SECURITISING HEALTH CRISSES ON REGIONAL COOPERATION: HINDERING OR FACILITATING COOPERATION?

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ABSTRACT
The securitisation theory (ST) often gives rise to the debate on the positive and negative dimensions of security. ST is frequently quoted in this debate to explore what happens when threats are labelled as a security issue. The positive and negative points in the debate on ST are closely related to migration, environment, and health. However, like other international relations (IR) theories, the ST debate often fails to reflect the voices and experiences of different regional contexts. This article contributed to the securitisation debates by adding the perspectives and experiences of the Southeast Asia region by applying critical literature review analysis, using primary and secondary sources data collection. Although public health challenges are global phenomena, the way they are addressed may vary across geographical regions. The article reviews the consequences of securitising on contagious diseases in Southeast Asia as the region is often associated with distinctive political cultures that shape the governing norms. Securitisation has clearly made a positive impact on the health security cooperation in the region. Instead of encouraging state-centric thinking, the securitisation of health crises has prompted ASEAN countries to be more region-centric, ultimately challenging the regional norms that have historically obstructed cooperation across the nations.

Keywords: ASEAN, health security, regional cooperation, securitisation theory, Southeast Asia.

1.0 INTRODUCTION

The debate on the positive and negative dimensions of security tends to draw from ST. ST has provided a service to this debate by exploring what happens when particular threats are labelled as a security issue by the securitising actors (Buzan et al., 1998). Scholars in this field argue that if an issue is successfully securitised, it moves from the realm of ‘normal’ politics to the realm of ‘emergency’ politics. In this case, issues are treated differently, and exceptional measures are legitimised, including the use of threat, defence, and other state-centred solutions (Wæver, 1995). In this context, the security dynamic provides the securitising actors with the means to legitimise their actions to garner extra attention and resources for an issue that may otherwise be overlooked. Aradau, (2004) draws on ST and critiques securitisation as negative because of the processes involved (non-democratic, fast-tracked procedures) and its outcomes (produces categories of the enemy). In contrast, some have suggested that securitisation is not necessarily negative (Floyd, 2011; Roe, 2012). Roe, for example, while recognising that security/securitisation can be problematic, argues that securitisation can also lead to a positive impact. The consequences of securitisation debates have been furthered explored in other non-traditional security (NTS) issues such as HIV/AIDS (Selgelid & Enemark, 2008), climate change (Scott, 2012), migration (Carrera & Hernanz, 2015) and pandemics (Elbe, 2010; Enemark, 2009).

However, like other International Relations theories, ST is too Western-centric as it does not represent the voices, experiences, knowledge claims, and contributions of most of the societies and states in the world, beyond the West (Acharya, 2014). The presence of a Euro-centric bias in the ST has been said to weaken the application of the framework outside of the Western context, particularly in the non-Western, non-democratic and transitional states (Curley & Herington, 2011). In contrast, the Southeast Asia region has been regularly deployed in securitisation debates on NTS issues (Caballero-Anthony, 2008; Herington, 2010). Nevertheless, in the non-Western regions, literature on the health-security linkage remains scarce (Curley & Herington, 2011). Although health issues are a global phenomenon, how they are addressed varies across geographic regions, and in Southeast Asia this is shaped by the political culture known as the ASEAN Way. Therefore, adding more voices and experiences from non-Western contexts, from the Southeast Asian region, can challenge the assumptions about the consequences of securitization theory. Regarding this, our article aimed to strengthen the ST by adding the perspective of a non-Western area, i.e., the Southeast Asia region.

Southeast Asia is a complex testing site for the securitisation processes and debates in relation to a key public ‘security’ challenge, namely that of public health. The article analyses
the consequences of securitising health issues in Southeast Asia, focusing particularly on regional health cooperation in addressing contagious diseases. To that end, this article follows a qualitative research methodology. Document analysis is used to gather secondary data and it has been complemented by interviews with key elite informants as the primary data. Although public health challenges are a global phenomenon, they are addressed in various ways across different geographic regions. Even though Southeast Asia is often associated with distinctive political cultures that shape the governing norms, the analysis demonstrated that securitisation has clearly made a positive impact on health security cooperation in the region. Instead of encouraging state-centric thinking, the securitisation of health crises has prompted ASEAN countries to be more region-centric, ultimately challenging the regional norms that have historically obstructed cooperation across the nations.

2.0 REGIONAL HEALTH SECURITY

Health securitisation at the regional level only sprouted after the active promotion by the World Health Organisation (WHO) in recent years even though it has been widely practised in the Western countries. Hence, most of the published research on the link between health and regional security centred on developed countries. Western countries, especially those in the European region have witnessed a progressive securitisation of health since 2001 due to the fear of bioterrorism following a series of outbreaks from SARS, H5N1, to H1N1. Hence, the debates on regional health security have broadly grown out of two lines of inquiry, namely 1) an empirical line that focused on the nexus between regional and health security (Bengtsson & Rhinard, 2019) and 2) advantages and disadvantages of such moves on the link (Youde, 2018).

Meanwhile, most of the published literature on regional health security involved the comparison of two regional bodies, i.e., the European Union (EU) and ASEAN (Lamy & Phua, 2012) or the African Union (AU) (Haacke & Williams, 2008) despite some of the arguments that the theory is not applicable outside of the Western context (Peoples & Vaughan-Williams, 2010). In recent years, the Copenhagen School of ST has exhibited an increasing presence in many places (Bilgin, 2011). Therefore, it is crucial to analyse regional health security in other regions.

Although ASEAN has securitised diseases with pandemic potential, analysts struggle to explain the gap between the security discourse and the regional practice (Jones, 2011). The practice of the ASEAN has been the central debate in the study of Southeast Asia’s actions and inactions. The recent security environment in Southeast Asia indicated that NTS such as climate change, migration, and pandemics can play a vital role in dictating the regional
cooperation between the member states (Caballero-Anthony, 2018). There is a noticeable trend among state and non-state actors to turn to regional and multilevel relationships as their preferred frameworks in response to the NTS threats, especially through the authority of regional institutions (Caballero-Anthony & Cook, 2013; Zimmerman, 2014). For some, NTS issues could act as a catalyst driving a normative and operational shift in the institutions besides pushing the region to move past rhetorical arguments toward deeper institutional commitments (Pennisi di Floristella, 2012). However, scholars such as Emmers (2003a) opined that there is little evidence to show that securitisation could encourage policy makers to improve regional cooperation. The difference in perceptions shows a stark gap between the security discourse and actual practice following the emergence of NTS issues. Furthermore, although interdependency between actors has increased internationally, little has been done to shed light on the impact of addressing non-military issues on regional institutions (Pennisi di Floristella, 2012).

Prominent scholars on the Southeast Asia region like Acharya (2005) has argued that the regional norms and identity formation offer a more complete explanation of Southeast Asian regionalism, including its achievements and failures. ASEAN security practice has been driven by the practice of the ASEAN Way – where sovereignty of member states has been preserved by the practice of non-interference with member states’ domestic issues and decision-making based on consultation and consensus – which has been suggested as the reason why ASEAN managed to avoid any conflict between member states (Haacke, 2009). However, the rise of NTS threats has brought a significant debate to the institutional practice of the norms. Most observers like Kamradt-Scott (2011); Maier-Knapp (2011) concur with the argument that the region’s preference for national sovereignty has been maintained even in the face of serious transnational threats.

For instance, it was due to the non-interference norm that obstructed the institution from the Myanmar issue. Additionally, Loh (2016) argued that it was the norms of respecting sovereignty and consensual decision-making which has constrained ASEAN’s response to the Haiyan disaster and the uncoordinated search efforts for the missing flight MH370. In fact, some scholars Elbe (2010) also agreed that securitisation of infectious diseases ended up further complicating international health cooperation due to narrower calculations of national interest. While norms do matter, they do not necessarily matter in a positive or progressive manner. Norms can matter negatively, by creating barriers and obstacles to change (Acharya, 2009). The common understanding that ASEAN has reasserted their sovereignty by refusing to cooperate by adopting a common policy response has been challenged. The norm of non-
interference, however, does not mean that AMS have never interfered in each other’s affairs. In reality, Jones (2010) argued that the norm has been violated repeatedly. This has been further proven in recent years as the rise of NTS threats highlighted the interdependency of AMS because of the characteristics of NTS would lead to the emergence of security problems emanating from one member to directly impact on others.

Nevertheless, ASEAN elites appear to collectively securitised diseases with the risk of becoming pandemic, i.e.: SARS, H5N1 and H1N1, and articulated them in security terms while limited collective securitisation can be observed during the spread of HIV/AIDS (Mohd Azmi, 2020). The threat posed by the series of infectious disease outbreaks was portrayed in the regional declarations and communiques as a threat to the wellbeing of the people as well as to regional economic development. This indicated the urgency of the problem and led to political attention at the highest diplomatic level. A closer inspection of ASEAN’s response to the series of infectious disease outbreaks suggests that this established view on the region cannot fully explain ASEAN’s positive response in securitisising the health crises. ASEAN has increased the number of regional mechanisms. In fact, their regional measures to overcome the health crises has been backed by substantial regional mechanisms which have drove ASEAN to act with alacrity, with no less than 25 ASEAN instruments covering SARS, H5N1 and H1N1 compared with other NTS issue (Kheng-Lian, 2012). Other scholars like Davies (2012); Hameiri (2014) are against the argument that the member states have hindered cooperation due to strict adherence to the regional norms. In fact, there is evidence that the rationality of non-interference and consensus decision-making has changed over time (Jones, 2010; Yukawa, 2018). What this mixed picture, that the regional norms have obstructed or loosened the regional cooperation, demonstrates is the lack of empirical evidence of how the regional norms have affected the regional health cooperation. Therefore, the next section aims to examine the consequences of securitisising the pandemic diseases for ASEAN’s regional practices.

3.0 SECURITISATION AND REGIONAL-CENTRIC

This section focuses on three themes, which are based on the parallel debate on the impact of securitisation on cooperation; securitisation as hindering cooperation; and securitisation as facilitating cooperation and its impacts on the ASEAN’s practice of regional norms. The norms have been said to be the source of ASEAN’s inaction in addressing NTS issues as cooperation depends on the narrowly defined interests of the member states, demonstrating a state-centric approach within a multilateral cooperation as national considerations take precedence in the case of disagreement. However, a significant change can be found in the practice of ASEAN’s
regional norms due to the securitisation of the health crises. Instead of causing member states to become more state-centric, thus hindering cooperation, framing pandemic as a regional security issue leads member states to become more region-centric.

3.1 Securitisation as Hindering Cooperation

Regarding Southeast Asia’s security environment, there is a serious concern as to the ability of securitisation in strengthening regional cooperation to address the potential transnational threat of diseases. The conventional ASEAN style of institutionalism places a great value on sovereign equality and group unity or harmony that is manifested in a non-interference principle, consensus-driven decision-making, and non-binding institutionally minimalist regionalism (Ba, 2014). These norms and practices stand in contrast with the international relations (IR) theoretical concept of organisation. Thus, they have been viewed as the main reason for ASEAN’s ineffectiveness in formulating regional policy that can threaten the member states’ national interests (Jones & Smith, 2007).

Based on the results, four incidents highlighted how securitisation hindered regional cooperation. The first case was the insufficient level of transparency among ASEAN Member States (AMS) and their counterparts. China has been criticised for its action in withholding significant information from other countries in the region during the SARS outbreak, resulting in a great delay in the implementation of early contingency plans. With this incident in mind, the WHO member states, including the AMS, shared their expectation that states should report any potential outbreaks openly and promptly. However, some of the AMS did not learn from China’s lesson and remained stubborn and performed cover-ups. According to Curley and Herington (2011), actions by these AMS were not shocking as they seemed to fit the broader picture of the region’s dedication to preserving national sovereignty.

Indonesia, for instance, was warned by a veterinarian researcher in November 2003 about an H5N1 outbreak in the state. However, the country insisted that no cases of bird flu had been detected. Instead, it blamed Newcastle disease, a contagious and fatal avian virus as the source of the deaths of chickens. Meanwhile, in Vietnam, the first sign of the H5N1 virus was detected as early as July 2003. However, the spread of the disease went unnoticed as the Vietnamese government adopted a policy of quiet mitigation as they were preparing to host a regional sporting event later that year. Similarly, in Thailand, massive chicken deaths were reported in November 2003, but the Thai government declared the cause of cholera and bronchitis (Deutsche Presse-Agentur, 2004). The motivation behind the ‘Westphalian’ action of these states could be economically driven (Lo Yuk-Ping & Thomas, 2010). A common
understanding that emerged from the H5N1 outbreak showed that Southeast Asia states asserted their sovereignty by refusing to comply with international disease-reporting requirements.

The major concern about the assertion of sovereignty by the affected states manifested in the famous event of ‘viral sovereignty’ between Indonesia and the international community. Under the Global Influenza Surveillance Network (GISN) of WHO, a coordinated international regime for managing seasonal and pandemic influenza, it has been a long-standing practice for states to share their influenza virus samples with all the WHO-collaborating laboratories. However, in December 2006, Indonesia ceased to share the H5N1 specimens collected with the WHO. The Indonesian Health Minister created a new doctrine labelled ‘viral sovereignty’ to justify the country’s action. In this context, it was claimed that viruses formed part of the biological patrimony of the nations in which they were found, and thus the country of origin should hold exclusive rights to them (Smallman, 2013). In other words, viruses are considered biological resources owned by the countries where they are first detected, rather than public health information that must be shared freely with the world. The ‘rebellious’ act of Indonesia was also spread to other developing countries including Thailand, Brazil, and India as well as others in the Third World Countries.

Although these states did not completely follow Indonesia’s action of ceasing sharing viruses, the fallout demonstrated that the securitisation of infectious diseases might bring unintended consequences that were not necessarily positive as expected. Indonesia’s response reminded us that ‘one has to weigh the potential problematic side effects of applying a mindset of security against the possible advantages of focus, attention, and mobilisation’ (Buzan et al., 1998). As issues become securitised, it tends to attract a higher level of close attention from governments. However, the involvement of states, in this case, Indonesia, ended up with unanticipated complications in international health cooperation as some states suddenly began to query and contest the international virus-sharing mechanism in the name of safeguarding national interest (Elbe, 2010). The actions of Indonesia did not surprise scholars studying issues related to the Southeast Asia region. To them, the scenario seemed to fit the broader picture of the region’s dedication to preserving national sovereignty at almost all costs. The response also demonstrated that even in the face of a serious transnational threat, many states in Southeast Asia prioritised their national sovereignty (Acharya, 2009). This viral dispute might have reaffirmed Elbe's (2010) argument that ‘securitising infectious disease brings unintended consequences in terms of further complicating health cooperation’. This was the second incident that highlighted the negative implications of securitisation at the regional level.
One commonly observed effect of the securitisation processes is how governments often resort to emergency measures and engage in ‘extraordinary defensive moves’ to meet that perceived threat once any issues become securitised (Buzan et al., 1998). Simply put, securitisation has encouraged states to implement emergency response measures. However, the pursuit of national self-interest can hinder international cooperation. During the early stage of the H5N1 outbreak, AMS and their counterparts vowed to follow recommendations from international institutions such as the World Organisation for Animal Health (OIE), WHO, and the Food and Agriculture Organisation (FAO) to contain the aggressive spread of the H5N1 outbreak in the region. Among the emergency measures suggested was rapid culling of the poultry, a highly controversial mechanism. The measure was proposed based on the success of Hong Kong in averting an epidemic after killing 1.5 million chickens in three days during the first H5N1 outbreak in 1997 (Shuchman, 2007). Being the top poultry exporters in the region, affected states like Thailand and Vietnam agreed to the suggestion.

In contrast, Indonesia was against the massive culling of chickens. The Indonesian Agriculture Minister made a statement claiming that there was no evidence a cull would effectively contain the spread of the lethal virus and that he would only implement the action if the virus was transmitted to humans. His statement was supported by the fact that the virus had not infected any humans at that time and to protect their economy. This is highly relevant because the poultry industry is a big business in Indonesia. As the world's most populous Muslim country, chicken is the most popular meat among the local people in Indonesia. Thus, the actions taken by the Indonesian government once again illustrated how securitisation can cause the state to become state-centric and hinder international cooperation.

Besides being an instrument of securitising the national interest of the member states, the strict adherence of ASEAN’s nation to the principle of sovereignty has been driven by deep feelings of suspicion and historical animosities dating back to pre-independence and colonial days, some even pre-dating the colonial era (Emmers, 2017). A level of mistrust is said to prevail among AMS, making it a key factor in explaining the lack of progress made toward conflict resolution (Liow, 2003). Instead of strengthening the regional health cooperation, securitising the health crises might have sown the seed of mistrust between member states. The relationship between Malaysia and Singapore is one such example. Singapore’s secession from the Federation of Malaysia in 1965 has caused lingering suspicions among officials, leaders, and ministers of both countries until today. Their relationship has been marred by a number of high-profile bilateral spats, from land, water, and airspace disputes to the SARS virus.

Health securitisation has also been described from the perspectives of political realism,
national, and diplomatic interests (Nathan, 2002). The result of securitising SARS through ASEAN has led to the consensus among AMS to implement strict border inspections. AMS like Malaysia and Singapore with shared borders agreed to such implementation. However, behind the cooperation between both states, the health-security linkage also witnessed a worsening mutual suspicion between the two founding states of ASEAN. The animosity was evident during the SARS outbreak. Due to certain weaknesses in border screening procedures, in particular the incapability of the thermal scanners to measure the patient’s skin temperature accurately and the lack of expertise in screening thousands of people commuting daily through the Singapore-Malaysia causeway, suspected SARS cases had slipped through the border. As Malaysia was the less affected state, negative perceptions of Singapore arose when a few suspected SARS cases crossed the border from Singapore to Malaysia. It was reported as if Singapore was trying to export ‘chemical weapons’ to the neighbouring country (“Singapura perlu”, 2003). Sadly, the mistrust between Malaysia and Singapore undermined the ability of both countries to comprehensively combat the SARS outbreak.

In short, the culmination of these events in the series of infectious disease outbreaks from the instances of delayed reporting by Thailand, Vietnam, and Indonesia, followed by the virus-sharing dispute from Indonesia, consolidated the argument that securitisation can hinder close cooperation when the countries are being state-centric (Elbe, 2010; Enemark, 2009). Recent outbreak of COVID-19 seems to support the argument. Despite the experience of SARS, H5N1 and H1N1 that forced the region to securitise the threats, ‘ASEAN’s collective responses to the virus outbreak have been late, mainly declaratory, and slow in implementation (Rüland, 2021). It took weeks from the WHO announcement on the COVID-19 outbreak in December 2019 for AMS to initiate a regional meeting. In fact, it was the defence ministers meeting that first discussed the outbreak at the regional level in February 2020 (Mohd Ashraf, 2020). As the outbreak needed plodding responses, ASEAN’s attitude seemed to conform with the sovereignty norms embedded in the ASEAN Way. Much of the mechanisms initiated to tackle the virus is either at the national level or bilateral which is usually ad hoc, rather than through ASEAN (Pramudianto et al., 2022; Rüland, 2021). Indeed, in the case of Southeast Asia, the failure of member states to cooperate in managing transboundary diseases was attributed to the regional commitment to national sovereignty (Caballero-Anthony, 2008; Maier-Knapp, 2011). Nevertheless, it is possible that the claims about how securitisation hindered regional cooperation dominated the general perception due to the lack of empirical evidence of how AMS responded to the securitisation process at the regional level. However, such evidence only reflects part of the picture. The next section will examine whether
securitisation of infectious diseases has also prevented cooperation between AMS due to the regional norms.

3.2 Securitisation as Facilitating Cooperation

Securitising infectious diseases, as argued by Elbe (2010); Kamradt-Scott and Lee (2011) has complicated international health cooperation due to the regional perseverance of the norms of sovereignty, in which national considerations take precedence in the case of disagreements. Consequently, member states might slow down or even stop their multilateral cooperation if they believe the collective actions may undermine their domestic interests (Emmers, 2003b). However, these scholars’ claims do not reflect the overall issue as their evidence only showed that securitisation only hinders international health cooperation, whereas at the regional level, framing the health crises has never obstructed cooperation. One important example is the states’ behaviour in reporting outbreaks. Tracing the reporting behaviour of the Asian states using a disease monitoring website known as ProMED Mail (PMM) and comparing it with the report issued by the WHO. Davies (2012) in her empirical analysis found that the East Asian region had a steady reporting pattern to the WHO that correlated closely with the number of cases reported in the region. In fact, states that have been regularly criticised for not complying with the duty to report, like Indonesia and Thailand, were found reporting regularly. This suggests that sovereignty has not been evoked to deny the duty to report an outbreak nor has it led to states abrogating their perceived duty.

Even at the regional level, sovereignty was never used as an excuse to avoid cooperation as AMS have always notified each other about the current health situation in their countries. This is despite the fact some of the information might be confidential, including information on outbreaks and inventories of laboratory tests. As noted by one of the elites in ASEAN, ‘Although some information might be confidential to share with others, AMS have so far, no problem of sharing information on disease-related issues. ‘We will notify others immediately if there is an outbreak in our country’ (Officer 5, personal communication, 19th July 2016). Of course, there is concern about the late response of some ASEAN member states’ action of withholding crucial information during the initial outbreak of H5N1. While there is concern that ASEAN member states’ action in late announcing is more like trying to protect their national interest (Vu, 2011) which likely suggests that member states used the principle of non-interference to justify their actions, ASEAN member states did not see it in the same way. They see this issue is more to avoid chaos and panic, as what happened during the SARS outbreak. In that outbreak, mass panic hit the region when panic over SARS was keeping people away
from hotels and restaurants and, in fact, whole countries. There was some evidence of panic buying by customers anxious to stock up on fruit and vegetables while travellers were even spooked at the idea of changing flights at airports in countries affected by SARS (Yale Global Online, 2003). The panic was compounded by the fact that there was no known cure for SARS. Even ASEAN leaders who attended the SARS emergency meeting in Bangkok agreed that SARS engendered more panic than pain inflicted in terms of health and lives (Henson, 2003). Following this experience, some ASEAN states were reluctant to come to the public in the very beginning as they were trying to confirm the finding first to avoid panic. For instance, Thaksin in his statement justifying his action was quoted as saying, ‘Please trust the government. It did not make an announcement at the very beginning because it did not want the public to panic. I know what I'm doing’. This observation was confirmed to the author through interviews with ASEAN’s elite. As one officer explained in the interview, ‘Some of the people might perceive it as a late announcement. It’s not a late announcement. Not... Because we are the government it is more about trying to verify, to validate. You validate, you verify the situation. It’s the matter of validating and verifying the facts. (Officer 4, personal communication, 11th May 2016).

In the case of Indonesia’s famous doctrine of viral sovereignty, against the common understanding that securitising infectious diseases turned out to further complicate international health cooperation (Elbe, 2010), surprisingly Indonesia did not actually cease sharing H5N1 samples virus with the FAO and at the same time, cooperation between the WHO and Indonesian health officials was generally unaffected (Hameiri, 2014). In fact, considerable interventions into the governance of H5N1 in Indonesia through large projects like the Participatory Disease Surveillance and Response (PDSR) and District Surveillance Officer (DSO) Programme were intensified and persistent (Hameiri, 2014). This just demonstrated that cooperation between states had been strengthened and not hindered. For instance, Indonesia was the first country that USAID developed their first disease surveillance and response programme through their Avian Influenza (AI) unit. Indonesia relies on the PDSR to serve as the mechanism to obtain initial notifications from backyard poultry producers to track and respond to suspected bird flu outbreaks (USAID [United States of America Agency for International Development] 2007).

The presence of PDSR in surveillance of the Indonesia domestic context suggests that Indonesia did not use sovereignty to cease cooperation as the international cooperation was never hampered. Moreover, Davies, through her empirical analysis, concluded that ‘Indonesia still sought to inform the WHO of outbreaks, even during the height of the dispute, and the
Ministry officials appeared to trust the WHO official sufficiently to continue reporting information it did not want publicised’ (Davies, 2012). Another example is the US government still supported the government of Indonesia in combating the avian flu. They provided various mechanisms to help Indonesia, including establishing regional avian influenza coordination hubs carrying out risk communication activities and funding and supporting seasonal surveillance which suggests that sovereignty has never been the problem for cooperation as other organisations have already intervened in helping Indonesia combat the threat U.S Department of State, 2007). Indonesia not only cooperates at the international level, but also at the regional level. In fact, the H5N1 security linkage did not stop Indonesia from cooperating with the ASEAN. As noted by Indonesia’s elite in an interview, ‘You cannot just have a good global collaboration, but [at the same time] you do not take care of your national or your regional collaboration. Every pillar is as equally important as the other’ (Officer 6, personal communication, 24th July 2016). For instance, Indonesia followed ASEAN’s suggestion of having standardised airport procedures, even though they had already implemented their national mechanisms in addressing the SARS outbreak.

Meanwhile, in the H5N1 outbreak, despite being criticised as hiding initial information of the avian flu outbreak, Indonesia, as the one of the Component Coordinating Countries (CCC), was entrusted to handle regional networking and information-sharing between ASEAN member states and had developed a regional surveillance website known as Ads-Net. As the CCC country, Indonesia showed a good example to their neighbouring states. They were consistently uploading information and urged their neighbouring states to do the same thing. As one Indonesian officer was quoted saying, ‘The exchange of epidemiological information and disease surveillance between ASEAN + 3 countries is very important in efforts to prevent and control diseases in the region. Therefore, the countries involved in it must proactively fill and update the data and information on the site’ (Wibisono, 2008). ASEAN health officials interviewed insisted that Indonesia never hid information from the regional states. In fact, they have prioritised their neighbouring states in disseminating crucial information. One high-level Indonesia’s official stated, ‘You prioritise, you contain it nationally, and then, the next ring is your regional neighbour and then you notify the global level’ (Officer 6, personal communication, 24th July 2016).

As the first chair of the ASEAN Technical Working Group on Pandemic Preparedness and Response (ATWGPPR), Indonesia initiated several key activities in pandemic preparedness and response, including developing ASEAN non-health indicators for pandemic preparedness and response and assessing other ASEAN member states and their levels of
preparedness for the non-health sectors. Indonesia had successfully led the group in overcoming challenges in strengthening ASEAN’s capacity in coping with pandemics by establishing several key activities. One of ATWGPRR’s aims was to develop an indicator system for the assessment of national multi-sector pandemic preparedness capacities of non-health sectors. The original plan was to involve teams from other AMS to test the system in 2009. However, due to the outbreak of H1N1 in 2009, other states withdrew from participating in the test. With limited resources, such as a lack of required expertise, skills and manpower, Indonesia volunteered to pilot test the system. As a result, some important lessons that were later used to revise the assessment methodology with regards to pandemic preparedness planning of non-health sectors, including public and private service providers, were found during the pilot assessment. This example alone shows Indonesia’s commitment to regional cooperation.

Cooperation in security affairs is possible, even in the area where institutionalists predicted that cooperation would be hardest to achieve (Fawcett, 2008). In ASEAN, the structures of health issues cooperation in the security field are being progressively developed. The issue of pandemic diseases is linked to the question of national security as it threatens the national sovereignty and integrity of the independent state. As the pandemic disease is a transnational issue, interstate cooperation is needed. However, by interstate cooperation it means that the state needs to surrender state sovereignty. A section of national sovereignty needs to be abandoned for it to be protected more effectively (Emmers, 2003a). This might be the biggest challenge of ASEAN’s multilateral cooperation in addressing the NTS issue. Nevertheless, a significant change can be traced when ASEAN securitised the pandemic issue as member states begin to ‘surrender their state sovereignty’.

The significance of the ASEAN+3 EID programme cannot be overstated considering that it helped bring political legitimacy to the regional surveillance activities. For instance, the launch of Ads-Net resulted in more open reporting moves among the member states. The project website served as a platform for sharing epidemiological data and surveillance information across member states. It provided outbreak reports by country and daily information on health developments in the region such as avian flu (The South Centre, 2007). Regional surveillance was operated when member states were encouraged to transfer national data into the regional database maintained in the Ads-net (AusAID, 2007). The website successfully shared important information on epidemic transmission without compromising national sensitivity and confidentiality concerns despite the fact the website is not compliance-driven like the International Health Regulations (IHR) and despite the possibility of potential
threats from bioterrorism and adverse impacts on the tourism and trade sectors when certain communicable diseases were detected and acknowledged to other states (AusAID, 2007). In fact, due to the increasing transparency and sharing of information on emerging infectious diseases within ASEAN member states, some development partners of AusAID considered that their investment in the ASEAN+3 Emerging Infectious Disease Programme ‘to be the best investment Australia had made, as they believed that it laid the foundation for this significant development’ (Schierhout et al., 2017).

The website has since been replaced by a new website. Yet, information sharing between member states continues and has further intensified. ASEAN has used three different mechanisms to speed up the process of disseminating results of the surveillance; through focal points, contact person and the ASEAN Emergency Operations Centre (EOC) Network (Officer 5, personal communication, 19th July 2016). While the ASEAN EOC network uses newsletters to disseminate information, events, and best practices among member states, in the event of a pandemic, focal points and contact persons are the key people who have been appointed by the governments to share any information of an outbreak to the WHO and neighbouring countries. Hence, with a vast choice of distributing information the procedure of notifying other states becomes much easier as it cuts out bureaucracy. This mechanism continues to play a significant role in addressing the COVID-19 outbreak. AMS and their partners have been receiving daily updates and technical exchanges on the virus through the network. This network also provides regional surveillance, early warning and sharing information among AMS and its partners.

Meanwhile, any information on the pandemic can be accessed by the public through ASEAN social media platforms and the ASEAN website (Fernando et al., 2020).

Another significant impact of the establishment of the regional surveillance mechanism is AMS are becoming more transparent in notifying and alerting their neighbours (Officer 3, personal communication, 11th May 2016). Their transparency in disease surveillance and reporting pandemics resulted in the region being more prepared in dealing with the pandemic disease. Even the WHO noted that following their experience with SARS and avian influenza, ‘[The region] is more prepared than other regions to respond to a possible pandemic with its existing mechanisms of surveillance and transparency’ (Caballero-Anthony & Amul, 2016). ASEAN’s effort to enhance their regional surveillance indicates the desire of member states to raise the level of security cooperation in the region to a higher level. In particular, the impetus sharing of information that might be sensitive and confidential to some countries indicated that securitising the pandemic diseases has made member states more transparent, which has been translated into credible mechanisms of regional monitoring.
The recent outbreak of Covid-19 pandemic also shows similar results. Despite the initial crisis of paralysis where AMS responded differently to the outbreak according to their respective socio-economic and political circumstances (Kliem, 2021), ASEAN still conducted the Foreign Ministerial Meeting at the regional level. ASEAN health experts and ASEAN leaders hold regular meetings to share information about COVID-19 prevention, treatment and facing new cases. Pre-existing health sector mechanisms as well as newly created ad-hoc mechanisms have been created as response to the pandemic. The mechanisms involved in ASEAN’s response to the COVID-19 are the ASEAN BioDiaspora Virtual Centre – produce report on risk assessment and disease surveillance of COVID-19 thrice a week, ASEAN Regional Public Health Laboratories (RPHL) – facilitating exchanges on laboratory readiness, technical and material support, as well as laboratory surveillance, and the ASEAN Risk Assessment and Risk Communication Centre – combating fake news and hoaxes related to COVID-19. Additionally, several ad-hoc agencies including ASEAN-China Ad-Hoc Health Ministers Joint Task Force and ad-hoc meetings like ASEAN Special Summit on Covid-19 have been created to inform and coordinate AMS response on COVID-19 (Fernando et al., 2020). Elite officers attending the meetings were not afraid to exchange technical data about COVID-19 prevention, treatment, and facing new cases (Arnakim & Kibtiah, 2021). Looking at this significant change, it demonstrates that the region’s sovereignty regime has been far less coherent.

4.0 CONCLUSION

Most of the positive/negative debate on security only reflects the European experience. Empirically, the meaning of security tells us that security means different things in different contexts. The case of securitising infectious diseases in Southeast Asia indicates that ST is applicable outside of the Western realm. Moreover, adding more voices and experience from non-Western context, in this case Southeast Asia region, where the region’s strict adherence to the norms and practices and different demographic and level of socioeconomic between member states have been identified as the source of ASEAN’s actions and inactions, have challenge the assumptions about the consequences of ST. In order to determine the consequences of securitising diseases with pandemic potential on regional cooperation, this article used a debate that states securitisation can hinder cooperation as the centre of the study. The article review that, in some instances, securitisation may result in security dilemmas which create competitive logic that hinders cooperation. However, the negative impact only happened during the SARS outbreak. Instead of causing member states to become more state-centric, and
thus hinder cooperation, framing pandemic as a regional security issue caused member states to become more region-centric, setting aside the region’s norm. This challenges the deeply ingrained view that security should be seen as negative since it will only bring more particular emergency politics which are not necessarily positive and unproductive.

Framing pandemic diseases as a regional security issue successfully made some of the AMS more proactive towards the issues faced by other states. As evidenced by the case study, securitising the health crises did not cause ASEAN to adopt a ‘state-centric’ mode. Instead, the AMS were becoming more region centric. As one of the officers was quoted saying, ‘The pandemic issue is not only the matter of security for the country but the security of the ASEAN region’ (Officer 4, personal communication, 11th May 2016). Securitising pandemic diseases at the regional level brought on significant changes to the regional practice, showing how the principle of ASEAN Way is not static but continues to evolve toward a greater level of institutionalisation.

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