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Response to reviews of Containing Contagion by Sara E. Davies

Containing Contagion: The Politics of Disease Outbreaks in Southeast Asia. Sara E. Davies. Johns Hopkins University Press, Baltimore, USA, 2019, pp. xii + 212. ISBN 978-1-421-42739-3 (pbk).

Containing Contagion stemmed from two health emergencies that followed each other in quick succession: the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 and H5N1 Avian Influenza outbreak the following year. Questions arose such as what were states obliged by international law to do? Must they notify their neighbours and if so, when? Should virus samples be shared? Answering these questions required conversations about public health capacity and risk communication, but also about the responsibilities of states and the roles of regional actors. Sixteen years later, it is tempting to see these earlier experiences as a forewarning of COVID-19. As Kate Seewald explains, it is hard to think of global health security pre COVID-19 without reflecting on its prescience for this contemporary crisis (Seewald, 2021).

If the past is prologue, then—as I explained in Containing Contagion—the heart of the question of responsibility lies in the International Health Regulations (IHR). The IHR was first adopted by the World Health Assembly, the member state legislative assembly attached to the World Health Organization (WHO), in 1951. The IHR was to guide states with notification and quarantine measures in the event of an outbreak that was listed as a notifiable disease under the Regulations. Revising the IHR had been tabled since 1995 but had lacked diplomatic momentum until SARS. This outbreak, followed by animal to human transmission of Avian Influenza H5N1 in the Southeast Asian region in 2004, helped speed up the sense of urgency and the IHR’s relatively smooth passage to adoption by the World Health Assembly in 2005.
The revised IHR was different in three substantial ways. First, no list of notifiable diseases. This time there was a definition and a matrix that states use to determine whether their outbreak event, whether biological, environmental, chemical, radioactive, or natural, requires notification to the Director-General of the WHO as a potential ‘public health emergency of international concern’—a PHEIC. The second, related, substantial change was the positive duties placed on states to meet the surveillance, reporting, and verification expectations laid out in the revised IHR. To complete a matrix assessment of risk, there had to be 24 to 48 hours notification timelines, and 48 hour verification of events. This required the appointment of a 24 hours/7 days a week National Focal Point as the point-of-contact for the WHO should a PHEIC be declared. To fulfill these functions, the revised IHR included core capacities ranging from legislative reform, to budget expenditure, to risk communication processes and minimal laboratory benchmarks, that all 194 signatory countries were expected to meet by 2012 with extended timeframes available for low income countries. Finally, the third substantial change was the expectation that states would refrain from taking punitive measures into their own hands. Specifically, no arbitrary restrictive trade and travel measures against a state experiencing a PHEIC. This was vital to end the practice of states failing to report events early and often when they did not trust that more harm came from reporting outbreaks than seeking to hide them. Enhanced capacity to detect and respond was only one half of the change envisioned by the revised IHR—the other change envisioned was that reporting outbreaks would become normalized and regularized.

In that same year, 2005, two of WHO’s six regional offices adopted a co-designed implementation instrument to assist them with implementing the revised IHR. The Asia Pacific Strategy for Emerging Infectious Diseases was adopted by the WHO Regional Office for the Western Pacific (WPRO) and South East Asia (SEARO). This program comprised a 5 year (2005–2010) effort to assist member states with meeting their core capacity requirements. Containing Contagion explored why these two regions adopted their own unique regional instrument of IHR implementation. I examined a nested case of states covered the regional membership of SEARO and WPRO: the member states of ASEAN. I found that though there were profound differences between them, overall, ASEAN states had responded positively to the concept of shared infectious disease surveillance and the reporting of infectious disease outbreaks, both endemic and emerging diseases, to neighbouring states. The depth of cooperation, however, was limited—states retained control of both the targets and of how their performance was assessed. Moreover, some core IHR capacities grow apace of others. The system of response may be prompt but the health system capacity to endure a health emergency to its end remains uneven and unpredictable in the region—as COVID-19 attests. Nonetheless, a region with a deep tradition of reticence towards international legal frameworks APSED seemed special and unusual.

The essays here raise important questions about the issues raised in Containing Contagion. With the privilege of COVID-19 hindsight, three seem especially important.

First, Tim Brown is right to highlight the complex regional politics of international norm diffusion and internalization (Brown, 2021). It was always known that implementing the IHR was going to be a long and difficult journey for many countries in the region, one pursued alongside other equally important health goals such as universal health care and vaccination coverage. Challenges and questions abounded. Diplomatically, what had states agreed to in the panic of SARS and what would they continue to agree to five and ten years after SARS, especially if no pandemic arose
during that period of time? Economically, what was sustainable for states to commit to in the realm of future health risks as opposed to immediate health priorities? And finally, how to organize compliance? Should states go it alone? Should they act bilaterally? In regions? In economic blocs? In Containing Contagion, my interest was in the regional pursuit of a cooperation around the revised IHR. I was particularly interested in how ASEAN balanced its tradition of eschewing international law with its proactive engagement with supporting its members to implement the IHR, an especially difficult challenge given the diversity of its member states, ranging from authoritarian to democratic, low income to high income, conflict-ridden to peaceful, and centralized high capacity public health systems to decentralized, volunteer dependent, public-private hybrid forms of health care. Why was a regional mechanism so attractive to these vastly different states?

Of course, as all three commentators note, we can—and must—expand our understanding of norm diffusion and contestation beyond national governments and regional organizations. Place and space are political. As Alan Ingram notes, there are regional and relational dynamics relating to international public health (Ingram, 2021). We need also to capture the local understanding of health security. When and how do the local dynamics intersect with the international narrative, if at all, in the daily functions of public health officials, doctors, nurses, and volunteer health care workers. What is the lived reality of detecting a potential public health emergency, of deciding whether or not to report it, and the scientific and bureaucratic pathways to alert a government and then the WHO, of a potential outbreak? What is the economic and political cost involved to raise the alert, from the local level to the national level, often multiple times throughout a calendar year, as required by the IHR instrument? The local matters greatly, but it is important not to lose sight of the fact that both the normative and material conditions of possibility are often framed by the national.

A second theme to emerge from this conversation is that human rights has a strong background role in public health emergency management. I argued that the relationship between public health and human rights was central for thinking about health emergency response yet still too often overlooked. It remains a significant gap in the entire global health security narrative. The COVID-19 pandemic has clearly demonstrated the cost of failing to incorporate a human rights framework as one of the essential core capacity requirements for meeting the IHR. Human rights—their inclusion or absence—affect the foundations of public health emergency response in a myriad of ways. Thought needs to be given to how human rights can better underpin the IHR and attention paid to the relationship between civil and political rights and duties during health emergencies. This is contentious ground. On the matter of universal human rights, states are more fractured and divided. If Kate Seewald is right (Seewald, 2021) and the wave of human rights violations committed by states in the wake of COVID-19 is the consequence of a deliberate strategy to securitize public health discourse in hybrid regimes including those in Asia (Grundy-Warr & Lin, 2020), the only recourse would seem to be to ground health security in human rights. This is an urgent and complex issue I raised in Containing Contagion.

The third theme to emerge from this conversation is the politics of context. Context is needed to understand how the international is infused with meaning that compels a state to seek compliance rather than outright rejection. We can take the macro approach and study all 194 states reporting performance against the IHR annual reporting tool but we will miss the regional variations and ‘small n’ idiosyncrasies that may explain where internalization is progressing and where compliance is dependent
on context. But this approach risks unduly rewarding the wealthy global North for meeting the core capacities (regardless of whether they are effective in crisis, as COVID-19 reveals) and neglecting the resilience and ingenuity that may be occurring in the global South to build capacity in the absence of large budgets. The Asia Pacific Strategy for Emerging Infectious Diseases (APSED) was developed to assist the two regional offices member states come to grips with the capacities required under the revised IHR. As I observed in the book, APSED’s adaptation of the IHR was contentious for some at WHO Headquarters. The argument for its existence came from those who knew regional interest in the revised IHR was possible but it required a niche model of implementation. The differences across Southeast Asia, let alone the Asia Pacific region, are vast—economically, politically, and socially. The common factor was a shared space that is vulnerable in the presence of shared threat. APSED defined the common regional threat and created a shared regional purpose for all states, irrespective of income and regime. I witnessed, first hand, the difficult conversations that could be achieved in informal group dynamics away from the ‘formal’ pressures of evaluations and observers. Anecdotes on how to manage centralized authoritarian structures and political party-affiliated scientists were exchanged over coffee breaks and ‘role play’ exercises. Formal evaluations and metrics were, for the most part, absent. APSED was about the socialization of international norms through locally adapted methods of shared exercises, simulations, and informal dialogue. Problems exist in this model. Would APSED work as a regional approach everywhere? Probably not. Does the APSED structure remove human rights conversations from the formal agenda? Definitely. Does the APSED experience show regional approaches to global health security matter? Absolutely.

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