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Lesson Learned in Containing Contagion: The Politics of Disease Outbreaks in Southeast Asia

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Abstract

Before the outbreak of Coronavirus disease (COVID -19), Southeast Asia had already experienced a wave of emerging and endemic infectious disease outbreaks ranging from Nipah, SARS, and Avian Flu to Dengue and Japanese Encephalitis. For over a decade, Southeast Asian states showed their commitment to pursue a collective approach to the surveillance and communication of outbreaks. This commentary discusses can be learnt from previous experiences to assist with the COVID-19 response. The commentary explores how the region interpreted their obligation to the revised International Health Regulations (IHR) through the deliberate alignment of political interests and regional cooperation. It argues for continued regional investment in a cooperative health diplomacy relationship in the COVID-19 era.

Disease Diplomacy

Due to the emergence of the new contagious diseases, health has become "a key contemporary foreign and security policy concern" that shapes international cooperation.[1] In the 1990s, successive waves of infectious disease outbreaks and the emergence of novel infectious diseases pushed countries to collaborate on issues pertaining to health security, leading to the World Health Assembly decision to revise the the International Health Regulations (IHR) in 1995. The IHR was initially adopted in 1951, following the creation of the World Health Organization (WHO) in 1948. This was the only legal instrument that guided states on the control of infectious disease outbreaks. By the 1990s, states realized that the IHR were out of date: it was overly disease-specific and was not being complied with by signatory states. The IHR was useful for prescriptively handling precedent epidemics like yellow fever, but states realized they proved insufficient in addressing novel outbreaks and there were no mechanisms for information-sharing in the event of a global health crisis. The IHR revision process slowly progress, however the SARS epidemic of 2002-2003 would serve as a springboard for states to rapidly revise the IHR to mitigate future outbreaks, to better define the role of the WHO in providing medical advice and recommendations, and to set Core Capacities for countries to meet in response to future health crises.[2]

Careful examination on disease diplomacy found that states' cooperation was not confined to the institution of the WHO, as states would come together to discuss the IHR not only on the global stage but also in more regional contexts. During the H5N1 outbreak, with the IHR revisions were being adopted, ASEAN+3 member nations met and held dialogues about the implementation of the IHR in Southeast Asia specifically, irrespective of countries' healthcare capacities. Existing explanations for this sense of urgency has been: (i) the capacity to engage was contingent on states feeling that doing so would be safe and beneficial – it did not threaten existing sovereignty and governance norms, (ii) ASEAN states were frequently meeting to discuss setting up Core Capacity mechanisms but without following through entirely in implementation, and (iii) engagement was limited to securitization in an attempt to protect economic activity. A fourth explanation is that ASEAN states were motivated to pursue individual and collective activities that tried to meet IHR Core Capacities with a strong sense of urgency and compliance. Two WHO regional offices, Western Pacific and South East Asia, created a five-year Phase 1 Asia Pacific Strategy for Emerging Diseases (APSED) 2005-2010 to promote compliance with the IHR and adapt capacities to the different social, political, economic environments in the region. APSED has, and continues, to serve as an important instrument to promote technical and political partnership in health security, tapping into political arrangements in which regional actors feel comfortable taking part.

Early Years of Contagious Disease Reporting in ASEAN

Despite having different health systems, with varying public health capacities, different infectious disease burdens, and variation in GDP incomes and political systems, the ten ASEAN member states agreed to the core capacity requirements of the IHR in the 2005 World Health Assembly. In the first phase of APSED 1, one core capacity identified as a priority for IHR implementation was surveillance and reporting. Within this phase, ASEAN members' behavior of surveillance and reporting practices on contagious diseases outbreak changed, with improved levels of information sharing amongst states and increased sharing of outbreak events within states states. APSED promoted a culture of reporting responsibility, and this was well adapted to the ASEAN Charter. Between the two periods of 1996-

[1] This commentary is produced from Sara E. Davies talk at the CSIS Lecture Series on Regional Dynamics, Tuesday, 16 June 2020 with notes by Quincy J. H. Clarke.

[2] Sara E. Davies, Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security*, (Baltimore: John Hopkins University Press, 2015).

2010 and 2010-2015, most ASEAN states have dramatically increased their efforts to improve their state-level reporting processes by reporting earlier and more often to combat the spread of rumors and false information.[3] Additionally, this increased efficiency, productivity, and transparency of information came with states reporting more readily on endemic diseases, particularly dengue outbreaks.

The successful management of the APSED Phase 1 went beyond pushing for IHR implementation, it helped to normalize health security cooperation in what were potentially cooperation-resistant areas. As ASEAN expanded its institutions following the 2009 Charter reform, the creation of new committees allowed for APSED to be woven into the ASEAN health agenda and to foster peer-to-peer cooperation and competition due to more frequent meetings about IHR compliance. In the first phase of APSED, the upsurge of endemic diseases such as dengue created a shared sense of urgency that aided in states' cooperative securitization. Opportunities for frank exchange was also important. Beyond tracking the compliance of states, APSED provided a forum for trust and open exchange through discussions between mid to high ranking officials, always held under the Chatham House Rules, which permitted opportunities to share experiences on sensitive issues like censorship and executive processes on surveillance, reporting, contact tracing, and risk communication.

When the Momentum Does Not Last

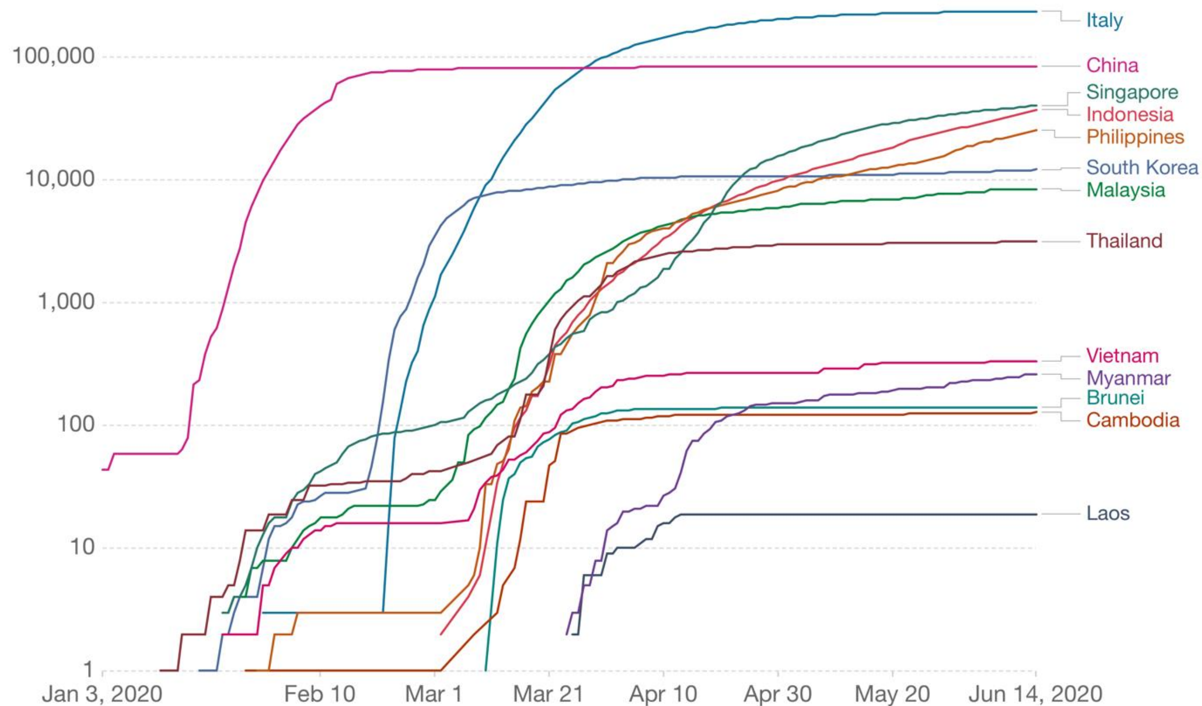
By 2010-2015, during its second phase, APSED was starting to lose funding momentum and while there was still an emphasis on endemic outbreaks, the challenge was how to transition states preparedness to self-report to external evaluation in order to demonstrate value for money in APSED. Another issue came from the IHR reporting and measurements seeming to have not progressed. The Ebola outbreak in West Africa in 2014 shifted emphasis away from state level and regional level discussions on compliance to the need for a global compliance strategy. A global compliance strategy required evaluations and monitoring frameworks directed from WHO Headquarters.

Meanwhile, there were gaps in surveillance and response within the ASEAN-led mechanisms and APSED: both were driven by state-centric approaches and, thus, there was not much attention paid to the inclusion of civil society organizations, unpaid community healthcare workers, and the added complications of surveillance and response within politically-restrictive environments. This gap can be said not just of APSED but WHO as a whole: despite the IHR advising on surveillance and reporting, including the right of non-state actors to report outbreaks, , there is little strategy on how to mitigate cases of (non)reporting due to government censorship or reports being managed by states not in an effort to communicate but to prevent the public from questioning their state capacities. Health as a human right has not been sufficiently released within the practice and evaluation of the IHR, and health officials will not be able to accurately report if they feel threatened for doing so and populations will not come forward for testing if they are frightened.

[3] Sara E. Davies, *Containing Contagion: The Politics of Disease Outbreaks in Southeast Asia*, (Baltimore: Johns Hopkins University Press, 2019).

Total confirmed COVID-19 cases

The number of confirmed cases is lower than the number of total cases. The main reason for this is limited testing.



Source: European CDC – Situation Update Worldwide – Last updated 14th June, 11:15 (London time)OurWorldInData.org/coronavirus • CC BY

In recent years, the IHR has gone through a massive paradigm shift. Countries now must meet progressive benchmarks in each capacity, and the number of these capacities has been extended in large part due to the IHR Core Capacities being included in the Sustainable Development Goals. The number of, and emphasis on, indicators has also increased, causing more bilateral evaluations as seen in a number of ASEAN states agreeing to WHO Joint External Evaluations which compare and evaluate state-reported IHR figures of compliance. These reports look into the scale of capacity compliance and it seems, in most cases, states tend to accurately report their compliance capacity. When observing the timeline of states' COVID-19 reporting, questions should be raised as to why some states reported their first detected cases sooner than others. The observable challenges in COVID-19 in Southeast Asia is the capacity to upscale testing capacity, earn public trust in both testing and risk communication (information), and contact tracing. There is also a need to radically rethink how populations in the region consume and trust public health information. Outpacing 'infodemics' requires a proactive public health communication strategy, but state control of media and social media to the point of infringing on civil and political rights will harm long-term trust in state issued advice on COVID-19.

Looking Forward

On the whole, the ASEAN Secretariat has been able to respond to COVID-19 in a timely manner, and because of the years of varying (health, economic and security) sectors discussion on health security through the IHR and APSED mechanisms, its member states has been responsive to calls for high-level meetings and regional-level assessments of capacity. The region has been promoted as being more pandemic prepared than other regions and it will be vital to conduct evidence-based

research into these areas of success. There are commitments in place to commit to cooperation in areas of emergency response, laboratory readiness and a response fund package. Rising tensions between the US and China, and the relationships of ASEAN members states to these great powers, however, may increasingly inhibit coordination and cooperation amongst members. Moving forward, there needs to be more effort to create opportunities for health diplomacy within the ASEAN bloc, and recognition of its potential normative influence in the area of health security. In-depth, comparative studies on ASEAN states interpretation of their IHR capacities need to study the technical capacities, but also the interactions between citizens and their governments, and how the roles of civil society, health care workers, scientists, and media interact and engage. The IHR Core Capacities and the JEE must function less like a template and become more adaptable to individual state circumstances.

Within ASEAN states, there have been important questions asked about the validity and reliability of government data. Understanding how ASEAN states have improved their contagious disease reporting since the revised IHR has also revealed the areas where there remains need-for-improvement. As the ASEAN Intergovernmental Commission on Human Rights statement said: "measures taken to protect public health must ensure that all persons at risk or infected by COVID-19, including women, children, the elderly, persons with disabilities, migrant workers, and vulnerable and marginalised groups, can also access essential healthcare services".[4] The COVID-19 outbreak is a moment of opportunity for cooperative initiatives that include the mobilization of civil society organizations and marginalized people.. ASEAN as a region has grown in economic and political strength since the 2000s and there is an unprecedented sense of obligation that its member states have displayed during this pandemic. Nonetheless, COVID-19 has also shined a light on how much more work must be done to combat future outbreaks, defend at-risk and marginalized groups, share information, and address factors which aid in the spread of infectious disease.

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[4] https://aichr.org/news/press-release-on-coronavirus-disease-2019-COVID-19-by-the-asean-intergovernmental-commission-on-human-rights-aichr/ 1 May 2020.