e-health services are managed in a professional way.

Conclusion

Patient expectations in healthcare are high, and this creates a serious challenge for healthcare providers. In this article, we suggest a model to address patients' demand by combining the concept of value chain and value configuration in healthcare organisations, CRM, and Social Networks. The model incorporates customer empowerment through healthcare organisation to patient as well as patient to patient relationships. Recent Web technology offers a broader outlook on customers' empowerment in many ways and levels depend on the needs and policies of the organisations. These range from digitalising medical records to the customers' ability in accessing their EHR.

We conducted a survey to verify our empowerment features established in the CRM 2.0 model. The result of the survey confirms that customers prefer the empowerment features deriving from the model. They prefer to have control over information on their health and over applications that may affect their health. Moreover, it also confirms that the availability of an online health educator proposed in the model is important in order to achieve the goals of e-health in educating and promoting better health to customers. CRM 2.0 shares the exceptional capabilities of social media and social networks that provide a new approach which transcends traditional CRM. The majority of respondents agreed that both social networks and social support online should be part of an e-health system.

The future direction of the study is to design a prototype based on our model. The prototype will be used to validate our model and to confirm that the empowerment featured in an e-health system is essential and highly recommended.

References

AITI (2010). *Brunei Darussalam Household ICT Survey Report 2010*. Brunei Darussalam: Authority for Info-Communications Technology Industry of Brunei Darussalam.

Anderson, R. M., Funnel, M. M., Butler, P. M., Arnold, M. S., Fitzgerald, J. T., & Feste, C. (1995). Patient empowerment: results of a randomised control trial. *Diabetes Care, 18*(7), 943-949.

Anshari M., & Almunawar, M. N. (2011). Evaluating CRM Implementation in Healthcare Organization. *International Proceedings of Economics Development and Research, 9*, 30-34.

Anshari, M., & Almunawar, M. N. (2012). *Framework of Social Customer Relationship Management in E-Health Services*. Retrieved 12 May 2012 from http://www.ibimapublishing.com/journals/JEHM/2012/766268/766268.html

Anshari, M., Almunawar, M. N., & Low, K. C. P. (2012). CRM 2.0 Within E-Health Systems: Towards Achieving Health Literacy and Customer Satisfaction. *Journal of Development Informatics, 1*(1), 40-48.

Almunawar, M. N., Wint, Z., Low, K. C. P., & Anshari, M. (2012). E-Health Initiative and Customer's Expectation: Case Brunei. *CiiT International Journal of Automation and Autonomous System,* February 2012, 1-8.

Aujoulat, I., d' Hoore, W., & Deccache, A. (2006). Patient empowerment in theory and practice: Polysemy or cacophony? *Patient Education and Counselling, 66*(1), 13-20.

Cipriani, F. (2008). *Social CRM; Concept, Benefits and Approach to adopt*. Retrieved 12 May 2012 from http://www.slideshare.net/fhcipriani/social-crm-presentation-761225

Davison, B. J., & Degner, L. F. (1997). Empowerment of men newly diagnosed with prostate cancer. *Cancer Nursing, 20*(3), 187-196.

Desbiens S. A., Wu, A. W., Yasui Y., Lynn J., Alzola, C., Wenger, N. S., Connors, A. F., Phillips, R. S., & Fulkerson W. (1998). Patient empowerment and feedback did not decrease pain in seriously ill hospitalised patients. *Pain, 75*(2-3), 237-246.

Dijkstra, R., Braspenning, J., & Grol, R. (2002). Empowering patients: how to implement a diabetes passport in hospital care. *Patient Education and Counseling, 47*(2), 173-177.

Golant, M., Altman, T., & Martin, C. (2003). Managing cancer side effects to improve quality of life: a cancer psychoeducation program. *Cancer Nursing, 26*(1), 37-44.

Kieffer, C. H. (1984). Citizen empowerment: a developmental perspective. In J. Rappaport, C. Swift, & R. Hess (Eds.), *Studies in empowerment: steps towards understanding and action* (pp. 9-36). New York: The Haworth Press.

Low, P. K. C., (2002). *Strategic Customer Management: Enhancing Customer Retention and Service Recovery*. BusinesscrAFT Consultancy, Singapore.

Maliski, S. L., Clerkin, B., & Letwin, M. S. (2004). Describing a nurse case manager intervention to empower low-income men with prostate cancer. *Oncology Nursing Forum, 31*(1), 57-64.

McCann, S., & Weinman, J. (1996). Empowering the patient in the consultation: a pilot study. *Patient Education and Counselling, 27*(3), 227-234.

McWilliam, C. L., Stewart, M., Brown, J. B., McNair, S., Desai, K., Patterson, M. L., Del Maestro, N., & Pittman, B. J. (1997). Creating empowering meaning: an interactive process of promoting health with chronically ill older Canadians. *Health Promotion International, 12*(2), 111-123.

NEHTA (2012). *What is a PCEHR*. Retrieved 12 May 2012 from http://www.nehta.gov.au/ehealth-implementation/what-is-a-pcher

Paterson, B. (2001). Myth of empowerment in chronic illness. *Journal of Advanced Nursing, 34*(5), 574-581.

Segal, L. (1998). The importance of patient empowerment in health system reform. *Health Policy, 44*(1), 31-44.

Skelton, A. M. (1997). Patient education for the millennium: beyond control and emancipation? *Patient Education and Counselling, 31*(2), 151-158.

van Dam, H. A., van der Horst, F., van den Borne, B., Ryckman, R., & Crebolder, H. (2003). Provider–patient interaction in diabetes care: effects on patient self-care and outcomes. A systematic review. *Patient Education and Counselling, 51*(1), 17-28.

Consumption and Nutritive Values of Traditional Mon Food

Kanvee Viwatpanich[1]

Citation Viwatpanich, K. (2012). Consumption and Nutritive Values of Traditional Mon Food. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 152-160.

Introduction[2]

Traditional foods, consumed by people over a long period of time, play an important role in establishing local identity, culture, and custom, and they transfer cultural heritage from generation to generation (Albayrak & Gunes, 2010; Inamdar, Chimmad, & Naik, 2005). During the past two decades, several researchers have claimed that traditional foods are healthier products and good sources of micronutrients. However, such statements have been poorly described in scientific literature (Albayrak & Gunes, 2010; Inamdar et al., 2005; Kuhnlein, 2003; Salehi, Kuhnlein, Shahbazi, & Kimiagar, 2005). This paper is based on an exploration in an ethnic minority village of Mon people in Thailand. It aims to identify traditional Mon food, describe its nutritive values, and illuminate selected aspects of food consumption behaviour.

Indigenous peoples who live in remote areas mostly rely on traditional foods that are collected from the local surrounding environment (Azar & Aminpour, 1996). The Mon are considered to be one of the earliest peoples in mainland South-East Asia. They were already exposed to Theravada Buddhism more than thousand years before the arrival of the Thai and Burmese in the area, and their language was influential on other languages in the region. More recent migration movements to Thailand appeared

doi 10.4232/10.ASEAS-5.1-9 www.seas.at SEAS
creative commons BY-NC-ND

1 Kanvee Viwatpanich is Assistant Professor at the Department of Community Medicine, Faculty of Medicine, Thammasat University, Thailand. Contact: kanvee@tu.ac.th

2 An earlier version of this paper was first published in the conference proceedings of the International Interdisciplinary Conference, which took place on 15-18 April 2012, in Palermo, Italy. For further information, refer to the International Institute for Social and Economic Sciences (IISES) website at http://www.iises.net/conferences/palermo/conference-proceedings

in the years following 1948, after the civil war and the subsequent installation of military dictatorship in Myanmar. Even though the Mon in Thailand have been integrated into an economic market system and have adopted many aspects of Thai mainstream society, preparation and consumption of traditional food is a practice that can help to perpetuate Mon identity. In the following, this paper presents the study context, introduces 10 traditional Mon dishes, and discusses the nutritive values of the food.

Research Methodology

The following research was carried out in Ban Dong Sak, Sangkhlaburi district, Kanchanaburi province, Thailand. The research protocol was approved by the ethical committee of the Faculty of Medicine, Thammasat University. The research procedure was divided into three main phases. During the first phase, a food survey was conducted and checklists disseminated among 50 households in Ban Dong Sak to identify common foods in everyday consumption. The results of the survey pointed out 79 kinds of food, which were then categorised into eight groups: curry soups (38 recipes), soups (18 recipes), stir-fried food (8 recipes), deep-fried food (7 recipes), chilli pastes (5 recipes), salads (2 recipes), and grilled food (1 recipe). The 10 most frequently consumed foods were purposively selected as representative samples in the study of nutritive values of traditional Mon food.

The second phase of the research dealt with a discussion of traditional Mon food and its ingredients, cooking methods, and consumption. In this phase, 10 housewives, who normally did the cooking for the households, were invited to participate in a focus group discussion. During the process of discussion, the 10 recipes selected in the survey were presented and the cooks agreed to use these as representative for traditional Mon food as all of these dishes (1) were cooked and consumed in Myanmar before they migrated to Thailand, (2) had been consumed for many generations, and (3) were still regularly prepared. The food ingredients and the process of cooking were then recorded to present the standard recipes for this research.

The third phase consisted of cooking demonstrations as one housewife from the focus group consented to do a cooking demonstration of all 10 representative recipes. Following the standardised recipes from the focus group discussion, most ingre-

dients were collected from the forest near the village while only a few were bought from the local market. All ingredients were weighted in raw condition by digital scales before starting to cook. In the case of nutritive value, all data in grams were computed by using the INMUCAL programme which was developed by the Institute of Nutrition, Mahidol University, and measures calories, protein, fat, carbohydrate, fibre, calcium, phosphorus, iron, vitamin A, vitamin B1, vitamin B2, niacin, and vitamin C.

Food Consumption Behaviour

The objective of this part is to explain the food patterns of Mon ethnicity in Ban Dong Sak. Generally, the Mon in this village consume two meals a day. In case of agriculturalists or workforces breakfast is taken between 6 and 7 am before work. The elderly or persons who work at home consume breakfast around 10 or 11 am. The other meal is dinner which is normally eaten around 5 or 6 pm. In between these two meals the consumption of small snacks or salad often occurs. At the time of this research, it was only Papaya salad (including raw Papaya, shrimp paste, salt, dry shrimp, peanuts, fresh chilli, and fermented marian plum), which was consumed this way. This meal is always consumed in a group and more people meet to prepare and eat together.

Rice is the staple food which is served to each person on a separate plate. Apart of this, two or three side dishes are served on plates in the middle of the group where everyone can take whatever they want. Traditionally, the Mon ate their food by using their hands. Due to social interaction with members of modernised Thai society, this behaviour in food consumption changed and some of the younger generation now prefer to eat with spoons and forks.[3]

The consumption of fruits or desserts after the main dish is very rare. As a general characteristic it was found that a sour taste, combined with a spicy and a salty flavour is much preferred in Mon cuisine. The use of oil and sugar as ingredients for food plays only a marginal role. The sour taste comes from tamarind, fermented marian plum, lemon, rosella leaves, or acacia concinna leaves. The salty flavour is from salt and shrimp paste. Fish sauce, which is a popular ingredient in Thai dishes, is not

3 Traditionally, though, Thais also ate their food using hands.

used in Mon cuisine. Just as in Thai cuisine, a few ingredients are used to increase the taste of their dishes. For example, Mono Sodium Glutamate (MSG) is added to almost every kind of dish.

Culinary interaction also enters in Mon society, and nowadays mobile food vendors from outside the Mon community offer their goods too, for example, ice-cream, fish balls, and sausages. Additionally, Mon can easily buy Thai or Western (junk) food in the nearby convenience stores. For economic reasons, in order to gain supplementary income, some Mon opened small shops in their houses and sell industrially produced small snacks and candies for children. Some women also sell home-made snacks or foods in front of their houses. Mostly, dishes are given in the style of 'take-away', but some of them also offer places to sit and eat. At this point it is obvious that food patterns of the Mon are changing and that in addition to home-made and self-produced ingredients industrially produced foods are consumed too. Consequently, change in the living environment also leads to change in consumption behaviour and patterns.

Traditional Mon Foods

10 representative cooking recipes and the methods used to prepare traditional Mon food are explained below. The details of recipes and ingredients are presented in Table 1.

1. **Roselle Soup *(Kang Krajeab)***: Boil the water in a small pot. Add clean roselle leaves and stir until the soup becomes glutinous. Add shrimp paste and salt as needed.
2. **Fish Curry *(Kang Pla)***: For this curry, pound galangal, garlic, shallots, fermented marian plum, fresh chilli, salt, and shrimp paste in the mortar until it is smooth. Marinate the fresh fish with the curry paste in the pot by hand. Heat it up and add water to cover the fish. Sprinkle a pinch of curcuma powder over the dish to decrease the smell of the fish. Before serving, sprinkle with fresh sliced parsley leaves to increase the taste and aroma.
3. **Dried Shrimp Paste *(Naam Prik Kung Haeng)***: Grill fresh chilli, garlic, and shallots and mix them with salt in the mortar. Add dried shrimp and pound it until it attains a smooth consistence. Add lemon juice to increase the taste and aroma. Serve with egg plant, okra, and cucumber as side dishes.
4. **Acacia Concinna Curry *(Kang Som Poi)***: Boil water and add shrimp paste as well as salt. Add pieces of grilled barb fish. Add clean acacia concinna leaves. Wait until it is cooked.

5. **Hunglei Curry *(Kang Hunglei)***: For this curry, ground galangal, garlic, shallots, dried chilli, salt, shrimp paste, and curcuma powder in a mortar until smooth. Heat a pan, put some oil in it, and fry the curry paste with some dark soy sauce. Add the meat which can be pork, chicken, or beef, and fry it with the soy sauce and the curry paste. Add some water, cover the pan, and steam the dish until the meat is tender. Finally, ground and sprinkle dried coriander seeds over the dish to increase the aroma.
6. **Dillenia Indica Curry *(Kang Look San)***: Boil water in a small pot and add sliced garlic. Slice the dillenia indica into small pieces and put them into the boiling water. Add shrimp paste, salt, and monosodium glutamate to increase the taste.
7. **Wax Gourd Curry *(Kang Fag Kheao)***: Grind chilli, garlic, shallots, salt, shrimp paste, and curcuma powder in the mortar until smooth. Heat the pan, add some oil, and fry with

Table 1: List of Ingredients in the Selected Recipes

FOOD ITEM	MAJOR INGREDIENTS (IN PERCENT)
Roselle Soup	Fresh chilli (3.6) roselle leave (81.1) shrimp paste (8.1) salt (5.4) MSG (1.8)
Fish Curry	Fresh fish (65.8) galangal (1.6) shallot (4.5) garlic (4.5) fresh chilli (4.5) salt (1.2) shrimp paste (4.1) fermented marian plum (9.1) curcuma powder (0.4) parsley leave (3.3) MSG (0.8)
Dried Shrimp Paste	Fresh chilli (9.7) shallot (38.7) garlic (12.9) shrimp paste (5.6) salt (2.4) lemon juice (19.4) dried shrimp (9.7) MSG (1.6)
Acacia Concinna Curry	Acacia concinna leave (35.8) shrimp paste (14.9) grilled fish (40.3) salt (6.0) MSG (3.0)
Hunglei Curry	Pork meat (74.1) oil (5.5) galangal (2.4) shallot (7.4) garlic (4.0) dried chilli (1.7) shrimp paste (0.9) salt (1.7) curcuma powder (0.2) dark soy sauce (1.2) coriander seed (0.5) MSG (0.3)
Dillenia Indica Curry	Dillenia indica (73.7) shallot (9.3) garlic (7.6) shrimp paste (3.4) salt (4.2) MSG (1.7)
Wax Gourd Curry	Wax gourd (48.3) chicken (36.2) fresh chilli (1.2) shallot (5.6) garlic (2.0) salt (1.0) shrimp paste (1.6) curcuma powder (0.2) oil (2.8) parsley leave (0.5) MSG (0.7)
Lasia Spinosa Curry	Lasia spinosa leave (29.9) fresh fish (43.9) shallot (9.0) garlic (4.5) shrimp paste (2.3) fermented marian plum (7.3) salt (1.1) fresh chilli (0.6) curcuma powder (0.3g) MSG (1.1)
Monkey Apple Curry	Monkey apple (52.3) fresh shrimp (32.1) shallot (7.8) garlic (3.2) shrimp paste (1.8) salt (2.3) MSG (0.5)
Tomato Curry	Tomato (57.9) dried mackerel (20.2) oil (6.2) shallot (6.5) garlic (3.4) salt (1.3) shrimp paste (2.6) dried chilli (1.3) curcuma powder (0.3) MSG (0.5)

Source: Author's Compilation

curry paste. Add chicken and continue to stir until it is cooked. Pour in some water and wait until it is boiling again. Put small cubes of wax gourds into the curry soup, add a bit more water until the food is covered, and wait until the chicken and wax gourds are tender. Before serving, sprinkle with fresh sliced parsley leaves to increase taste and aroma.

8. **Lasia Spinosa Curry *(Kang Pak Nham)***: Mix lasia spinosa leaves, garlic, shallots, fermented marian plum, salt, shrimp paste, galangal, and fresh fish together by hand. Squeeze it until the water from the lasia spinosa comes out. Boil water in a pot, add all ingredients, pour in some more water, and wait until it reheats. Before serving, add sliced fresh chilli as decoration and to increase the aroma and taste.
9. **Monkey Apple Curry *(Kang Pud Sar)***: Put slices of garlic and shallots into boiling water. Add shrimp paste and salt. After this, add mashed monkey apples and wait until the water is boiling again. Finally, add clean fresh shrimps and boil until it is done.
10. **Tomato Curry *(Kang Ma Khuea Ted)***: The curry paste of this dish consists of dried chilli, garlic, shallots, salt, shrimp paste, and curcuma powder. To prepare this dish, heat a pan, add some oil, and fry the curry paste. Next, add tomatoes and dried mackerel. Pour in a little bit of water and cook until done.

Nutritive Values of Mon Foods

The nutrient composition in 100g edible portions of the 10 recipes is shown in Table 2. *Kang hunglei* contains the highest number of calories (1050.45 Kcal/100g), followed by wax gourd curry (666.14 Kcal/100g), tomato curry (470.04 Kcal/100g), and fish curry (265.15 Kcal/100g), while roselle soup, which was the most frequently consumed, had least calories compared to other foods (32.59 Kcal/100g).

Total dietary fibre ranged from 0.20 to 7.09 g/100g and 7 out of 10 recipes possessed more than 2.0g/100g (Acacia concinna curry was the only dish in which such amount of fibre was not found as the main ingredient is only small leaves from Acacia concinna). The highest level was found in wax gourd curry, which contained a relatively high amount of dietary fibre, 7.1g/100g.

The highest protein and fat contents were found in *kang hunglei* (95.45g/100g and 62.74g/100g, respectively) as the main ingredients are pork and oil. This was followed by wax gourd curry (41.91g/100g of protein and 43.12g/100g of fat) due to the chicken and oil which are added. For the other foods, especially the vegetable soup and curry,

Table 2: Proximate Composition of 10 Recipes per 100g Edible Portion

	Kang Hunglei	*Wax Gourd Curry*	*Tomato Curry*	*Fish Curry*	*Monkey Apple Curry*	*Lasia Spinosa Curry*	*Dried Shrimp Paste*	*Acacia Concinna Curry*	*Dillenia Indica Curry*	*Roselle Soup*
Energy (Kcal)	1050.45	666.14	470.04	265.15	184.42	140.98	120.60	82.93	33.57	32.59
Protein (g.)	95.45	41.91	32.80	28.90	14.42	15.42	10.65	9.37	1.40	1.22
Fat (g.)	62.74	43.12	25.81	7.34	1.89	3.64	0.73	2.07	0.06	0.12
CHO (g.)	25.67	26.88	23.38	14.08	26.19	7.87	17.08	3.66	6.31	6.14
Fiber (g)	3.31	7.09	4.42	2.50	5.07	2.31	3.19	0.00	0.69	0.20
MINERALS										
Ca (mg.)	133.66	216.96	234.63	79.24	188.53	96.66	146.57	170.13	62.88	67.24
P. (mg.)	1128.91	450.61	356.51	330.34	258.58	188.64	225.64	130.19	49.72	30.04
Fe (mg.)	8.28	4.77	5.23	2.03	3.05	2.12	2.66	2.62	1.22	0.97
VITAMINS										
A (IU)	69.43	24.59	117.36	46.94	2.28	15.21	8.57	0.00	11.75	31.30
B1 (mg.)	7.09	0.26	0.33	0.21	0.09	0.10	0.18	0.01	0.07	0.05
B2 (mg.)	0.38	0.40	0.15	0.17	0.83	0.16	0.11	0.04	0.09	0.12
Niacin (mg.)	23.76	12.24	10.00	5.81	3.23	3.35	2.21	1.64	0.96	2.24
C (mg.)	11.16	100.71	71.25	35.57	53.18	28.72	19.88	0.00	4.32	20.78
ENERGY DISTRIBUTION										
CHO	9.79	16.21	20.46	23.67	58.39	24.99	58.14	20.67	80.47	80.47
Protein	36.39	25.28	28.71	48.57	32.15	48.98	36.24	52.96	17.80	15.99
Fat	53.82	58.52	50.82	27.76	9.46	26.03	5.62	26.37	1.72	3.54

Source: Author's Analysis via INMUCAL

the nutritive value of the food was low in fat and energy levels, for example, dillenia indica curry (0.06g/100g of fat and 33.57 Kcal/100 g) and roselle soup (0.12g/100g of fat and 32.59 Kcal/100g). Carbohydrate showed a variation between 3.66g/100g and 26.88g/100g.

The highest carbohydrate value was found in wax gourd curry while the lowest was in acacia concinna curry.

Generally, traditional Mon foods are good sources of calcium and phosphorus, especially tomato curry (234.63 mg/100g of calcium and 356.51 mg/100 g of phosphorus) and *kang hunglei* (133.66 mg/100g of calcium and 1128.91 mg/100g of phosphorus). The reason for this is the shrimp paste, which plays a major role in Mon cuisine and thus presents an important ingredient for all recipes. Finally, the dishes contributed 9.79-80.47%, 15.99-52.96%, and 1.72-58.52% of the total food energy from carbohydrate, protein, and fat, respectively.

Conclusion

The majority of traditional Mon food in everyday life is based on curry and prepared by boiling. Generally, fried foods are very rare. The nutrition value of the dishes reveals a high variation in nutrient composition. Dishes with high content of calcium and phosphorus are also identified. There is some traditional food, which is identified as low in carbohydrate and fat, especially dishes which are based on vegetables. In order to increase the nutrient value of the dishes, fish or meat is recommended due to their valuable nutrient composition. The consumption of Mono Sodium Glutamate (MSG) is high as it is used in almost all dishes in Mon cuisine. Although MSG presents a flavour enhancer which is widely considered safe for human consumption, a reduction of daily intake may be of benefit. Studies convey that high consumption of MSG may lead to an increasing food desire, to overconsumption and, eventually, to gain in weight (He et al., 2008; Hermanussen et al., 2005; Hirata, Andrade, Vaskevicius, & Dolnikoff, 1997). According to informal observations and an interview with the vice-village headman of Ban Dong Sak, obesity in the Mon village is increasing and the high intakes of MSG were considered one of the reasons for that. Besides, hypertension and diabetes are also explained by increasing obesity.

The recommendations from the study are twofold. First, all relevant information concerning the nutritional composition of local foods, and especially information on the acceptable daily intake of MSG, should be provided and communicated to the villagers by local health institutions. Second, additional material concerning the negative impact of food consumption related to a ‘Western’ or a ‘modern’ lifestyle, especially in relation to junk food and fast food, should be provided to local schools in order to target the young generation. As the knowledge of the nutritional value of local food increases, both food preparation and consumption patterns might be preserved and improved.

References

Albayrak, M., & Gunes, E. (2010). Traditional Foods: Interaction between Local and Global Foods in Turkey. *African Journal of Business Management, 4*, 555-561.

Azar, M., & Aminpour, A. (1996). Composition and Nutritional Value of Traditional Rural Iranian Foods. *Eastern Mediterrenean Health Journal, 2*, 261-267.

He, K., Zhao, L., Daviglus, M. L., Dyer, A. R., Horn, L. V., Garside, D., Zhu, L., Guo, D., Wu, Y., Zhou, B., & Stamler, J. (2008) Association of monosodium glutamate intake with overweight in Chinese adults: the INTERMAP Study. *Obesity (Silver Spring), 16*, 1875-1880.

Hermanussen, M., Garcia, A. P., Sunder, M., Voigt, M., Salazar, V., & Tresguerres, J. A. (2005). Obesity, voracity, and short stature: the impact of glutamate on the regulation of appetite. *European Journal of Clinical Nutrition, 60*, 25-31.

Hirata, A. E., Andrade, I. S., Vaskevicius, P., & Dolnikoff, M. S. (1997). Monosodium glutamate (MSG)-obese rats develop glucose intolerance and insulin resistance to peripheral glucose uptake. *Brazilian Journal of Medical and Biological Research, 30*, 671-674.

Inamdar, V., Chimmad, B. V., & Naik, R. (2005). Nutrient Composition of Traditional Festival Foods of North Karnataka. *Journal of Human Ecology, 18*, 43-48.

Kuhnlein, H. V. (2003). Micronutrient, Nutrition, and Traditional Food Systems of Indigenous Peoples. *Food, Nutrition and Agriculture (FNA/ANA) 32*, 33-39. Retrieved 22 April 2011 from ftp://ftp.fao.org/docrep/fao/005/y8346m/ y8346m04.pdf

Salehi, M., Kuhnlein, H. V., Shahbazi, M., & Kimiagar, S. (2005). Effect of traditional food on nutrition improvement of Iranian tribeswomen. *Ecology of Food and Nutrition, 44*, 81-95.

Das philippinische Gesetz zur reproduktiven Gesundheit und seine Bedeutung für feministische sowie entwicklungspolitische (Bildungs-)Arbeit

Michael Reckordt[1]

Citation Reckordt, M. (2012). Das philippinische Gesetz zur reproduktiven Gesundheit und seine Bedeutung für feministische sowie entwicklungspolitische (Bildungs-)Arbeit. *ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften, 5*(1), 161-165.

Das Philippinenbüro arbeitet im Bereich der politischen Bildungsarbeit seit Jahren zu Themen, die die philippinische Zivilgesellschaft bewegen. Der 1987 gegründete Verein kann auf eine Vielzahl an Seminaren und Publikationen zurückblicken, in denen er Themen der philippinischen Zivilgesellschaft identifizierte und versuchte, eine Sensibilisierung für diese Diskussionen im deutschsprachigen Raum zu erreichen. Ziel der politischen Bildungsarbeit ist ein reger Austausch sowie ein gegenseitiges Verstehen und Lernen. Selten zuvor war ein Thema so schwer aufzuarbeiten, wie das Seminar zu reproduktiver Gesundheit in den Philippinen, welches am 24. und 25. März 2012 abgehalten wurde. Bereits bei der Vorbereitung dieses Seminars war es schwieriger als sonst, ReferentInnen und GeldgeberInnen von der Notwendigkeit einer Diskussion über die *Reproductive Health Bill* in Deutschland zu überzeugen. Unserer Ansicht nach ging es dabei weniger um die Relevanz des Themas in der entwicklungspolitischen Debatte, wie die Betonung der Millenniumentwicklungsziele[2] vielfach zeigt, als darum, dass einzelne Organisationen und Personen befürchteten, zu einer Positionierung gezwungen zu werden. Außer der Stiftung Umverteilen und dem AKE Bildungswerk Vlotho ließen sich daher keine PartnerInnen gewinnen.

Zur Einstimmung des Seminars „Die Diskussion um das philippinische Reproduc-

1 Michael Reckordt ist Geograph und arbeitet seit 2008 im **philippinen**büro, dessen Geschäftsführer er seit 2009 ist. Im Rahmen einer Philippinenreise im Jahr 2011 führte er viele Interviews mit AktivistInnen zum Thema reproduktive Gesundheit. Kontakt: michael.reckordt@asienhaus.de

2 Das fünfte Millenniumentwicklungsziel behandelt die Verbesserung der Gesundheitsversorgung von Müttern und möchte zwischen 1990 und 2015 die Sterberate von Müttern um drei Viertel senken sowie bis 2015 einen allgemeinen Zugang zu reproduktiver Gesundheit erreichen.

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-10

creative commons BY-NC-ND

tive Health Gesetz – Ursachen und die Bedeutung für feministische sowie entwicklungspolitische (Bildungs-)Arbeit" wurden thematisch passende Fotoimpressionen aus den Philippinen gezeigt. Viele Kirchen, religiöse Einrichtungen und Einzelpersonen zeigen ihre Ablehnung durch großflächige Plakate, während die BefürworterInnen des Gesetzes ihre Unterstützung ebenfalls sichtbar mit Demonstrationen auf die Straße tragen.

Nach dem visuellen Einstieg führte Maitet Ledesma von *Pinay sa Holland-GABRIELA*, einem niederländischen Netzwerk philippinischer Migrantinnen, das der philippinischen Partei *GABRIELA* nahesteht, in den Gesetzesentwurf und die damit verbundene Diskussion ein. Sie zeigte die historischen Kontinuitäten der Probleme und sozialen Kämpfe um dieses Gesetz auf. In einem Vergleich mit anderen Ländern in der Region Südostasien fielen vor allem die hohe Sterberate von Müttern bei der Geburt, die hohe Anzahl an illegalen Schwangerschaftsabbrüchen sowie der Wunsch vieler Frauen nach einer besseren Familienplanung auf (siehe dazu auch den Beitrag von Marina Wetzlmaier in der vorliegenden ASEAS-Ausgabe). In der anschließenden Diskussion wurde die Rolle der katholischen Amtskirche thematisiert, die die stärkste Opposition gegen das Gesetz stellt. Die Diskussion ist in den Philippinen hochgradig emotional aufgeladen und selbst Personen wie der Jesuit John Carroll, der sich als Vermittler anbieten würde, wird für seine Positionierung drastisch angegriffen. Obwohl einige Ordensgemeinschaften größere Freiheiten bei einer Positionierung zu dem Gesetz haben, äußern sie sich ebenfalls nur sehr vorsichtig. In der Diskussion wurde auch angemahnt, dass progressive Bischöfe gestärkt werden müssten.

Um das Thema nicht allein aus der philippinischen Perspektive zu diskutieren, sondern auch einen Bezug zum politischen Diskurs in Deutschland herzustellen, berichtete Jutta Kühl, ehemalige Referentin für feministische Politik der Partei *Die Linke*, im Anschluss an den Vortrag von Maitet Ledesma über reproduktive Gesundheit in Deutschland. Aus ihrer Sicht sind Debatten im Bundestag, welche diese Thematik betreffen, in der Regel entideologisiert und der Fraktionszwang ist aufgehoben. Das ist auf der einen Seite positiv, weil die Meinungsbildung mit offenerem Ausgang geschieht. Auf der anderen Seite wird somit aber auch die Diskussion stärker entpolitisiert, da sich keine konservativen, sozialdemokratischen oder linken Positionen identifizieren lassen und die Entscheidungen der PolitikerInnen individualisiert werden. Dadurch wird die (frauen-)politische Dimension aus der Diskussion genommen, ein-

zelne PolitikerInnen aus denselben Parteien können gar entgegengesetzte Meinungen vertreten und ethische Argumente dominieren. Für die WählerInnen bedeutet dies auch, dass sie de facto durch ihre Stimme für eine bestimmte Partei die Diskussion nicht mit gestalten können. Doch nicht nur die Entpolitisierung der Diskussion ist zu bemängeln. Tatsächlich haben sich durch die Hartz IV-Gesetzgebung und Umgestaltungen in der Gesundheitspolitik für Frauen in Deutschland einige grundlegende Dinge verändert. So ist zum Beispiel die Pille als Verhütungsmittel für Frauen ab dem 20. Lebensjahr nicht mehr kostenlos erhältlich. Die betroffenen Frauen müssen sowohl Praxisgebühren als auch die Kosten für die Pille selbst übernehmen, was vor allem für ärmere Bevölkerungsschichten, die auf Sozialleistungen angewiesen sind, eine finanzielle Hürde darstellen kann. Im Endeffekt führt es dazu, dass Familienplanung für ärmere Familien schwieriger wird. Ein anderer Punkt ist, dass in Deutschland der Zugang zur „Pille danach" eingeschränkt ist. Diese Pille ist keine Abtreibungspille, sondern lässt den Zyklus schneller beginnen und sorgt zum Beispiel nach gerissenen Kondomen oder Vergewaltigungen dafür, dass eine unfreiwillige Schwangerschaft verhindert wird. In vielen europäischen Ländern ist diese Pille in Apotheken frei zugänglich, in Deutschland ist sie immer noch verschreibungspflichtig, obwohl dies 2002 von der EU und 2003 von einem Sachverständigenrat kritisiert wurde. Vor allem in Regionen mit niedriger ÄrztInnendichte und für Frauen ohne Dokumente kann dies zu ungewollten Schwangerschaften führen.

Am 25. März 2012 stellten Eleanor Koch und Elsie Joy dela Cruz die Positionen der MigrantInnen in Deutschland sowie die Position der *United Church of Christ in the Philippines* (UCCP) vor. Eleanor Koch von PhilNetz, einem Verein, der sich aus der philippinischen Diaspora in Deutschland gegründet hat und als Netzwerk an Themen zur Integration und Entwicklungszusammenarbeit arbeitet, zeigte anhand ihrer eigenen Biographie Kontinuitäten in der Diskussion auf. Zur Zeit des Kriegsrechtes in der Marcos-Diktatur arbeitete sie als Lehrerin auf den Philippinen, nahm an Fortbildungen teil und wurde zur Gesundheitsarbeiterin ausgebildet. In diesem Zusammenhang wurden Trainingsworkshops angeboten und auch Verhütungsmittel wie Kondome verteilt. Marcos hatte 1967 die *Population Control Bill* unterschrieben, ein Projekt, das von der *United States Agency for International Development* (USAID) finanziert worden war, um das Bevölkerungswachstum einzudämmen. In diesem politischen Ziel ist gleichzeitig der Hauptwiderspruch zum heutigen Gesetzentwurf zu sehen, denn es

geht den AktivistInnen von Organisationen wie *Likhaan* - eine philippinische NGO, die Gesundheitsversorgung für marginalisierte Frauen anbietet und deren Mitglieder sich aktiv für die RH Bill einsetzen - oder *GABRIELA* aktuell darum, Frauen und ihren Familien die Wahlfreiheit zu ermöglichen, wie viele Kinder sie bekommen möchten, und nicht darum, der Bevölkerung eine ideale Familiengröße aufzuzwingen. Der Slogan lautet „Freedom of choice" ohne staatlichem Zwang zu einer Zwei-, Drei- oder Vier-Kindpolitik. Eleanor Koch berichtete auch, dass in der philippinischen Diaspora in Deutschland die Unterstützung für das Gesetz überwiegt. Dennoch sei die Diskussion eine sehr persönliche Sache und es mangele vor allem an Informationen über das Gesetz als auch über Verhütungsmethoden.

Zum Abschluss referierte Elsie Joy dela Cruz über die Position der UCCP. Sie ist Pastorin der UCCP und freie Mitarbeiterin bei der *Vereinten Evangelischen Mission* (VEM) in Deutschland. Die UCCP ist eine sogenannte *Mainline Church*, eine moderate protestantische Kirche, deren theologische Ansätze als offen für gesellschaftliche Veränderungen gelten. Im Gegensatz zur katholischen Amtskirche unterstützen viele protestantische Kirchen offiziell das Gesetz und somit die Frauenrechtsgruppen. Die VertreterInnen der UCCP haben sich mehrfach öffentlich, in Zeitungen oder durch Presseerklärungen für die *Reproductive Health Bill* ausgesprochen. Elsie Joy dela Cruz stellte Übereinstimmungen mit vielen Positionen der Frauenrechtsgruppen vor, betonte auf der anderen Seite aber auch, dass das Thema nicht im Zentrum der politischen Arbeit der UCCP stehen würde.

Im Anschluss an den Vortrag wurde die Rolle der Kirchen thematisiert und einige der Teilnehmenden konnten aus ihrer eigenen Biographie – und vor allem aus dem Besuch von religiösen Schulen – die Diskussion bereichern. Eine Teilnehmerin sagte, dass Deutschland und die Philippinen in verschiedenen Zeiten leben würden. Eine andere Teilnehmerin widersprach dem vehement und betonte, dass dies vielleicht für den religiösen Konservatismus stimme, jedoch die Mittelschicht in den urbanen Zentren der Philippinen, die eine durchschnittliche Anzahl an Kindern habe, die mit Europa oder den USA vergleichbar ist, im Bezug auf die RH Bill mit Sicherheit nicht rückwärtsgewandter sei.

Zum Abschluss folgte eine Diskussion, inwieweit auch die TeilnehmerInnen in Deutschland in die Diskussion eingreifen, PartnerInnen in den Philippinen unterstützen und Informationsarbeit zu dem Thema entwickeln können. Dem Philippinenbüro

wurde vor allem der Auftrag erteilt, weiter an diesem Thema zu arbeiten sowie Informationsmaterialien zu erstellen und zu verteilen. Ein möglicher Ansatzpunkt, diese Arbeit besser zu verankern, könnten die Millenniumsentwicklungsziele sein, die bis 2015 erreicht werden sollten. Auch die Erfahrungen und der Austausch von feministischen AktivistInnen in Deutschland und den Philippinen könnten eine Möglichkeit darstellen, durch gegenseitiges Lernen reproduktive Gesundheit als Thema in den Fokus der Öffentlichkeit zu bringen.

Weitere Informationen, der Seminar-Reader sowie die Präsentationen sind allen Interessierten online unter www.philippinenbuero.de zugänglich.

Der lange Schatten struktureller Fehlentscheidungen: FachärztInnenmangel in der Frauenheilkunde in Laos und Vietnam. Im Gespräch mit Michael Runge (Universität Freiburg)

Lan-Katharina Schippers[1]

Citation Schippers, L.-K. (2012). Der lange Schatten struktureller Fehlentscheidungen: FachärztInnenmangel in der Frauenheilkunde in Laos und Vietnam. Im Gespräch mit Michael Runge (Universität Freiburg). *ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften, 5*(1), 166-173.

Seit über 50 Jahren sind Vietnam und Laos Zielländer der westlichen Entwicklungszusammenarbeit. Dennoch ist der Zustand der Gesundheitssysteme in den Ländern weiterhin von gravierenden Mängeln geprägt. Besonders in der Frauenheilkunde und Geburtshilfe fehlt es an gut ausgebildeten medizinischen Fachkräften. Der deutsche Gynäkologe Prof. Dr. Michael Runge engagiert sich seit einem Vierteljahrhundert für bessere Frauengesundheit in Südostasien. Seine Projekte basieren auf der Überzeugung, dass die Ausbildung der Fachkräfte in den Zielländern den Schlüssel für ein funktionierendes Gesundheitssystem darstellt. Im Gespräch mit ASEAS spricht Runge über die medizinische Ausbildung in Südostasien, strukturelle Fehlentscheidungen der Entwicklungshilfe und die Erfolge seiner Projekte.

For over 50 years, Vietnam and Laos have been target countries of Western development cooperation. Nevertheless, the state of the healthcare systems in these countries is still characterised by serious shortcomings. Particularly in obstetrics and gynaecology, there is a lack of well-trained medical professionals. For a quarter century, German gynaecologist Prof. Dr. Michael Runge has worked on improving women's health in South-East Asia. His projects are based on the conviction that education for skilled workers in target countries is key to a functioning health system. In this interview, Runge talks about medical training in South-East Asia, structural mistakes of development assistance, and successes of his projects.

SEAS www.seas.at
doi 10.4232/10.ASEAS-5.1-11
creative commons BY-NC-ND

LAN-KATHARINA SCHIPPERS: **Seit wie vielen Jahren engagieren Sie sich in Südostasien, was hat Sie anfangs in die Region gebracht und in welchem Bereich sind Sie schwerpunktmäßig aktiv?**

MICHAEL RUNGE: Ich war früher Mitglied des „Deutschen Komitees Notärzte Cap Anamur". Die Cap Anamur war ein Rettungsschiff im südchinesischen Meer und hat Ende der 1970er-Jahre ungefähr 10.000 Boatpeople[2] aus der Seenot gerettet. Dies war der ursprüngliche Kon-

1 Lan-Katharina Schippers hat Politikwissenschaft mit den Schwerpunkten Entwicklungspolitik, Migrationspolitik und Staatstheorie an der Universität Wien, Österreich, und der University of Nottingham, Großbritannien, studiert.

2 Anmerkung der ASEAS-Redaktion: Der Begriff „Boatpeople" bezeichnete ab Mitte der 1970er-Jahre die in Folge des

takt in die Region. Hinzu kommt, dass die medizinische Fakultät der Universität Hue in Vietnam unter Mithilfe der Freiburger Universität aufgebaut wurde. Die früheren Lehrer aus meinem Studium haben in Hue unterrichtet. Bei der Tet-Offensive 1968 des Vietcong gegen die Amerikaner wurden sie zum großen Teil getötet. Danach brach der Kontakt erst einmal ab. Deutschland ist damals ja den Vorgaben der Alliierten gefolgt und hat Vietnam wirtschaftlich, politisch und auch im Gesundheitsbereich in jeder Form boykottiert. Genauso erging es Laos, das ab 1975 von den Pathet Lao regiert wurde. Beide Länder wurden isoliert.

In dieser politischen Isolation, in der sich Vietnam und auch Laos befanden, ging es diesen Ländern wirtschaftlich immer schlechter, sodass es zu Hungersnöten kam. Bis Ende der 1980er-Jahre haben große Teile der vietnamesischen Bevölkerung richtig gehungert, die Cap Anamur brachte damals noch Reislieferungen nach Vietnam. Insofern war Vietnam an einem historischen Tiefpunkt angekommen, das Volk hungerte, die Wirtschaft lag danieder, und, was ich damals noch nicht wusste, die akademische Situation hatte sich seit Beginn des Krieges 1961 auch enorm verschlechtert.

Nach Stationen in Afrika und auf den Cook-Inseln bin ich dann 1993 nach Deutschland zurückgekommen und habe mit Freunden eine Frauengesundheitsstiftung gegründet: MATERRA. Später kam dann das *Collaborating Centre for Postgraduate Training and Research in Reproductive Health* an der Universitätsfrauenklinik Freiburg hinzu. Über die Jahre konnten wir unsere Projekte mit Hilfe von öffentlichen und privaten Förderungen, beispielsweise von der Else Kröner-Fresenius-Stiftung, der Mercator-Stiftung, dem Wissenschaftsministerium Baden-Württemberg, dem Deutschen Akademischen Austauschdienst (DAAD) sowie dem Asia-Link-Programm der EU umsetzen.

Schon 1993 hatten wir dann in mehreren Ländern Projekte, unter anderem auch in Vietnam. Dort haben wir mit einem Kleinkreditprojekt für Landfrauen begonnen, ähnlich dem System der Grameen-Bank in Pakistan. Das Projekt läuft bis heute in Nordvietnam, da es sich als sehr erfolgreich herausstellte. Ebenso haben wir ein Trainingszentrum für die Berufsausbildung für Frauen in Hue aufgebaut. Als ich damals diese Projekte besucht habe, konnte ich dann erste Kontakte zu den medizinischen Fakultäten in Hanoi, Hue und Ho-Chi-Minh-Stadt aufbauen.

Ich habe dort gesehen, dass die Universitäten in einem schrecklichen Zustand waren. Zum einen gab es kaum mehr ausgebildete ProfessorInnen oder Lehrkräfte. Es waren Leute tätig, die selbst nur zwei Jahre Berufserfahrung hatten und die dann wiederum MedizinstudentInnen und FachärztInnen ausbilden sollten. Damit waren sie natürlich komplett überfordert. Es gab einfach keine vernünftige FachärztInnenausbildung mehr, weil es an Fachkräften gefehlt hat. Seit 1968 wurden zudem keine medizinischen Fachbücher mehr geschrieben. Für die FachärztInnenausbildung gab es überhaupt keinerlei Bücher.

Im Vergleich dazu: Wir haben ungefähr 3.000 laufende Titel in Deutschland in deutscher Sprache allein zu Frauenheilkunde und Geburtshilfe jedes Jahr. Damals gab es kein einziges für ein 80 Millionen-Volk. Es gab also keine Lehrmaterialien, es gab keine ausgebildeten Hoch-

Indochinakriegs auf dem Seeweg geflohenen Menschen zumeist vietnamesischer Herkunft. Heute wird er auch in anderen Weltregionen verwendet.

schullehrerInnen, und der technische Stand der Medizin entsprach dem der 1960-er Jahre. Als ich diese drei Faktoren gesehen habe, dachte ich, dass da etwas in der akademischen Ausbildung getan werden muss, um die Universitäten wieder zu stärken. Denn ohne Universitäten mit guten HochschullehrerInnen gibt es niemanden, der die Fach- und AllgemeinärztInnen, Hebammen und das Pflegepersonal ausbilden kann.

Welchen Schwierigkeiten begegnen Sie bei der täglichen Arbeit vor Ort?

In den ersten Jahren war es in Vietnam sehr schwierig, weil die kommunistischen Kader damals versucht haben zu intervenieren, ihre Leute zu bevorzugen und anderen Steine in den Weg zu legen.

In Laos waren von der lokalen Seite her alle immer hilfsbereit, nur die Effizienz der einheimischen Strukturen ließ zu wünschen übrig. Wenn in Vietnam zum Beispiel ein Krankenhaus oder die Verwaltung sagt, „Wir machen das!“, dann wird das auch schnellstmöglich umgesetzt. Wenn in Laos jemand sagt, „Wir machen das!“, dann passiert noch lange nichts. Die zentrale Regierung in Laos hat eigentlich kaum Einfluss in der Peripherie, das Durchsetzungsvermögen von zentralen Entscheidungen ist da sehr schwierig.

Darunter leiden natürlich auch alle Projekte. Wenn es auf Provinzniveau ein paar korrupte BeamtInnen gibt, die nicht mitmachen, dann ändert sich da nichts. Die Korruption und die Vorteilsnahme vieler AmtsträgerInnen sowie das fehlende Interesse am Gemeinwohl verhindern immer noch häufig zügige Verbesserungen. Das ist heute in Laos noch wesentlich problematischer als in Vietnam.

Können Sie noch ein bisschen genauer auf die Projekte eingehen, die Sie in Laos und Vietnam umgesetzt haben?

Wir haben für die vietnamesischen Universitäten und die Universität in Laos Lehrmaterialien in englischer Sprache entwickelt, 18 Lehrbücher, 25 Powerpoint-Module und 14 DVDs. Die Lehrmaterialien wurden alle in die vietnamesische und laotische Sprache übertragen.

Über 10 Jahre lang haben 27 Freiburger und andere deutsche Professoren und Dozenten in Vietnam und Laos diese Module unterrichtet, Abschlussprüfungen durchgeführt und die Teilnahme innerhalb des nationalen Curriculums für die FachärztInnenausbildung in Frauenheilkunde und Geburtshilfe zertifiziert. Der Projektleiter hat 10 Jahre in Laos und Vietnam gelebt und gearbeitet, die vielfältigen Aktivitäten des Projektes koordiniert und darauf geachtet, dass die Lehrinhalte in einem *On-the-job*-Training umgesetzt wurden.

Im Jahr 2010 wurde dieses von uns konzipierte Lehrprogramm nach 14 Jahren in die alleinige Verantwortung der vietnamesischen KollegInnen übergeben. Für Laos gilt dies nach 10 Jahren intensiver Zusammenarbeit ab diesem Jahr. Wir haben aber eine Nachbetreuungsphase von drei Jahren in Laos, damit wären wir dann bei insgesamt 13 Jahren Engagement vor Ort.

In dieser Zeit hat sich auch wirklich etwas geändert. Laos hatte davor keine selbst ausgebildeten FachärztInnen im Bereich der Frauenheilkunde. Wir haben damit angefangen. Heute sind

in 17 Provinzkrankenhäusern jeweils mindestens zwei FachärztInnen tätig und in der Hauptstadt Vientiane auch noch einmal 20. Früher fehlte diese Expertise und daher gab es auch keine Überweisungsmöglichkeit für schwer kranke Frauen und geburtshilfliche Notfälle.

Wenn Expertise vermittelt und gleichzeitig in der Umsetzung den Strukturen vor Ort angepasst wird, dann kann man auch langfristig mit Erfolg rechnen. Man muss schon einen langen Atem für solche Projekte mitbringen, aber gerade für die Ausbildung gilt: besseres Wissen wird angewandt, wenn die Strukturen es erlauben. Als Ergebnis geht es den Frauen und Kindern besser, und zusammen mit anderen internationalen Projekten ist es gelungen, die mütterliche und kindliche Sterblichkeit deutlich zu senken. In Vietnam ist dies bereits passiert, in Laos geht alles etwas langsamer, aber auch dort zeigen die Zahlen, dass es bereits deutliche Verbesserungen gegeben hat.

Man muss die einheimischen ProjektpartnerInnen mit verpflichten und an den Projekten beteiligen, auch im Sinne der finanziellen Verantwortung. Man sollte daher keine Projekte machen, wo einem Land etwas geschenkt wird. Das ist ein wichtiger Grundsatz unserer Zusammenarbeit. Im Schnitt müssen unsere Partnerorganisationen 10 bis 20 Prozent der Projektkosten mittragen.

Wie war die konkrete Situation in der Frauenheilkunde damals, als Sie Ihre Arbeit in Südostasien begonnen haben? An wen haben sich die Frauen in Notfällen gewandt?

Bei Notfällen sind die Frauen in die Krankenhäuser gegangen und wurden dort überwiegend von Allgemeinmedizinern, die ihrerseits auch nicht gut ausgebildet waren, versorgt. Die frauenärztliche Versorgung war miserabel. Das konnte man vor allem an den Gesundheitsparametern wie Mütter- und Kindersterblichkeit und den Erkrankungsraten in diesen Fachbereichen ablesen.

Laos war zum Beispiel das Land in Südostasien mit der höchsten Müttersterblichkeit. Im Jahr 1998, als ich das erste Mal nach Laos kam, gab es dort eine Müttersterblichkeit von 700 pro 100.000 Lebendgeburten. Jede dreizehnte bis fünfzehnte Frau ist an geburtshilflichen Komplikationen gestorben. Das heißt, wenn eine Frau damals in so einem Land schwanger wurde – und das gilt heute noch für das ländliche Laos –, dann wusste sie, dass sie unter Umständen an Schwangerschaft, Geburt oder Wochenbett sterben wird. Stellen Sie sich einmal vor, Sie sagen das einer deutschen Frau im Jahr 2012!

In Laos ist im Jahr 1998 auch noch jedes vierte Kind vor dem fünften Lebensjahr gestorben, heute ist es nur noch jedes elfte Kind. Die Müttersterblichkeit ist in diesem Zeitraum von über 700 auf unter 300 pro 100.000 Lebendgeburten gesunken. Es ist schon enorm viel besser geworden als in den Jahrzehnten davor. Das liegt natürlich nicht nur an den Projekten, die wir gemacht haben, sondern vor allem auch an den erfolgreichen Projekten vieler anderer internationaler Organisationen.

An den Universitäten haben allerdings in erster Linie wir uns engagiert, weil viele Organisationen einfach nicht erkannt haben, wie wichtig fachärztliche Medizin ist. 1978 gab es eine Weltgesundheitskonferenz in Alma Ata unter der Leitung der WHO und dem UNDP. Damals hat

man gesagt, um die Gesundheitsprobleme in der „Dritten Welt" lösen zu können, muss man zwei Dinge tun: Erstens muss man die kommunale Basisgesundheitsversorgung auf ländlichem Niveau (*community level*) stärken und zweitens muss man *capacity building* auf ministerieller Ebene betreiben, um richtige gesundheitspolitische Entscheidungen treffen zu können.

Der ganze Sektor Ausbildung und Universitäten wurde damals ausgeklammert und in Folge nicht mehr gefördert. Zum Beispiel gab es damals bei der Deutschen Gesellschaft für Technische Zusammenarbeit/GTZ[3] eine Abteilung für Hochschulzusammenarbeit mit mehreren hundert MitarbeiterInnen. Diese ganze Abteilung wurde in Folge dieser Entscheidung eingestampft und auf null heruntergefahren.

Und wer hat sich dann noch um die Universitäten gekümmert? Nicht mehr die Entwicklungshilfe, sondern die Kulturzusammenarbeit, sprich der DAAD. Und beim DAAD waren plötzlich die Medizin und die Gesundheit nur noch eine von vielen Fakultäten und Bereichen, und entsprechend klein wurden dann das Budget und auch das Interesse. Das heißt, es gab kaum mehr Förderung der akademischen Zusammenarbeit und keine Ausbildungsprogramme mehr.

In Ihren Augen kam es also zu einer strukturellen Fehlentscheidung?

Das war eine massive strukturelle Fehlentscheidung mit der Konsequenz, dass die Universitäten in vielen Entwicklungsländern nicht nur auf Grund der schlechten wirtschaftlichen Situation und ungenügenden Staatsführung dieser Länder ihre Qualität einbüßten, sondern auch weil die internationale Unterstützung fehlte. Mit dem Resultat, dass es in letzter Konsequenz kaum mehr ausgebildete Fachleute in diesen Ländern gab.

Gleichzeitig haben die Weltgesundheitsorganisation (WHO) und das Entwicklungsprogramm der Vereinten Nationen (UNDP) noch weitere Fehlentscheidungen getroffen. Sie argumentierten, dass mehr im kommunalen Bereich getan werden müsse, um die mütterliche und kindliche Sterblichkeit zu senken – was grundsätzlich richtig ist, dem stimme ich zu, aber man muss dort qualifizierte Leute haben. Stattdessen wurden die fachärztliche Medizin und die qualifizierte Hebammenausbildung massiv heruntergefahren.

Infolge der Fehlentscheidungen von 1978 wurde die Geburtshilfe von AllgemeinärztInnen und Gemeindehebammen übernommen, die in großer Zahl ausgebildet wurden. Die Ausbildungszeit betrug lediglich 14 bis 16 Wochen für das gesamte Fach Frauenheilkunde und Geburtshilfe – das heißt, nicht mehr als sieben bis acht Wochen in der Geburtshilfe, während international eine dreijährige Ausbildung für Hebammen und eine fünfjährige FachärztInnenausbildung üblich sind. Dieses Gesundheitspersonal wurde dann auf die Bevölkerung losgelassen. Wundert es Sie da, dass die Mehrzahl der Projekte zur Senkung der Mütter- und Kindersterblichkeit fehlschlugen? Der Unsinn ging sogar so weit, dass die WHO selbst 1997 die bestehende Hebammenschule in Vientiane zugunsten der 14-wöchigen Ausbildung schloss.

---

3 Anmerkung der Redaktion: 2011 entstand aus dem Zusammenschluss der GTZ, des Deutschen Entwicklungsdienst und der Internationalen Weiterbildung und Entwicklung gGmbH die Gesellschaft für Internationale Zusammenarbeit (GIZ).

Das ist in der Tat eine fragwürdige Entscheidung und nur schwer zu rechtfertigen.

Ja, das ist das Resultat, wenn Leute Entscheidungen fällen, die keinerlei fachärztliche Ausbildung und/oder Felderfahrung vor Ort haben und die Situation nicht wirklich kennen. Außerdem muss man diese Länder individuell sehen, man kann nicht ein Konzept für alle entwickeln, das funktioniert nicht. Man braucht für jedes Land eigene Expertise und maßgeschneiderte Programme.

Es fehlen einfach Leute, die Felderfahrung haben und bei der Ausarbeitung von Entwicklungshilfekonzepten mitarbeiten. Da gibt es Leute wie mich, die 10, 20 oder 30 Jahre vor Ort Erfahrung gesammelt haben und die wissen, was geht und was nicht – ich bin ja nicht der Einzige. Das größte Problem sind die großen Entwicklungshilfeorganisationen selbst. Sie verharren oft in dem Irrglauben, dass sie die Alleinwissenden sind, nur weil sie groß sind und an den Geldquellen sitzen. Hinzu kommt, dass das, was andere ExpertInnen zu sagen hätten, nicht in ihr Denken und ihre Programme passt.

Womöglich ist das auch eine Frage der Interessen. Die neue Rohstoffstrategie Deutschlands in Laos ist zum Beispiel besser mit wirtschaftlichen Interessen vereinbar, als es die Förderung eines funktionierenden lokalen Gesundheitssystems wäre.

Es ist auch nicht immer in deren Interesse, richtig. Die Ergebnisse vor Ort interessieren eigentlich auch niemanden. Die Regierungen wollen erstmal, dass man vor Ort präsent ist und Meinung macht, aber die Ergebnisse der Projekte interessieren sie kaum. Die Entwicklungszusammenarbeit sollte stärker ergebnisorientiert sein. Sie sollte nachweisen können, wo Erfolge erzielt wurden und was daher sinnvoll ist.

Milliarden sind in der Entwicklungshilfe verschwunden. Impfprogramme und andere *Public-Health*-Programme waren in der Tat sehr erfolgreich und haben funktioniert. Aber im Bereich der kurativen Medizin ist in den letzten 30 Jahren nur weniges besser geworden, und in diese Wunde müssen wir unseren Finger legen.

Die vietnamesischen und laotischen Regierungen haben die Ausbildungskomponente in der Frauenheilkunde bzw. im reproduktiven Gesundheitssektor schon vor Jahren als eine der wesentlichen Säulen im Kampf gegen die mütterliche und kindliche Sterblichkeit definiert. Die haben das schon lange vor unseren Entwicklungshilfeorganisationen begriffen. Auch das muss einmal gesagt werden.

Was denken Sie über die Ausrichtung der momentanen Gesundheitspolitik im Rahmen der Entwicklungszusammenarbeit? Welche strukturellen Fehler bestehen weiterhin und wie könnten Verbesserungen erzielt werden?

Ich war beim Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ) in Deutschland eingeladen und habe dort mit einem Referatsleiter gesprochen, und da wurde mir gesagt: „Herr Runge, Sie haben Recht mit Ihren Ansätzen in der Ausbildung, aber

bis sich politische Schwerpunkte verändern, da vergehen Jahre. Da sind Sie nicht mehr in Amt und Würden und wir auch nicht mehr".

Und genau das ist der springende Punkt: Man muss sagen, dass selbst die GIZ und das BMZ bis zur Jahrtausendwende nicht begriffen haben, was im Gesundheitssektor der Entwicklungsländer wirklich falsch gelaufen ist. Neben vielen guten Dingen wurden die Universitäten und ihre Bedeutung für die Ausbildung vernachlässigt und die Entwicklungsländer daran gehindert, eigenes intellektuelles Potential aufzubauen. Das war kontraproduktiv und hat diesen Ländern sehr geschadet.

Viele Leute, die wie ich das Problem erkannt hatten, haben immer wieder ihre Bedenken geäußert, aber wir wurden nur belächelt. Die erste Organisation, die es überhaupt begriffen hat, war die Weltbank 2004. Damals hat sie das erste Mal in einem offiziellen Statement eingeräumt, dass die *Millennium Development Goals* nur dann erreicht werden können, wenn zusätzlich zu den bisherigen Bemühungen der tertiären Bildung eine ganz zentrale Rolle zukommt. Sie haben erkannt, dass die Universitäten in den Entwicklungsländern massiv gefördert werden müssen. Bis sich dieses neue Denken in veränderten politischen Schwerpunkten unseres Landes ausdrückt, werden wohl noch Jahre vergehen.

Wobei, so lange wie Sie bereits tätig sind, wäre ja genug Zeit für ein bisschen mehr Veränderung gewesen, oder?

Man konnte seine Bedenken und seine Meinung äußern, aber man wurde belächelt. Die GTZ hat mich auch als Referent eingeladen und in diesem Rahmen habe ich ihnen gesagt, was ich glaube, und ich habe auch mit Zahlen belegt, wie die Situation sich darstellt. Langsam setzt das Umdenken ein, mittlerweile hat die GIZ wieder eine Abteilung für Hochschulzusammenarbeit, die aber personell immer noch sehr schwach ausgestattet ist.

In der öffentlichen Wahrnehmung hat sich Deutschland aus dem Bereich der Gesundheit in der Entwicklungszusammenarbeit vielerorts verabschiedet und ist heute mehr in der Armutsbekämpfung und infrastrukturellen Maßnahmen tätig. Eigentlich sehr schade, da gerade Deutschland als ein Land mit einem der am besten funktionierenden Gesundheitssysteme, einem beispielhaften Sozialsystem, hervorragenden Ausbildungsstrukturen und Universitäten und einer weltführenden Medizintechnik als gutes Beispiel gerade in Entwicklungs- und Schwellenländern gesehen wird. Hier können von uns mit Recht mehr Führungseigenschaften und Input in die Gesundheitsentwicklung dieser Länder erwartet werden.

Das geht aber nicht im bisherigen Stil, indem man Workshops mit teuren ausländischen ExpertInnen organisiert und dann glaubt, dass sich in deren Folge etwas ändert. Solche Veranstaltungen rangieren häufig unter dem Codenamen NATO, was für *No Action, Talk Only* steht. Nein, nachhaltige Projekte im Bildungssektor und in der Gesundheit brauchen integrierte ExpertInnen vor Ort, die mit den KollegInnen vor Ort Weiterbildung organisieren, für Qualität sorgen, gemeinsam Prüfungen abnehmen, neues Wissen im medizinischen Alltag umsetzen. Es braucht langjährig engagierte Fachkräfte, die die Probleme in der Umsetzung sehen und gemeinsam mit den Counterparts in Universitäten und Verwaltung versuchen,

neue Standards zu definieren, um sie dann im Gesundheitswesen umzusetzen. Erst dann werden solche Projekte nachhaltig und tragfähig.

Mit kurzen Programmen, Interventionen und *Consultancies* ist das allerdings nicht zu machen. Unsere Projekte in Vietnam und Laos waren deshalb so erfolgreich, weil wir 10 Jahre pro Projekt investiert haben, vor Ort gelebt und als integrierte ExpertInnen mit den Leuten unter den lokalen Gegebenheiten zusammengearbeitet haben.

Was wünschen Sie sich konkret in Bezug auf Ihre Projekte?

Ich wünsche mir, dass meine laotischen und vietnamesischen KollegInnen noch besser und effektiver werden. Wir sind ja in den letzten 20 Jahren gemeinsam einen weiten Weg gegangen und ich hoffe, dass wir diesen Weg noch weiter gehen. Ich hoffe, dass die Universitätsstrukturen weiter gefestigt werden, um langfristig und nachhaltig eine bessere Ausbildung möglich zu machen. Wenn wir in den einzigen Ausbildungsstätten dieser Länder – nämlich in den Universitäten – die Ausbildung der FrauenärztInnen und Hebammen verbessern, dann kommt das Millionen von Frauen und Kindern zugute.

Was die Geberseite in Europa angeht, wünsche ich mir einen politischen Schwerpunkt in der universitären Zusammenarbeit und der Gesundheitsausbildung mit Entwicklungsländern. Die universitäre Ausbildung ist eine der wichtigsten Voraussetzungen für gesellschaftliche Entwicklung und ein tragfähiges Gesundheitswesen, das auch die Gesundheit der Frauen und ihrer Kinder in den Vordergrund stellt. In Europa haben wir das schon vor Jahrzehnten als richtig erkannt und umgesetzt. Warum sollten wir diese Erkenntnis den ärmeren Ländern vorenthalten?

Ich danke Ihnen sehr für dieses Interview.

Entwicklungs- und Gesundheitsarbeit des Österreichischen Roten Kreuzes in Südostasien: Im Gespräch mit Max Santner und Gerlinde Astleithner

Anna-Sophie Tomancok[1]

Citation Tomancok, A.-S. (2012). Entwicklungs- und Gesundheitsarbeit des Österreichischen Roten Kreuzes in Südostasien: Im Gespräch mit Max Santner und Gerlinde Astleithner. *ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften, 5*(1), 174-185.

Max Santner leitet den Bereich Internationale Hilfe (Humanitäre Hilfe und Entwicklungszusammenarbeit) im Generalsekretariat des Österreichischen Roten Kreuzes (ÖRK) in Wien. Gerlinde Astleithner ist als Asien-Länderreferentin des ÖRK unter anderem für die Zusammenarbeit in Südostasien (vor allem Laos und Myanmar sowie an Rande auch für Osttimor) verantwortlich. Im vorliegenden Gespräch bieten sie einen Überblick zur gegenwärtigen Lage der Entwicklungs- und Gesundheitsarbeit der internationalen Rotkreuzbewegung in Südostasien. Das Interview wurde am 19. März 2012 in Wien durchgeführt.

Max Santner is Head of International Aid (Humanitarian Aid and Development Co-operation) at the Austrian Red Cross (ARC) headquarters in Vienna. Gerlinde Astleithner, the ARC's country coordinator for Asia, is in charge of development co-operation in South-East Asia (particularly Lao PDR and Myanmar, but also Timor-Leste). In this interview, they give an overview on the International Red Cross movement's activities as well as the current state of development and health work in South-East Asia. The interview was conducted on 19 March 2012 in Vienna.

SEAS www.seas.at
doi 10.4232/10.ASEAS-5.1-12
creative commons BY-NC-ND

ANNA-SOPHIE TOMANCOK: **Lassen Sie mich mit einer allgemeinen Frage für jene LeserInnen beginnen, die nicht mit der Auslandsarbeit der Rotkreuzbewegung vertraut sind: Wie ist eigentlich die Arbeit des internationalen Roten Kreuzes organisiert?**

MAX SANTNER: Es gibt auf der einen Seite das Internationale Komitee des Roten Kreuzes (*International Committee of the Red Cross*/ICRC), das ein Völkerrechtssubjekt ist und als Hüter der Genfer Konvention vor allem in Konfliktfällen agiert. Darunter fällt zum Beispiel der Schutz von ZivilistInnen, wie es im Moment in Syrien geschieht. Dann gibt es auf der anderen Seite nationale Gesellschaften des Roten Kreuzes, wie zum Beispiel das Kambodschanische Rote Kreuz oder das Österreichische Rote Kreuz. Diese Gesellschaften haben nationale Mandate,

1 Anna-Sophie Tomancok ist Studentin am Institut für Kultur- und Sozialanthropologie, Universität Wien, Österreich und war von Oktober 2011 bis Juni 2012 Praktikantin bei SEAS - Gesellschaft für Südostasienwissenschaften.

meist in einem gesetzgebenden Rahmen gegenüber dem Staat und sind zur Hilfestellung verpflichtet. Die nationalen Organisationen wiederum sind zusammengeschlossen unter einem Dachverband, der Internationalen Föderation der Rotkreuz- und der Roter-Halbmond-Gesellschaften (*International Federation of Red Cross and Red Crescent Societies*/IFRC). Dieser Dachverband hat die Funktion, die nationalen Gesellschaften in ihrem Aufbau zu unterstützen und ist eine Schnittstelle für Kommunikation und Koordination, beispielsweise auch dann, wenn es zu Naturkatastrophen kommt. Vereinfacht dargestellt: Der Vater ist das ICRC, die Mutter ist die IFRC und die Kinder sind die einzelnen Nationalgesellschaften.

Welche Länder in Südostasien unterstützt das Österreichische Rote Kreuz im Moment?

GERLINDE ASTLEITHNER: In Südostasien sind wir derzeit in Osttimor, Laos und Myanmar tätig. In Südasien arbeiten wir in Nepal und Pakistan.

Bleiben wir bei Ihren Aktivitäten in Südostasien. Welche Aktivitäten finden in diesen Ländern statt?

ASTLEITHNER: Hauptsächlich machen wir gemeindebasierte Wasser- und Sanitärprojekte. In Laos und Osttimor haben wir noch eine *community-based health*-Komponente dabei. Alle unsere Projekte sind *community-based*, weil sie immer gemeinsam mit den Communities gemacht werden.

Was ist so eine *community-based health*-Komponente?

ASTLEITHNER: Es wird zunächst mit den Dörfern selbst erarbeitet, welche Krankheiten vorkommen – Durchfälle, Hauterkrankungen sowie Unter- und Mangelernährung sind dabei die drei häufigsten Erkrankungen bzw. Symptome. Was wir dann leisten können, richtet sich nach diesen Erhebungen. Es wird im nächsten Schritt mit der Community diskutiert, wo Hilfe und Unterstützung benötigt werden, und intern wird dann beim Roten Kreuz auch evaluiert, ob es die Möglichkeit gibt die lokale Bevölkerung dabei zu unterstützen. Dann werden Programme implementiert. Wasser- und Sanitärprojekte werden immer zusammen eingebracht, zum Beispiel ist der Zusammenhang zwischen praktiziertem Händewaschen und Durchfällen wesentlich. Der wichtigste Punkt ist dann eben Sauberkeit und Hygiene. Oder es werden Moskitonetze verteilt und erklärt, warum die Leute unter diesen schlafen sollen.

Der Wasser- und Sanitärbereich bzw. öffentliche Gesundheit sind ein Bestandteil vieler internationaler Entwicklungsaktivitäten. Inwiefern unterscheidet sich das Rote Kreuz in diesem Bereich von anderen Hilfsorganisationen?

ASTLEITHNER: Primär durch die Vernetzung und darin, dass wir durch unser großes Netzwerk die *most vulnerable groups* erreichen.

SANTNER: Und durch das spezielle Regelwerk oder die Gesetzeslage, die die nationalen RK-Gesellschaften gegenüber dem Staat haben. Es gibt auf der einen Seite NGOs, die meistens ein Regelwerk über die Sozialministerien haben und dann gibt es auch eigene „Rotkreuz-Gesetze“. Das heißt, dass die Gesetzeslage, in der wir uns mit dem Roten Kreuz bewegen, speziell ist. Ein anderer wichtiger Punkt ist, dass wir einerseits stark in den Communities verankert sind und andererseits durch unsere Vernetzung eine internationale Dimension hineinbringen können. Und diese Größe haben andere Organisationen nicht.

Was bedeutet nun die besondere Stellung der RK-Gesellschaften in Ihrer täglichen Arbeit im Feld?

ASTLEITHNER: Das RK hat immer einen gewissen Sonderstatus – es ist *auxiliary to the government*, also es ergänzt die Arbeit der Regierungen. Diese besondere Stellung erleichtert den Zugang zu allen Gruppen der Bevölkerung. Durch die nationalen Gesellschaften haben wir einen leichteren Zugang im Allgemeinen und speziell bei Katastrophen.

Da das ÖRK eng mit nationalen Behörden und den lokalen RK-Gesellschaften, die mit der betroffenen Bevölkerung interagieren, zusammenarbeitet, gibt es auch eine Beeinflussung Ihrer Arbeit durch die nationalen Regierungen?

ASTLEITHNER: Einerseits ist es unsere Aufgabe, den Regierungen das Mandat der Zivilbevölkerung nahe zu bringen. Andererseits versuchen wir politisch unabhängig zu sein. Das offizielle Mandat macht es uns einfach, direkten Zugang zu allen Gruppen einer Gesellschaft zu bekommen, also zu Behörden und zur Bevölkerung Kontakte herzustellen und Gespräche mit den lokalen Gemeinden zu führen. In manchen Ländern ist es dann aber auch schwierig zu unterscheiden, wo Politik anfängt und wo sie wieder aufhört. Das kommt dann immer auf den lokalen Kontext an.

Und umgekehrt gefragt: Beeinflusst Ihre Arbeit auch nationale Regierungen?

ASTLEITHNER: Das ist der Sinn, die Idee unserer Arbeit. Durch uns wird die Stimme der Zivilbevölkerung in die Politik eingebracht. Das geht manchmal besser und manchmal nicht so gut, aber es ist ein permanenter Dialog und eine permanente Einbringung. Die Präsenz in Netzwerken und die wiederholte Einbringung der Stimme der Zivilbevölkerung, das passiert laufend. Das Rote Kreuz gibt meistens eine Meinung zu bestimmten Themen in den Medien ab und das passiert auch in südostasiatischen Ländern.

Gibt es auch, überspitzt gefragt, irgendwelche Erfolgsmeldungen, wie zum Beispiel Gesetzesnovellierungen aufgrund ihrer internationalen Zusammenarbeit?

ASTLEITHNER: Das ist möglich, aber ich kann es im Detail nicht sagen. Ich weiß aber von unseren PartnerInnen in Myanmar, dass dort ein Austausch mit den jeweiligen Ministerien stattfindet und sich diese Stellen gegenseitig ergänzen.

Was zeichnet Südostasien im Gegensatz zu anderen Regionen aus?

ASTLEITHNER: Vor allem der Buddhismus ist in Südostasien prägend. Sonst sind die Projekte ähnlich, immer lokal und regional adaptiert. Südostasien zeichnet sich auch dadurch aus, dass es im Vergleich zu anderen Regionen tendenziell friedlich ist.

Aber Osttimor ist doch zum Beispiel katholisch geprägt und eine Postkonfliktregion, in Myanmar wurde das ICRC, das in Bürgerkriegsregionen tätig war, des Landes verwiesen?

ASTLEITHNER: Ja das stimmt, es sind Postkonfliktregionen, aber im Vergleich zu anderen Weltregionen läuft es in Südostasien friedlicher ab. Man kann dort leichter arbeiten, weil man keine Bombenanschläge erwarten muss. Gerade in Myanmar sind die Leute, aus meiner Sicht, auch aufgrund des Buddhismus friedlicher. Der Buddhismus macht schon etwas aus, wenn ich das jetzt mit anderen Weltregionen vergleiche.

Wie gestaltet sich die Zusammenarbeit mit regionalen und lokalen Partnerorganisationen?

ASTLEITHNER: Wir haben immer Partnerschaften mit den lokalen RK-Gesellschaften, zum Beispiel dem Laotischen oder Myanmarischen Roten Kreuz oder dem Malaysischen Roten Halbmond. Diese sind immer unser Ansprechpartner und unsere lokale Instanz, die auch die Projekte implementieren. Die Zusammenarbeit zeichnet sich durch die partnerschaftlich gestalteten Projekte aus. Die Stärke der Programme liegt in der stetigen Kommunikation mit den PartnerInnen vor Ort, da diese genau wissen, was in Form von Kapazitäten oder Entwicklung in den Communities gebraucht wird. Die MitarbeiterInnen unserer lokalen Partnerorganisationen sprechen auch die jeweiligen Landessprachen und können damit die Bedürfnisse genau herausfinden.

Gibt es auch Barrieren, die von den nationalen Regierungen gegenüber dem Roten Kreuz aufgestellt werden?

SANTNER: Vor allem in Bezug auf Geldmittel und Ressourcen gibt es Grenzen, und eine weitere Barriere für das Rote Kreuz ist auch, dass es begrenzte Kapazitäten gibt und der Staat im-

mer noch der Souverän im Land ist. Es ist also ein ambivalentes Verhältnis zwischen Hilfe von außen und Selbstbestimmung des Staates. Da wir in den nationalen Gesellschaften aufgrund der Gesetzeslage sehr oft einen gesetzlichen Auftrag haben, eben die sogenannte *auxiliary role*, ist aber damit eigentlich weitgehend abgesteckt, was gemacht werden kann. Und da gibt es dann einen Spielraum, je nachdem wie, auf nationaler oder regionaler Ebene, die BereichsleiterInnen oder die regionalen DirektorInnen mit den RegierungsbeamtInnen zusammenarbeiten. In Laos gibt es zum Beispiel oft eine Personalunion, das heißt die LeiterInnen des Gesundheitswesens des Bezirks sind oft auch LeiterInnen der lokalen Rotkreuzbewegung. In der Praxis hat das positive Auswirkungen, der-/diejenige hat dann Zugang zu Mitteln, die eine andere Organisation nicht hätte. Die Verankerung in der Bevölkerung ist auch stärker.

Ist es in der Regel oft so, dass Programme angenommen werden, oder gibt es da auch Ressentiments?

SANTNER: Es besteht grundsätzlich die Frage, ob man einen *top-down-* oder *bottom-up*-Ansatz hat. Das ist in der Praxis oft eine Mischung. Wenn aufgrund der Bedarfslage reagiert wird und dann das Richtige gemacht wird, dann ist es der am meisten Erfolg bringende Ansatz. Aufgrund der Verankerung in den Communities ist eine hohe Akzeptanz gegeben, aber allgemein gültig ist die Frage nicht zu beantworten. In Osttimor, zum Beispiel, wurden die Programme in einem Bezirk angenommen und in einem benachbarten Bezirks ist es schief gegangen, wegen verschiedenster lokaler Umstände. Es hängt auch einfach von den handelnden Personen ab. Aber aufgrund der Verankerung in der Bevölkerung wird unsere Hilfe oft angenommen, das kann man fast generalisieren. Aber es gibt dann auch Beispiele, wo es nicht funktioniert.

ASTLEITHNER: In Laos, zum Beispiel, in der Provinz, in der wir arbeiten, gibt es 34 verschiedene Ethnien. Da diese unterschiedlich sind, ist es oft schwer einen gemeinsamen Nenner zu finden. In den meisten Dörfern funktioniert es wunderbar. Und dann erwischt man ein Dorf, in dem eine Ethnie lebt, die mit unseren Maßnahmen wenig anfangen kann.

SANTNER: Oder ganz banal, die Ethnie oder das Dorf kommt einfach nicht mit dem/der ProjektleiterIn aus, weil er/sie von einer anderen Ethnie ist. Diese/n lassen sie dann nicht an sich heran und akzeptieren somit das gesamte Programm nicht. Das sind einfach menschliche Mechanismen, die dahinterliegen, die behindernd wirken und die man schwer im Vorfeld einschätzen kann. Da beginnt auch *ownership* zu wirken. Wenn die Betroffenen die *ownership* nicht übernehmen und sich dafür nicht verantwortlich fühlen, dann funktioniert es nicht. Wenn die Betroffenen, egal ob die lokale RK-Gesellschaft oder die Regierung, die Agenden akzeptieren und auf sich nehmen, dann hat ein Projekt Erfolg. Wenn es auf diese Weise nicht so angenommen wird, sondern das Gefühl besteht, dass es nur von außen implementiert wurde, dann wird es nicht funktionieren.

Also das Design aller Projekte wird in Zusammenarbeit mit den lokalen RK-Gesellschaften entwickelt?

ASTLEITHNER: Ja, Projekte werden vor Ort mit der RK-Gesellschaft und der Community entwickelt.

Ist dann das ÖRK, die nationale RK-Gesellschaft und die Community vor Ort? Also sind dann immer auch Leute aus der Community dabei?

ASTLEITHNER: Es sind immer die Wichtigsten dabei. So sitzen in den Besprechungen immer die VertreterInnen lokaler Verbände, beispielsweise der *Youth* oder der *Women's Union*, oder aber auch Lehrer, Hebammen und andere einflussreiche Leute.

Dann stellen Sie aber fest, dass die Leute die Projekte aufgrund fehlenden *ownerships* **nicht annehmen. Wie ist das unter einen Hut zu bringen?**

ASTLEITHNER: Es ist sehr unterschiedlich. Damit die Leute die Programme annehmen, ist es wichtig, dass sie von Anfang an bei der Entwicklung beteiligt sind. Das birgt aber auch eine gewisse Gefahr, weil die Beteiligten sich dann viel erwarten. Wenn man das Projekt zu offensiv entwickelt, dann gibt es gewisse Erwartungen der Betroffenen und damit muss man auch vorsichtig sein. Denn oft bekommt man dann das Geld für ein solches Projekt nicht bewilligt und man kann es dann nicht in Gang bringen. Man muss die Balance finden – Bedürfnisse gemeinsam herausfinden ohne Erwartungen zu schüren.

Es mangelt also nicht an Partnerschaftlichkeit? Die ist dann immer gegeben?

ASTLEITHNER: An und für sich schon. In Laos, zum Beispiel, nehmen von 100 Dörfern zwei oder drei das Programm aus ethnischen Gründen nicht an. Aber dann kann man es mit diesen halt nicht machen.

Heißt das dann, dass sich das ÖRK oder die nationale RK-Gesellschaft aus diesen Dörfern zurückzieht? Nach dem Motto „Lebt euer Leben wie ihr wollt"?

ASTLEITHNER: Implementiert wird immer von der nationalen RK-Gesellschaft, weil diese MitarbeiterInnen die Sprachen sprechen, akzeptiert und respektiert werden.

Wenn jetzt aber die Bereitschaft in der Bevölkerung nicht vorhanden ist?

ASTLEITHNER: Dann versucht man es später wieder einmal.

Es wird dann also nicht gesagt „Wir machen es jetzt trotzdem“?

ASTLEITHNER: Nein, das würde nichts bringen.

Sie kommen also nicht mit vorgefertigten Plänen dort hin und fragen dann die lokalen Behörden und die von der Entwicklung Betroffenen, ob sie das mit Ihnen in dieser Form machen wollen? Können Sie vielleicht ein Beispiel für so einen Designprozess geben?

ASTLEITHNER: Also in unseren Wasserprogrammen, da gibt es TechnikerInnen des nationalen RK und jene von der lokalen Wasserbehörde. In Laos ist es zum Beispiel so, dass immer die Behörde mit Hilfe des RK implementiert. Und alleine dadurch, dass dort die Regierung hinkommt, mit Unterstützung des Roten Kreuzes, ist die Akzeptanz gegeben. Es muss im Vorfeld immer der Bedarf eruiert werden.

So wie Sie es jetzt ausgedrückt haben, klingt es aber eher nach einer *top-down*-Herangehensweise. Das RK kommt in ein Gebiet, und sagt „Wir wollen das jetzt für euch machen – ist das in Ordnung für euch?“ Ist das letztlich dann noch ein gemeinschaftlich entwickeltes Projekt?

ASTLEITHNER: Schon, weil die Bevölkerung meistens nach Wasser schreit und sie Bedarf danach haben.

Also die Bedürfnisse der Bevölkerung werden zuerst eingeschätzt und dann überlegt das RK, wohin es jetzt mit seinem technischen Know-how geht?

ASTLEITHNER: Das kann man nicht so generalisieren, weil es Hand in Hand geht. Manchmal ist es zuerst die Bevölkerung, manchmal das RK, das den Handlungsbedarf äußert. Auch die Regierungen wissen, wo es noch Bedarf gibt und wo Wasser- bzw. Sanitärzugänge bereits gedeckt sind. Dann muss bewertet werden, ob das passt oder nicht. Ist das verständlich?

Ja, ich habe nur ein wenig Schwierigkeiten festzustellen, wie jetzt die Partizipation der Bevölkerung konkret passiert.

ASTLEITHNER: Die Bevölkerung ist bei der Einschätzung der Situation dabei, zum Beispiel beim Wasser: Sie baut zum Beispiel das Wassersystem, trägt Materialen bei, baut die Latrinen selbst etc.

Der Kern des Projekts ist aber aus Europa transferiert, richtig? Ist es europäisches Gedankengut, das von der Gemeinde selbst implementiert wird?

ASTLEITHNER: Ich weiß nicht, ob unsere Unterstützung als europäisches Gedankengut bezeichnet werden kann – Wassertechnik gibt es ja nicht nur in Europa. Die Gemeinden arbeiten jedenfalls mit Unterstützung der TechnikerInnen. Denn könnten Sie ihr Wassersystem allein bauen? Genauso wenig können es die Laoten. Das muss schon Hand in Hand gehen. Ich muss sagen – es ist eine komplexe Arbeit und es ist schwer zu erfassen. Man muss da hineinwachsen.

Nun zu einem anderen Thema – gibt es in Südostasien spezielle Initiativen, die versuchen, die Armut zu reduzieren?

ASTLEITHNER: *Poverty reduction* stellt immer das große Oberziel unserer Projekte dar. Da es allerdings ein so großes Feld ist, können unsere Programme immer nur dazu beitragen. Spezielle Interventionen gibt es generell viele.

Wie interagieren Programme zur Reduktion der Armut mit Programmen zur Verbesserung von Gesundheitsstandards?

ASTLEITHNER: Wir arbeiten immer, wenn man das plakativ beschreibt, in Form eines *logframes*[2]. An oberster Stelle steht immer das Überziel, *overall objective*, die Armutsreduzierung, eingetragen. Zu der leistet man einen Beitrag. Im Einzelnen versuchen wir dann Resultate zu definieren, die auch erreichbar sind, wie zum Beispiel die Reduktion von Durchfallerkrankungen in einer Gemeinde. Dies geschieht durch Hygienemaßnahmen, Bereitstellung von sauberem Wasser, aktiver Gesundheits- und Bewusstseinsbildung etc. Sauberes Wasser, Hände waschen, sauberes Essen und so weiter, tragen wieder zu mehr Gesundheit bei. Das größte Problem ist jedoch die Mutter-Kind-Gesundheit sowie die hohe Kindersterblichkeit.

Wenn Mutter-Kind-Erkrankungen ein großes Thema beim RK und in der EZA generell sind, welche Maßnahmen werden von Ihnen in diesem Bereich getroffen?

ASTLEITHNER: Wir haben zum Beispiel ein gerade auslaufendes Projekt in Laos, wo wir mit der Gesundheitsbehörde auf Bezirksebene zusammengearbeitet haben und mit der Behörde in die Dörfer gegangen sind, um die Leute in den Bereichen *pre- and postnatal care*, zum Beispiel Stillen, Ernährung etc., aber auch in Fällen von komplizierten Geburten, zu schulen. Im Vorfeld muss es dabei eine logistische Abklärung geben, da die Krankenhäuser weit von den Dörfern entfernt sind.

2 Anmerkung der ASEAS-Redaktion: Der *Logical Framework Approach* (LFA) ist ein Werkzeug des Projektzyklusmanagements in der Entwicklungszusammenarbeit.

SANTNER: Ergänzend dazu: Eigentlich ist es nicht oder nur ganz wenig Aufgabe des Roten Kreuzes, in das bestehende Spitalswesen einzugreifen. Aber es gibt im Rahmen solcher Projekte sehr selten auch Unterstützungen für einen Gesundheitsposten, weil es integrative Projekte sind. Für ein Projekt ist es nicht Ziel, einen solchen Gesundheitsposten zu errichten oder das Spitalswesen zu verändern, sondern die Lebensbedingungen in den bestehenden Rahmen zu verbessern.

ASTLEITHNER: Unser Fokus liegt auf *primary health* in den Communities und nicht so sehr darauf, das bestehende Gesundheitssystem zu ersetzen, sondern dieses zu ergänzen.

Aber ich könnte mir vorstellen, wenn jetzt ein solcher Gesundheitsposten aufgestellt wird, dass der ja mehr frequentiert wird als das Krankenhaus vor Ort. Ist das nicht schlecht für das öffentliche Gesundheitssystem?

SANTNER: Natürlich, darum ist ja auch der Versuch, in den bestehenden Strukturen zu arbeiten und nicht außerhalb der, zugegebenermaßen, rudimentären Struktur etwas in Form einer Parallelstruktur aufzubauen. Man hat natürlich das Defizit, dass man dann keine schöne Gesundheitsstation herzeigen kann. Aber man weiß genau, dass diese nicht nachhaltig ist. Das ist ein Dilemma, in dem wir immer wieder stecken, da wir oft von privaten SpenderInnen gebeten werden, eine Gesundheitsstation aufzubauen. Das Spitalswesen ist weniger unser Ding, wir sind eher auf die *community-based* Aktivitäten spezialisiert. *Public health*, Schulungen und Prävention an den *grassroots* sind unsere Hauptaugenmerke.

ASTLEITHNER: In Zeiten von schlimmen Katastrophen oder Notfällen werden aber bei Bedarf Gesundheitsposten aufgestellt, die mobil sind und nur während der speziellen Krisensituation existieren. Das ÖRK hat den Ansatz, die vorhandenen Kräfte zu stärken, damit sie sich selbst organisieren können.

Wie sieht es mit HIV-Infektionen bzw. AIDS in Südostasien aus?

ASTLEITHNER: Also generell muss man sagen, dass im Vergleich zu anderen Weltregionen, im Speziellen zu Afrika, HIV in Südostasien ein relativ geringes Problem ist. In den Grenzregionen Thailands, Myanmars und Laos, also im Goldenen Dreieck, ist es allerdings schon ein Problem – unserer Ansicht nach vor allem wegen der Armut und dem Versuch, irgendwie Geld aufzutreiben, oftmals eben durch Prostitution. Hier muss man aufpassen, dass die Rate nicht steigt und dass man die Infizierten entsprechend unterstützt. Das ÖRK arbeitet nicht zu HIV und AIDS, allerdings gibt es Programme, die von anderen RK-Gesellschaften unterstützt werden. Die Idee dabei ist eben, die Infektionsrate möglichst gering zu halten.

Und wie sehen solche Programme aus?

ASTLEITHNER: Hauptsächlich machen die anderen RK-Gesellschaften auf die Themen aufmerksam und wollen so zu einem verstärkten Bewusstsein über die damit verbundenen Probleme beitragen. Es werden also vor allem Aufklärungsprogramme implementiert. Wenn ein Programm über das RK-Netzwerk läuft, dann läuft es über Freiwillige, die in den Dörfern stationiert sind. Diese leben vor Ort und sie werden geschult, gewisse Themen anzusprechen und Aufklärung zu betreiben. Diese Leute gehen dann von Haushalt zu Haushalt und sprechen in den Familien bestimmte Themen an. Einerseits ist es Aufklärung und andererseits werden sie animiert Kondome zu benutzen, was allerdings schwierig mit der Kultur ist.

Inwiefern erschwert „die Kultur“ eine derartige Arbeit?

ASTLEITHNER: Das mit der Verteilung von Kondomen ist so eine Sache: Was tut man und wie schützt man sich? Durch Kondome. Insofern muss man diese verbreiten und anpreisen. Wenn die Bevölkerung das weiß, sie aber nicht verwendet, dann ist das immer schwierig. Man kann sie aber nicht zwingen, sondern es ihnen nur schmackhaft machen.

Ich habe gehört, dass auch Herzkreislauf- und Stoffwechselerkrankungen sowie Krebs häufige Todesursachen in Südostasien sind - Tendenz steigend. Welche Maßnahmen werden in diesen Bereichen getroffen?

ASTLEITHNER: Richtig, diese Krankheitsgruppen sind auch in Südostasien im Vormarsch. Aber es gibt in den Dörfern so viele dringendere Themen, die schneller zum Tod führen als diese genannten Erkrankungen. Wir sind vor allem in den Bereichen der Hygiene tätig, die wieder auf die Reduktion von Durchfallerkrankungen abzielen. Mutter-Kind-Gesundheit ist auch eines der größeren Themen im Bereich der Reduktion der hohen Mütter- und Kindersterblichkeit, im Besonderen von Kindern bis fünf Jahren. Ernährung ist ein großes Thema, weil sie oft sehr einseitig ist und oft nicht genügend Nahrungsmittel zur Verfügung stehen. Wir sind operativ in diese Richtung tätig, weil die Bevölkerungsgruppen, mit denen wir arbeiten, unmittelbar von diesen Erkrankungen betroffen sind.

Da Katastrophenhilfe einer der Kernbereiche des Roten Kreuzes ist, können Sie bitte ein konkretes Beispiel für Katastrophenhilfe in Südostasien nennen und dieses kurz beschreiben?

SANTNER: Das Thema der Katastrophenhilfe hat mehrere Ebenen. Es gibt einerseits Katastrophen, die nur das Land, in dem sich die Katastrophe ereignet, betreffen. Das heißt, wenn es sich um eine regionale oder lokale Katastrophe handelt, dann ist das eine Sache für die

lokalen Behörden. Beispielsweise, ereignet sich eine Katastrophe in Indonesien, dann ist das die Sache des Indonesischen Roten Kreuzes oder eben der lokalen Rotkreuz- oder Roter-Halbmond-Gesellschaft. Andererseits gibt es aber auch Landesgrenzen überschreitende überregionale Katastrophen. Dann wird das IFRC-Zonenbüro angesprochen, welches sich in Kuala Lumpur, Malaysia, befindet und für 38 Staaten im Raum Asien und Pazifik zuständig ist.

Von dort aus wird überregional kommuniziert und koordiniert. Wenn es notwendig ist, wird dort Hilfe von außen, sprich von potenten nationalen Gesellschaften, angefordert. Es wird zunächst geprüft, ob die eigenen Kapazitäten des Staates ausreichen, um mit der Katastrophe allein umgehen zu können oder ob die Hilfe der internationalen Gemeinschaft benötigt wird. Das gilt sowohl auf Staatenebene als auch bei den lokalen RK-Gesellschaften.

Nehmen wir als Beispiel den Tsunami 2004 in Banda Aceh, Indonesien. Das war eine sehr große Katastrophe und die ganze humanitäre Welt ist dort hingekommen. Das Zonenbüro in Kuala Lumpur koordinierte den Einsatz im Gebiet in Verbindung mit den nationalen Behörden und mit den Hilfsorganisationen. Daraus ist dann ein längerfristiges Projekt entstanden, das zwei bis vier Jahre dauerte und sich in mehrere Phasen aufgliederte. Die erste Phase betrifft die unmittelbare Nothilfe, in der die Betroffenen geborgen werden – das kann mehrere Stunden, aber auch Tage dauern. Die zweite Phase ist eine Art Konsolidierungsphase, in der man die Überlebenden mit Nahrungsmitteln und Trinkwasser versorgt. Darunter fällt auch der Aufbau von Lagern. Die dritte Phase, die Phase des Wiederaufbaus, beginnt sechs bis sieben Wochen nach der eigentlichen Katastrophe. Diese Phase kann Jahre dauern.

Bleiben wir bei Indonesien: Dort gibt es auch immer wieder Vulkanausbrüche. Dann tritt die lokale Stelle des Roten Kreuzes ein. Die Katastrophenpläne enthalten spezielle Aufgaben wie zum Beispiel Trinkwasseraufbereitung, Errichtung von Notunterkünften oder Lieferung von Nahrungsmittelpaketen – sowohl für die RK-Gesellschaft als auch für die nationale Behörde. Dies wird in Abstimmung mit den lokalen Behörden rund um den Vulkan gemacht. Es hängt immer mit der Dimension der Katastrophe und der Kompetenz der einzelnen Länder zusammen. Gut aufgestellt sind Länder wie Thailand, die Philippinen und Indonesien. Laos hingegen ist eher schlecht aufgestellt und verfügt nicht über die nötigen Kapazitäten und Notfallpläne. Laos würde demnach Hilfe von außen brauchen, da es das Problem nicht alleine bewältigen kann. Dazu kommt die regionale Hilfe, die im Zonenbüro in Kuala Lumpur koordiniert wird.

Gibt es auch Situationen, in denen das ÖRK eingreift?

SANTNER: Natürlich, erstens greifen wir durch Spendensammlungen ein, die den jeweiligen nationalen RK-Gesellschaften zur Verfügung gestellt werden, ohne dass wir selbst in der Krisenregion tätig werden. Zweitens, durch eine Direkthilfe des ÖRK in schwachen Staaten, in denen es wenige Strukturen gibt und keine lokalen Hilfskräfte. Bei großen Katastrophen, wie zum Beispiel in Banda Aceh, werden weltweit RK-Mitglieder angefordert, Logistiker aus Dänemark, Deutschland, Kanada, USA etc. und das ÖRK steuerte eine Trinkwasseraufbereitungsanlage bei. Die Sicherstellung und Aufbereitung von Trinkwasser zieht sich wie ein ro-

ter Faden durch die Entwicklungszusammenarbeit des ÖRK. Es werden über einen Raster verschiedenste Dinge aus den verschiedensten Regionen der Welt angefordert, zum Beispiel eine spezifische Wassermenge, die das ÖRK herstellen muss. Intern beginnt dann die Einberufung geschulter Leute, die ein Visum und ein Briefing bekommen, drei Tage später mit einer Ausrüstung von zwanzig bis dreißig Tonnen im Flugzeug sitzen und in das Krisengebiet fliegen. Sie kommen dann zur Logistikstelle und werden mit der Order ausgeschickt, eine gewisse Menge Wasser am Tag zu produzieren. Dann sind konkret MitarbeiterInnen des ÖRK im Netzwerk unterwegs.

Mit welchen Hindernissen sieht sich das RK im Moment in Südostasien konfrontiert?

SANTNER: Ich würde in diesem Bezug nicht von Hindernissen sprechen, sondern von einer Situation, mit der wir als europäische Organisation konfrontiert sind. Nachdem ich mich jetzt ein Jahr mit der Region Asien im Allgemeinen beschäftigt und mir auch ein Bild auf den Reisen gemacht habe, kann ich sagen, dass es eine enorme Wirtschaftsdynamik in diesen Ländern gibt. Das ist jetzt kein Hindernis, sondern eine Erkenntnis, dass es sich in dieser Region um dynamische Volkswirtschaften handelt. Sie entwickeln solche Eigenkapazitäten, dass die klassischen Bilder der Entwicklungszusammenarbeit, des Wissens- und Geldtransfers vom Westen bzw. vom Norden in den Süden, nicht mehr funktionieren.

Es ist so ein hohes Selbstbewusstsein in der Region entstanden, dass die klassischen Mechanismen der Entwicklungszusammenarbeit nicht mehr tragend sind. Es ist im Wesentlichen ein Auslaufmodell, auch jene Art der Entwicklungszusammenarbeit, die wir in der Region betreiben. Die Länder sind selbst im Stande, mit ihren Katastrophen fertig zu werden und ihre Entwicklung voranzutreiben. Sie brauchen uns mehr oder weniger nicht mehr.

ASTLEITHNER: Ich würde es eher als neue Chance sehen. Die Zusammenarbeit wird sich dementsprechend ändern und an die neuen Gegebenheiten adaptiert.

Ist dann die Entwicklungszusammenarbeit, die das Rote Kreuz anbietet, überhaupt noch notwendig?

ASTLEITHNER: Wir sind in den ärmsten Ländern dieser Region tätig und da ist die Entwicklungszusammenarbeit in dieser Form derzeit noch notwendig. Wie lange dies noch möglich ist, bleibt fraglich.

Vielen Dank für das Interview.

Südostasienforschung in Österreich: Die Sammlung Insulares Südostasien des Museums für Völkerkunde Wien

Sri Tjahjani Kuhnt-Saptodewo[1]

Citation Kuhnt-Saptodewo, S. T. (2012). Südostasienforschung in Österreich: Die Sammlung Insulares Südostasien des Museums für Völkerkunde Wien. *ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften, 5*(1), 186-189.

Das Museum für Völkerkunde Wien gehört zu den bedeutendsten Völkerkundemuseen der Welt. Hervorgegangen aus der Anthropologisch-Ethnographischen Abteilung des Naturhistorischen Museums befindet sich das 1928 gegründete Museum seither im *Corps de Logis* in der Neuen Burg, einem Teil der Hofburg am Wiener Heldenplatz. Die ältesten Bestände des Museums gelangten bereits im 16. Jahrhundert nach Österreich. Heute umfasst die Sammlung um die 200.000 Objekte und repräsentiert den Kulturbesitz außereuropäischer Bevölkerungsgruppen aus Afrika, Amerika, Asien, Australien und Ozeanien. Der Sammlungsbestand der Abteilung Insulares Südostasien beläuft sich auf etwa 21.000 Objekte.

Als ich 2005 meine Tätigkeit als Kuratorin begann, startete ich das Projekt *Sharing Cultural Memory*. Die Grundintention dieses Projektes war, im gegenseitigen Austausch mit Indonesien und den Philippinen das gemeinsame Erbe der ethnographischen Objekte (*cultural heritage*) zu erschließen und einer größtmöglichen Anzahl von InteressentInnen verfügbar zu machen. Die Aufarbeitung und Kontextualisierung der Objekte wurde und wird mit den Kulturangehörigen und lokalen Museen im Ursprungsland der Objekte durchgeführt, um so die „Biographie" der Objekte erschließen zu können. Die Objekte sollten auch mit Interpretationen aus den *insider perspectives* (der *source communities*) beleuchtet und somit in der Gegenwart kontextualisiert werden. Diesbezüglich ist beispielsweise 2005 eine Kooperation mit dem Museum

1 Sri Tjahjani Kuhnt-Saptodewo wurde in Jakarta, Indonesien, geboren und studierte Völkerkunde und Afrikanistik an der Ludwig-Maximilians-Universität in München. Im Jahr 2003 habilitierte sie sich an der Humboldt-Universität zu Berlin zum Thema „Getanzte Geschichte: Tanz, Religion und Geschichte auf Java". Seit 2005 ist sie Leiterin der Sammlung Insulares Südostasien am Museum für Völkerkunde in Wien. Kontakt: sri.kuhnt@ethno-museum.ac.at

SEAS www.seas.at doi 10.4232/10.ASEAS-5.1-13
creative commons BY-NC-ND

Siwalima in Ambon, Indonesien, entstanden und 2012 wurde dazu eine gemeinsame Publikation der Kollektionen beider Museen veröffentlicht. Das Projekt hat gezeigt, dass eine ganze Reihe von Kulturartefakten in Wien erhalten geblieben ist, die auf den Molukken vollkommen verschwanden und daher auch in den Sammlungen des Museums in Ambon nicht vorhanden sind. Andererseits befinden sich im Museum Siwalima Objekttypen, für die es im Museum für Völkerkunde in Wien keine Entsprechung gibt. Die historischen Molukken-Sammlungen in Wien und die – zumeist jüngeren – Sammlungen des Museums Siwalima in Ambon ergänzen sich deshalb hervorragend und zeichnen gemeinsam ein ganzheitliches und vollständigeres Bild der kulturellen Ausdrucksformen und deren Veränderungen auf den Molukken.

Ein anderes Projekt betrachtete das Werk des Sammlers Frantizek Czurda (1844-1886), der in Südsulawesi, Indonesien, arbeitete. Die Sammlung war Gegenstand des einjährigen *ForMuse*-Projekts *Sharing Cultural Memory*, das von Juli 2009 bis Juli 2010 durchgeführt wurde. Czurda wurde in Pisek, Südböhmen, geboren und war von 1867 bis 1882 auf Java, Sumatra und Sulawesi (Celebes) als Militärarzt stationiert. Er verbrachte drei Jahre auf Sulawesi und unternahm mehrere Inspektionsreisen in das Innere des Landes, wo bis dahin keine EuropäerInnen vorgedrungen waren. Seine Arbeit beschrieb er folgendermaßen:

> *Ich war auf Süd-Celebes bemüht, eine vollständige Sammlung systematisch anzulegen, Gegenstände zu bekommen, die das häusliche wie das gesellschaftliche Leben in zusammenhängender Folge vor die Augen des Beschauers bringen, uns über die Phantasie, die geistige Entwicklung, sowie über die mechanischen Fertigkeiten belehren, mit einem Worte den ganzen Menschen, mit Allem, was er hervorzubringen vermag, vor uns stellen. . . . Durch die Vollständigkeit hat diese Sammlung von Süd-Celebes wissenschaftlichen Werth, und meines Wissens ist in keinem Museum Europas, vielleicht das zu Leyden ausgenommen, dieser Inseltheil so reich vertreten als in der vorliegenden (Czurda, 1883, S. 111).*

1883 übernahm das Wiener Museum diese Kollektion (820 Objekte), während ein kleiner Teil der Sammlung (etwa 200 Objekte) ins Náprstek-Museum nach Prag ging. Bis heute ist Czurdas Sammlung die weltweit vollständigste Kollektion zu Sulawesi und sein Originalkatalog gilt als der erste ethnographische Katalog Indonesiens überhaupt. Die Aufbereitung der umfangreichen Sammlung wurde in Kooperation mit dem Naprstek-Museum in Prag und Halilintar Latief, einem Vertreter der *source community* aus Sulawesi, durchgeführt. Wir konnten den Originalkatalog von Czurda ins Englische und Indonesische übersetzen und die gesamte Kollektion von Wien und

Prag digitalisieren. Das Projekt *Sharing Cultural Memory* kann somit als eine „digitale Rückführung“ in das Herkunftsland der Objekte (*source communities*) betrachtet werden, weil den Kulturangehörigen auch die Möglichkeit eröffnet wird, weitere Forschung über die Objekte ihrer Kultur zu betreiben, die sich in Europa befinden.

Eine sensationelle Entdeckung der Werke des deutschen Malers Walter Spies und des balinesischen Malers I Gusti Nyoman Lempad führte vom 2. Februar bis 30. April 2010 zu einer spontanen Sonderausstellung „Bali. Kunst im Wandel“, die in Kooperation mit der Botschaft der Republik Indonesien durchgeführt wurde. Die Werke wurden 1935 von der Österreicherin Helen Potjewyd nach Wien gebracht und 1946 dem Museum für Völkerkunde geschenkt. Dank ihrer guten Beziehungen zu dem russisch-deutschen Künstler Walter Spies (1895–1942) konnte Helene Potjewyd (1872–1947) eine repräsentative Auswahl von Skulpturen und Zeichnungen der „neuen balinesischen Schule“ nach Österreich bringen. Unter ihnen befinden sich auch einige bisher unbekannte Meisterwerke I Gusti Nyoman Lempads (1862–1978), einem der renommiertesten Künstler Balis, die hier erstmalig präsentiert wurden. Die kürzlich wiederentdeckten Lamak-Skizzen von Walter Spies machen den gemeinsamen Dialog zwischen balinesischen und europäischen Künstlern der 1920er- und 1930er-Jahre auf dem Weg in die Moderne deutlich. Die Ausstellung wurde auch in Zusammenarbeit mit Soemantri, dem Kurator des Puri Lukisan Museum in Ubud, gestaltet, der die Ausstellung 2013 auch nach Bali holen wird.

Ein anderes Projekt, das mir wichtig ist, ist die Arbeit mit den Diaspora-Communities in Wien. Das Museum für Völkerkunde Wien arbeitet in diesem Zusammenhang im EU-Projekt *Read Me 2* mit anderen Museen Europas (Musée du Quai Branly in Paris, Royal Museum für Central Africa in Tervüren und Museo Nazionale Reistorivo Etnografico „Luigi Pigorini“ in Rom) zusammen, um ein Verhältnis zwischen ethnographischen Museen und Communities aufzubauen bzw. dieses zu verbessern. Das Thema Migration nimmt in den letzten Jahren in der internationalen Museumslandschaft einen immer wichtigeren Stellenwert ein und wird zunehmend in Ausstellungen und Projekten thematisiert. In diesem Sinne ergibt sich für uns eine Verknüpfung zu den Museumsbeständen: gerade das Museum für Völkerkunde verwahrt „migrierte“ Objekte, deren Bezug zu subjektiven Erlebnissen in den meisten Fällen verloren gegangen ist. Deshalb soll der Stellenwert unserer Bestände mit in Österreich lebenden Menschen aus den Herkunftsländern der Objekte diskutiert und so einigen davon

eine neue Geschichte oder Deutung verliehen werden. Als Institution befasst sich unser Museum mit der kulturellen Vielfalt der Welt und bietet sich daher als geeigneter Ort für eine Auseinandersetzung mit der Diversität in unserer Gesellschaft an. Diesbezüglich könnte das Museum auch als eine „Kontaktzone" der Kulturen fungieren. Als ersten Schritt dieses Projektes laden wir interessierte Mitglieder der Diaspora-Communities in Wien ein, Fotos von sich mit einem Objekt zu schicken, die eine Beziehung zur eigenen Herkunft herstellen. Am Thementag, dem 28. Juli 2012, werden wir den ganzen Tag Veranstaltungen zum Thema „Museum und Migration" abhalten, zu denen wir alle Mitglieder der Communities in das Museum einladen.

Mit den angeführten Projekten stellen wir uns den Anforderungen der Zeit, uns nicht nur mit Objekten, sondern auch mit den Kulturangehörigen selbst zu befassen. Das Museum für Völkerkunde in Wien zeigt damit, dass die Sammlung Österreich ein kulturelles Erbe präsentiert, das es gemeinsam zu erschließen gilt.

Ausgewählte Publikationen

Czurda, F. (1883). *Catalog mit Erklärungen der Etnografischen Privatsammlung des Dr. F.A.J. Czurda in Postelberg (Böhmen)*. Wien, Österreich: Wilhelm Braumüller.

Kuhnt-Saptodewo, S. T., Pospisilova, D., & Hesser, P. (Hg.). (2010). *Sulawesi and beyond: The Franticek Czurda Collection*. Wien, Österreich: Museum für Völkerkunde Wien.

Kuhnt-Saptodewo, S. T., Bohle, B., Brandl-Straka, U., & Moiseanu, O. (Hg.). (2009). *The Philippinies: Early Collections*. Wien, Österreich: Museum für Völkerkunde Wien.

Kuhnt-Saptodewo, S. T., Brandl-Straka, U., Maurer, R., & Tuarissa, T. (Hg.). (2012). *Maluku: Sharing Cultural Memory*. Wien, Österreich: Museum für Völkerkunde Wien.

Kuhnt-Saptodewo, S. T., Mittersakschmöller, R., Kartasasmita, G., & Reinthaler, L. (Hg.). (2010). *Balinese Art in Transition*. Wien, Österreich: Museum für Völkerkunde Wien.

Gainsborough, Martin (2010).
Vietnam: Rethinking the State.
London, UK: Zed Books. ISBN: 978-1-84813-310-5. 224 pages.

Citation Schippers, L.-K. (2012). Book Review: Gainsborough, M. (2010). Vietnam: Rethinking the State. *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 190-193.

Martin Gainsborough's latest book *Vietnam: Rethinking the State* is a long-awaited contribution to the discussion of the role of the state in Vietnam. Gainsborough is a reader in development politics at the University of Bristol, UK, and has spent more than 20 years working and living in Vietnam as an international consultant and scholar. His analysis is consequently strongly informed by his experiences. The book itself is based on field research conducted between 1996 and 2007.

As can be inferred from the title, the book aims at grasping the nature of the Vietnamese state. Yet, Gainsborough's analysis differs from those of other scholars who analyse the state by directly focusing on the "entity we call state" (p. 3) as such. Accordingly, he claims that his analytical approach differs from Weberian approaches insofar as he does not focus on the state itself, but rather applies a wider analysis of societal power relations in order to shed light on 'the state'. Gainsborough aims to advance an understanding of the state "by studying issues to do with politics and more pertinently power" (p. 2-3). He argues that focusing on the role of various societal actors and paying attention to their historical practices allows for an embedded understanding of the state. By applying his approach to the case of Vietnam, Gainsborough aims to address two key questions: "What is the nature of the state? And what is the relationship of the state to the political?" (p. 4).

Gainsborough argues that most scholars who currently work on Vietnam tend to overemphasise the aspect of 'change' since the launch of *doi moi* (renovation) in 1986. They thereby unquestioningly accept that the changes attributed to the 'reform years', such as economic openness, private sector development, and alignment with neoliberal policies, have undermined the power of the state. As a result of his empiri-

creative commons BY-NC-ND
doi 10.4232/10.ASEAS-5.1-14 www.seas.at SEAS

cal analyses over the years, Gainsborough challenges such notions and makes clear that "the book is not very sympathetic towards ideas of state retreat" (p. 2). Instead, he provides a rich analysis of different empirical cases in support of his argument that the Vietnamese state has been able to maintain its central role in organising society and the economy as a whole.

Rather than focusing on the overused label of 'reform' which is often understood as a move towards liberalisation, export-oriented trade, and privatisation (or 'equitisation' as called in the case of Vietnam), and thereby evoking a loss of influence of the Vietnamese state, he questions the "unmediated advance of neoliberalism" (p. 2) on a global scale. Gainsborough's analysis evolves around the empirical observation that despite formal changes, large "areas of continuity, in form of existing power structures, elite control over the economy and particular forms of rule" remain. He argues that a major reason for this is that "power continuously seeks to re-create itself" (p. 4) and in order to understand the Vietnamese state, it is crucial to detect where power structures have been re-created in order to secure existing power relations.

Each chapter presents an analysis of a distinct feature of contemporary Vietnamese politics. The major issues around which the analysis evolves are the unchallenged role of the Communist Party, the phenomena of corruption and patronage, the process of privatisation, the impact of globalisation on Vietnam as well as the minor influence of neoliberal ideas on the Vietnamese state. Taken together, each chapter fulfils the role of a puzzle piece necessary to see the whole picture.

Gainsborough argues that the economic and social change of the past decades did not harm the rule of the Vietnamese Communist Party because it was able to secure its central role in organising the social order. He regards this as a central reason why the Communist Party continues to rule in Vietnam today.

The originality of Gainsborough's analysis especially becomes clear when he discusses the process of 'equitisation' in Vietnam. He argues that the sale of state companies does not automatically indicate a retreat of the state from the realm of economics. Instead, the decision to allow for the privatisation of state assets was accompanied in such a way that the Vietnamese Communist Party could continue to control the new owners. They used 'uncertainty' as a means to exert power, as they did not sufficiently inform the new owners about their rights and duties. Hence, the

new owners became dependent on the state authorities.

Similar to 'equitisation', the author shows that globalisation did not lead to the retreat of the state either. By assessing the impact of globalisation on the local state in provincial Vietnam, he comes to the conclusion that the increase in cross-border flows and the rise of transnational and private actors did not lead to a weaker state. Globalisation, and neoliberalism as its underlying rationale, is regarded as less influential by the author than most scholars working on Vietnam would assume. Instead, Gainsborough shows that the local state elite has been able to maintain its rule by resisting international agreements and using the new developments to enhance its power.

By analysing the party congress, Gainsborough directs the attention towards another crucial aspect of political power in Vietnam: patronage and network politics, as well as uncertainty as the *modus operandi* of power in Vietnam. The Communist Party has been able to preserve its power by remaining tacit about the actual application of rules and procedures. In this sense, uncertainty fulfils a disciplinary function in order to enhance control over the Vietnamese population.

Gainsborough's critical stance towards the argument that we have witnessed a retreat of the state in the last decades is similar to the position of leftist scholars such as J. Hirsch (*Materialistische Staatstheorie*, 2005) and L. Panitch (*Globalisation and the State*, 1994) who argue that the state has remained vital in organising institutional and economic restructuring. Nevertheless, it would have been fruitful for his analysis to widen his definition of neoliberalism. Instead of understanding neoliberalism as a homogenising force, J. Peck and A. Tickle (*Neoliberalizing Space*, 2002, p. 36), for example, speak of "neoliberalism**s**", using the plural form of the term in order to stress that different forms of neoliberalisms exist and become manifested in "hybrid or composite structures". Hence, national specificities in light of neoliberal pressures for state restructuring do not necessarily constitute a contradiction but can instead be regarded as an essential feature of how past and present struggles interact and result in heterogeneous forms of statehood.

The author's analysis is driven by his critique of mainstream accounts of the state. Therefore, he explicitly calls for a new research agenda which turns away from analyses that stress the virtue of the state in the global North only to impose a governance agenda over the global South. He draws two major implications from this position.

First, "what is presented today as offering a robust analysis of the state is nothing of the sort, and in fact is a selective, politically motivated characterization of the state" (p.185). Second, in order to arrive at a better understanding of how power is organised, it is crucial to uncover "in whose interest the state is acting" (p.186). Only by pursuing such an approach it is possible to arrive at a contextual analysis of the state.

In a nutshell, *Vietnam: Rethinking the State* is a unique account of politics and the state in Vietnam. It challenges conventional analyses by offering rich empirical investigations of state 'change' and 'continuity' in an era of globalisation.

Lan-Katharina Schippers

University of Vienna, Austria

Yahuda, Michael (2011).
The International Politics of the Asia-Pacific (Third Edition).

London, UK and New York: Routledge. ISBN: 978-0-415-47480-1. xvi and 368 pages.

Citation Gerstl, A. (2012). Book Review: Yahuda, M. (2011). The International Politics of the Asia-Pacific (Third Edition). *ASEAS - Austrian Journal of South-East Asian Studies, 5*(1), 194-197.

In his speech to the Australian parliament in November 2011, Barack Obama emphasised that he has directed his national security team to make the United States' presence and mission in the Asia-Pacific a top priority. Unlike European politicians, their Australian counterparts were pleased to learn that the reductions in US defence spending would not come at the expense of the Asia-Pacific. However, as readers of Michael Yahuda's outstanding study will understand, Obama's announcement has not marked a significant policy shift: Since the end of World War Two, Washington has been the hegemonic power in the Asia-Pacific in the realms of security and economics. Yet, as Yahuda, Professor Emeritus of International Relations at the London School of Economics, demonstrates, China aims to challenge the United States' dominant position. This development is likely to change the fundamental dynamics in the region.

Accordingly, Beijing's dramatic economic and military ascent over the last 35 years, and particularly during the last decade, and Washington's relative decline during the same period, have given the author an incentive to re-write major parts of *The International Politics of the Asia-Pacific*. The book consists of eleven chapters, organised into two sections (1945 until 1989, and the post-Cold War period). While the first part, presenting a thorough analysis of the main political, economic, and security developments from 1945 until 1989, remains more or less unchanged compared with previous editions, the second part offers new, updated insights into the major trends since the end of the Cold War. This is especially valuable, as the author missed out on some of these trends in the second edition of his book.

Yahuda's theoretical and methodical approach is eclectic as he draws on Neoreal-

creative commons BY-NC-ND
doi 10.4232/10.ASEAS-5.1-15 www.seas.at SEAS

ism, Neoliberalism, and Constructivism to describe the overall pattern of cooperation and competition in the Asia-Pacific. Despite this mainstream approach, Yahuda's analysis is highly complex: First, he includes an assessment of the national systems of the US, China, Japan, and Russia to demonstrate how international, regional, and domestic developments influence each other in the Asia-Pacific. Secondly, even though the main geographical focus rests on North-East Asia, the other Asian sub-regions are also covered in depth and their interlinkages highlighted.

In the historical part, Yahuda provides an excellent analysis of the strategic interests of the US, the Soviet Union, China, and Japan after 1945. He demonstrates the paramount importance of the Korean War (1950–53) for the establishment of the regional Cold War order: Wary of the Sino-Soviet alliance, Washington was keen to normalise its relations with Tokyo. Due to the peace treaty of San Francisco in 1951, Japan re-entered the political and economic sphere in the Asia-Pacific. As Yahuda shows, the US-Japanese axis became the main structure in the region and bilateralism the method of choice. Still distrusting Tokyo, Australia, New Zealand, and the Philippines successfully pressured Washington to make political and military concessions in their bilateral defence treaties. These agreements further cemented the US predominance.

Similarly to Europe, the Cold War was the dominant regional political, military, and economic structural force shaping the politics of all nations. Unlike in Europe, however, in the Asia-Pacific the Cold War was a hot one, culminating in the Indochina War. The alliance system was further complicated after the collapse of the Sino-Russian alliance in the mid-1950s, when the Communist parties in the Asia-Pacific had to side either with Moscow or Beijing. Due to geography and ethnicity, the majority of the South-East Asian Communists turned to China. Both Moscow and Beijing supported rival Communist rebels, particularly in South-East Asia (e.g. Malaysia, Indonesia, the Philippines).

Ideological rivalries but also distrust dating back to the Colonial period were also responsible for multilateral cooperation remaining elusive, even among staunch Western allies such as South Korea, Taiwan, Thailand, the Philippines, Singapore, and Australia. However, Tokyo indirectly laid the seeds for regional collaboration in the mid-1970s: Due to the increasing labour costs in Japan and the appreciation of the Yen, Japanese companies started to shift labour-intensive production processes to

South-East Asia. Gradually, the complex production networks of today emerged, interlinking various economies in the Asia-Pacific.

The second part of *The International Politics of the Asia-Pacific* starts with a study of the new power relations since 1989 while the other three chapters deal with the US, China, and Japan. Similarly to Europe, the importance of multilateral institutions and norms is growing and regional collaboration has increased. Even though Yahuda stresses the importance of the Association of Southeast Asian Nations (ASEAN) for furthering regionalism in the Asia-Pacific, he is critical about ASEAN's real power, labelling it a "diplomatic community" (pp. 213-218). Despite the 2008 ASEAN Charter, regional cooperation remains limited in South-East Asia – yet it is still much deeper than in North-East Asia. The reason is that the dogma of sovereignty and non-interference prevails in the Charter.

In fact, more important for the promotion of regionalism in the Asia-Pacific are China's multilateralism and a general trend toward comprehensive security. Similarly to Washington's hub-and-spokes approach, until the mid-1990s China pursued its interests bilaterally. Since then, however, it has increasingly joined the multilateral institutions established by ASEAN. In common with the Association, "China's cooperative security approach was well suited to addressing these new security matters" (p. 211). Realistically, due to China's geographic size and economic power, transnational threats such as climate change, terrorism, organised crime, and migration can only be resolved with Beijing's involvement. This, however, further strengthens its regional influence.

While economically all nations in the Asia-Pacific have become increasingly dependent on China, strategically the majority of them still rely on America's engagement. Therefore, even during President George Bush's heavily criticised one-dimensional 'war on terror', Washington's leadership has not been contested. As Yahuda points out, both a conflict and a condominium between the US and China would be detrimental for the resident nations. While he predicts sharper diplomatic exchange and growing military tensions in the South China Sea, he does not believe that a full-scale war is likely to break out (pp. 341-346). Beijing, as Yahuda convincingly argues, relies heavily on a peaceful international climate to promote trade, investment, know-how, and technology transfer for its economic growth. However, China's future domestic political and social development raises many questions, in particular

anxieties about growing nationalism which, once unleashed, can be difficult to control even for an authoritarian leadership.

Apart from China's rise, two other developments have gained pace in the last two decades: India's re-engagement with Asia and Russia's increasingly marginal position. Yet, as Yahuda shows, not only have the traditional power relationships in the region changed, but also the region itself: Globalisation, increased trade, and multilateral fora have had a significant impact on the geographic boundaries of the Asia-Pacific as they have "become less precise' as Central and South Asia increasingly impinge on Southeast and Northeast Asia" (p. 341).

The International Politics of the Asia-Pacific is a well-written textbook that offers both experts on the Asia-Pacific and readers less familiar with this part of the world a comprehensive and concise analysis of the major developments since the end of World War Two. The analysis of South-East Asia is precise, and both the analysis and its length, compared to the parts on North-East Asia, demonstrate that for most of the time since 1945, South-East Asia has been an ally but also a dependent partner of the great powers with limited strategic influence in actively shaping politics in the Asia-Pacific. Yet it forms a crucial part of a dynamic region where multilateral collaboration has increased but obstacles for a peaceful future still remain. The future direction of strategic relations between Beijing and Washington is written in the fate of this dynamic and promising region.

Alfred Gerstl
University of Vienna, Austria

Call for Papers

ASEAS

Österreichische Zeitschrift für Südostasienwissenschaften
Austrian Journal of South-East Asian Studies

Focus SOCIAL MOVEMENTS

We also accept submissions OUTSIDE THE FOCUS!

The upcoming issue 6(1) of the Austrian Journal of South-East Asian Studies will feature a focus on *Social Movements* in South-East Asia, and will aim at bringing together established scholars and junior researchers from various academic fields in order to do the interdisciplinary nature of this broad topic justice. Emphasis shall be placed on both structure and dynamics of social movements and their specific local contextualisation as well as transnational predicaments. The intersection of this issue with larger topics of political and economic systems, labour, migration, health, environment, and peace, but also with aspects of culture, religion, gender, age, race and class, shifting along multiple scales and dimensions, shall contribute to a diversified approach of the publication.

If you intend to submit a paper, please contact the editorial board (aseas@seas.at), as this facilitates our planning process. Submissions dealing with one or several of the following issues are of special interest to the board of editors:

- Theoretical debates on social movements and conceptual challenges resulting from empirical research on recent developments;
- Social movements as genuine political actors and their relations to state, NGOs, and other institutionalised public and private actors;
- Strategic alliances, interventions, and collective action on local, national, and international scale and the role of transnational networks;
- Collective action, labour and trade unions, and their local, regional, cultural, and national specificities in the settings of influential global economic forces and neoliberal reforms;
- Urban movements, mobilisation, and the contestation of local policies and national regimes;
- Social media and digital space as the new environments for mobilisation, organisation, and protest;
- Civil rights movements and the construction of transnational solidarity across ethnic, religious, and geopolitical boundaries;
- Negotiation and contestation of difference within social movements – distinctions of culture, religion, gender, age, race, and class;
- Indigenous movements in connection with local policies in the settings of global networking and connectivity;
- Women's movements and the reconfiguration of gender relations with reference to concepts of social equality and justice;

- As always, book reviews and suggestions for interviews are welcome (for further details, please contact the board of editors);
- More information: www.seas.at / aseas@seas.at

Deadline
31 Dec 2012
Abstracts can be sent at any time.

SEAS *Gesellschaft für Südostasienwissenschaften*
Society for South-East Asian Studies

Einreichungen
Submissions

ASEAS

Die ***Österreichische Zeitschrift für Südostasienwissenschaften (ASEAS)*** ist ein Schwerpunktprojekt der ***Gesellschaft für Südostasienwissenschaften (SEAS)*** in Wien. Die Redaktion lädt etablierte wie auch angehende WissenschafterInnen dazu ein, Forschungsergebnisse und theoretische Abhandlungen zu präsentieren, Fachliteratur zu rezensieren sowie Konferenzberichte und Interviews mit SüdostasienexpertInnen zu veröffentlichen. Als interdisziplinäre Zeitschrift beinhalten die Beiträge historische und/oder aktuelle Analysen kultureller, sozialer, wirtschaftlicher und politischer Fragestellungen.

Veröffentlichte Artikel müssen einen Bezug zu Südostasien aufweisen, sollen aber nicht geographisch auf die Region beschränkt bleiben, sondern können, wie es beispielsweise in der Linguistik, bei Diaspora-Gruppen oder Formen des soziokulturellen Transfers der Fall ist, die räumlichen und politischen Grenzen Südostasiens überschreiten.

Falls Sie einen Beitrag in *ASEAS* publizieren möchten, besuchen Sie bitte unsere Homepage, wo Sie CfPs, nähere Informationen zu Einreichungen sowie unsere E-Mail-Kontaktadresse finden.

The ***Austrian Journal of South-East Asian Studies (ASEAS)*** is a core project of the ***Society for South-East Asian Studies (SEAS)*** in Vienna. The journal's editors invite both established as well as young scholars to present research results and theoretical papers, to review literature or to publish conference reports as well as interviews with experts on South-East Asia. As an interdisciplinary journal, ASEAS covers cultural, social, economic and political aspects of South-East Asia from a historical and/or a contemporary perspective.

Topics should be related to South-East Asia, but they do not need to be restricted to the geographical region, as in the case of - for example - linguistics, diaspora groups or forms of socio-cultural transfers where spatial and political borders of South-East Asia are crossed.

If you are interested in publishing a paper with *ASEAS*, please visit our website and find CfPs, further information about submissions as well as our e-mail address there.

SUBMISSION DEADLINES ASEAS 5(2): 31 July 2011 + ASEAS 6(2): 31 December 2012

CONTACT ASEAS - Österreichische Zeitschrift für Südostasienwissenschaften / Austrian Journal of South-East Asian Studies, Penzinger Straße 60/12, A-1140 Vienna, Austria

WEBSITE http://www.seas.at/aseas **E-MAIL** aseas@seas.at

ISSN 1999-253X