

Human security and public health in Southeast Asia: the SARS outbreak

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Severe acute respiratory syndrome (SARS) is now a global public health threat with many medical, ethical, social, economic, political, and legal implications. (Abdullah et al. 2003)

No man is an island. (John Donne)

The security of the state is dependent on the security of its individual citizens. If they are not secure, the state is not secure. Traditional, state-dominant, conceptions of security are ill-equipped to provide understanding into the array of security concerns that now confront nation-states. In November 2002, one of these new security concerns, a corona pulmonary virus jumped the species barrier to begin infecting people in southern China. Three months later this virus was unwittingly transmitted from mainland China to Hong Kong. From there it spread rapidly throughout most of Southeast Asia as well as through parts of the Americas and Europe. Now known as the SARS—Severe Acute Respiratory Syndrome—virus, it became a major threat to the stability and prosperity of Southeast Asian countries. This article reviews the spread and impact of the SARS virus within Southeast Asia from a human security perspective. It is intended that the utilisation of human security in this instance will not only provide a better understanding of the impact of SARS on regional states but will also advance the conceptualisation of the human security model.

Introduction

The security of the state resides in the security of the individual. In recent years the security of East Asia has been threatened by a number of crises, which have had a region-wide impact. In November 2002, the latest crisis—Severe Acute Respiratory Syndrome (SARS)—broke out in southern China. Though it was thought contained, an index case travelled to Hong Kong where he unwittingly passed on the virus to nine others. From this small beginning a major threat to public health spread rapidly across Southeast Asia and throughout the world. Such crises represent a non-traditional threat to regional security. Drawing on the SARS virus as the case study, this article will

seek to show how public health matters can cross national boundaries to threaten the security of neighbouring states.

This article begins by placing human security within the constellation of contemporary security studies, and then showing how major public health issues can, in some instances, evolve into security threats. A history of the outbreak of the SARS virus is briefly viewed, before exploring the impact the virus had in a number of Southeast Asian countries, as well as on the ASEAN group as a regional organisation. During this exploration, some of the key issues arising from the experiences in different Southeast Asian countries, as well as from the attempts of the ASEAN group, in addressing the threat of SARS will be examined. The final section of the article will be an analysis of the lessons learned from the outbreak and their utility in addressing other human security threats.

Human security and public health

After the Cold War, the contemporary debate in International Relations on security burgeoned to accommodate the diversification of what could be considered a 'threat' to state security. At the same time, it is true to say that the conceptual clarity of security within International Relations has atrophied in response to theoretical and methodology debates within the discipline that have questioned the utility of traditional concepts of security within realist and neo-realist constructions. This conceptual debate has been driven by the changing international environment, which presents a more fluid challenge to nation-states than was the case in the bipolar world order that characterised the Cold War period. Alternative sub-concepts of security—such as human security—have now emerged to accommodate and incorporate a variety of issues and processes considered outside of the 'traditional' framework.

Human security is a classically liberal concept, where a state's security rests on the premise that its citizens must be secure. Initially coming to prominence via the 1994 United Nations Development Report entitled *New Dimensions of Human Security*, (UNDP 1994) this concept was adopted by the IR community as a new mechanism for understanding security in the post-Cold War period; 'one that could cope with multidimensional threats that did not emanate from a state nor were necessarily directed against state interests but which nonetheless detracted from the security of a state' (Shannon & Thomas 2004). Human security concerns are therefore of interest to a wide range of actors, not only including states, but also international organisations, international non-governmental organisations (INGOs), domestic organisations, and the individual. Scholars and policy-makers have used the term to refer to the diverse array of issues that fall outside the purview of traditional military-centric security concerns.

However, the broad definitions used by the United Nations in the 1994 report created a problem for those seeking the theoretical clarity that had once

been assumed during the Cold War era. It has been argued elsewhere that the transnational component of the human security concept offers a way of accruing 'greater analytical and policy value'. (Thomas & Tow 2002) To achieve this clarity requires acknowledgement of three factors, namely that (1) insecurity arises from 'inadequacies in internal state systems [that] make individuals and groups within [other] states more vulnerable'; (2) that affected states and individuals frequently cannot address these threats unilaterally; and (3) that because of this some form of international assistance or intervention is required (Thomas & Tow 2002: 178).

Thus, when evaluating an event as a human security threat it is necessary that the issue emerge from within a domestic setting before crossing national boundaries to negatively affect other states or associated groups or individuals. The nature of a human security threat is such that affected states do have the capacity to resolve them by themselves but need to rely, to varying extents, on other states, international organisations and/or individuals. This is especially the case when threats become non-linear—'where causes and effects beyond the immediate area of the threat must be considered' (Thomas & Tow: 179).

Within East Asia, national security interests are still dominated by traditional security concerns of sovereignty and territoriality, governed by the belief in a structured order of states in the international system. Within Southeast Asia this system is, if anything, even stronger. The 'ASEAN Way' assiduously promotes non-interference and consensual decision-making as core principles of state behaviour; making attempts to resolve transnational human security threats difficult and regional responses to such threats from ASEAN problematic. However, in the last five years, there has been a growing recognition among the Southeast Asian countries that non-traditional security issues did threaten the stability and prosperity of the region. Despite this, because of its liberalist origins, few regional countries have been willing to shift to human security modelling of current or future threats.¹ Nevertheless, public health concerns such as HIV/AIDS or, most recently, Severe Acute Respiratory Syndrome (SARS) have forced states to go beyond such conceptions to consider human security responses to incipient or potential threats.

The recognition that health issues are vitally important to the human security of individuals and the security interests of states is not new. Pirages and Runci commented that,

Viruses, bacteria, and various kinds of plants and animals have never respected national borders. They have travelled across frontiers with the winds, waters, explorers, merchants, and mercenaries. Most of the time these crossings have been quite innocent, but occasionally whole societies or ecosystems have been reshaped by them. Now there is growing concern over the impact of increasing globalisation on the potential development and spread of new and resurgent diseases across increasingly porous borders (Pirages & Runci 2000: 176).

This comment is supported by Cusimano, who concluded that ‘while open society, open economy, and open technology forces can help contribute resources to combat the spread of infectious disease, these dynamics also create an infrastructure that allows and encourages diseases to spread’ (Cusimano 2000: 174).

In other areas of the health-security nexus, scholars and international organisations such as the World Health Organisation (WHO) have identified health and well-being as an important causal variable in conflict situations. One example of this is the Program on Human Security at Harvard University’s Centre for Basic Research in the Social Sciences that has explored causal relationships between public health and conflict, in particular how various types of conflict (intra-state, ethnic, civil war) and their duration impact on the public health of civilian populations (Program on Human Security n.d.).

The twinned questions that then arise are how and why health issues develop into human security threats? The answer to the first question is complex and relates to the specific disease or virus being investigated. In broad terms, SARS, although still not yet finally confirmed, appears to be a cross-over virus; one that normally resides in the civet cat (Peiris *et al.* 2003; Drosten *et al.* 2003; Günther *et al.* 2003). The civet cat is also a Southern Chinese delicacy. At some point in recent times the virus jumped the species divide, probably during the harvesting or consumption of the cats. (This is not the first lethal cross-over virus that the area has experienced. A strain of avian influenza, H5N1, has appeared several times in the last decade). Once the civet cats were identified as the most likely source of the SARS virus they were pulled from local menus. However, as the incidence of SARS declined, the Chinese authorities have again allowed the cat back on provincial tables. That decision, when coupled with wintry and unhygienic conditions, may yet see a return of the virus.

The second question can be ultimately answered as a failure—at some level or levels—of the host nation-state, which if left unchecked can, can spillover into other states. Colebatch and Larmour identify three sectors where such failures can occur: the bureaucracy, the market, or the community (Colebatch & Larmour 1993: 28–39). Bureaucratic failure occurs when time constraints and information requirements do not meet the needs of a particular case. This may be compounded by conflicting requirements between the central authorities and those implementing the policies at ‘street level’. This failure may be also come up when different organisational units have conflicting goals (Colebatch & Larmour 1993: 33–34). Market failure occurs when an information gap is present or when externalities are generated. It can also fail when the goods (in this case public health) are controlled by a narrower group of people than those immediately threatened (Colebatch & Larmour 1993: 29–33). Community failure can transpire when individuals’ overlapping needs and identities cause them to all not ‘pull in the same direction’, destabilising the nation-state (Colebatch & Larmour 1993: 35).

Thus, when considering where threats emerge to challenge state security, and given that it is 'inadequacies in internal state systems' that create vulnerabilities, this approach provides a model from which the origins of human security threat could be ascertained. Further, in a transnational setting, the identification of a threat emanating from a failed sector could assist in the identification of sectors most at risk in other states. Colebatch and Larmour conclude that the resolution a failure generally requires a mix of at least two other sectors, if not in addition to the remaining capacity from the failed sector. In other words, a market failure could require the combined resources of the bureaucratic and community sectors, and may even require market resources from other parts of the sector, to successfully overcome.

To test this model with the human security concept we will examine the domestic impact of the virus in the most affected Southeast countries before exploring the effectiveness of the organisational response at the regional level. After analysing the events and issues surrounding the SARS outbreak in Southeast Asia, the key lessons learned from this event will be reviewed. First, however, it is important to understand the manner by which the virus spread.

An overview of the outbreak

The first known SARS case was detected in mid-November 2002 in Foshan city, Guangdong province, China. However the World Health Organisation (WHO) only received a report from the Chinese authorities on 11 February 2003 stating that there had been an outbreak of atypical pneumonia in the province that had affected 305 persons and resulted in five deaths (Communicable Disease Surveillance and Response (CDSR 2003)). The WHO was officially made aware of the existence of a severe form of atypical pneumonia with no known cause on 28 February 2003 when Dr Carlo Urbani, alerted the WHO regional offices following the review of an American patient in the French Hospital who had contracted the virus (CDSR 2003).

The main SARS inflection left mainland China via 65-year old Dr Liu Jianlun from Guangdong province, who came to Hong Kong after treating SARS patients. He checked in to a room on the 9th floor of the Metropole Hotel, and subsequently infected other people staying on the floor. In returning to their home countries this group became the new index cases, spreading the disease to Singapore, Canada and Vietnam, as well as other parts of Hong Kong. Further outbreaks of the SARS virus occurred in Southeast Asia, in the Philippines, Malaysia and Thailand; though no local transmission of the disease was ever confirmed in Thailand.

On 12 March 2003, after the WHO had assessed the situation in Asia a global health alert was issued regarding 'cases of severe atypical pneumonia with unknown etiology that appeared to place health workers at high risk' (CDSR 2003). This was raised on 15 March 2003 to a rare emergency advisory.

As the situation worsened, the WHO recommended that all non-essential travel to Hong Kong and Guangdong province be postponed.

Meanwhile, the virus spread outside the region, to Europe and the United States, by infected air travellers. Following the WHO's global alert, countries started to take a range of precautions against the further spread of SARS. These measures included the temporary banning of flights from 'hot zones' (those areas most infected); temporarily stopping the issuance of visas to persons from these zones; health and temperature checks; and quarantining persons from infected countries for 10 days.

On 20 April China finally admitted to the spread of SARS from Guangdong to Beijing, with hundreds of cases as yet unreported. Although the Chinese Health Minister, Zhang Wenkang, and the Mayor of Beijing, Meng Xuenong, were both sacked for their lapse, this move was seen proverbially as 'scaring the chickens to catch the monkey'; a Chinese idiom meaning 'to create a fuss to deflect blame from those more senior in power'. This action came two-and-a-half weeks after WHO officials were allowed access to the main infectious sites in southern China (3 April), and nearly a month after the WHO made the preliminary identification of the index case coming from Foshan city in Guangdong province (28 March).² China's silence as to its knowledge of SARS can be seen as the major causes of its rapid spread and deadly effect.

On 28 April, Vietnam became the first country to be declared SARS-free. By mid-2003 all countries had either been declared free of the SARS virus or were finalising their quarantine period. An isolated infection occurred in Singapore in September 2003, arising from a breach of laboratory safety protocols. Although limited to a single individual, who later recovered, of most concern was that this infection did not exhibit all the SARS symptoms. Should the virus reoccur, its mutable nature could possibly make detection more problematic.

Incidence of SARS: country and regional case studies

In reviewing the Southeast countries affected by the SARS outbreak, Singapore and Vietnam stand out as the most severely threatened states. Other regional states such as Malaysia, the Philippines, or Thailand were also affected, but to a much lesser extent. Of those others that were affected, Thailand provides a good example of the negative impact popular opinion can have in a crisis situation. As was the case with the Asian Financial Crisis in 1997–98, similar problems in a number of Southeast Asian countries created the impression that SARS was a regional issue, one where ASEAN should play a role.

Vietnam

Vietnam was the first Southeast Asian country to deal with the SARS epidemic in late February, and the first country in the world to contain the highly

contagious disease. At the same time as Dr Urbani alerted the WHO to the existence of the atypical pneumonia he met with officials from the Vietnamese Ministry of Health and proposed strict quarantine measures (Savioli 2003). In addition to the quarantine measures, the Vietnamese government also established a cross-ministerial committee to monitor and respond to any developments. It was this rapid response that limited the spread of the virus, both in Vietnam as well as internationally. However, despite these efforts, by the time the outbreak was finished Vietnam had registered 63 SARS cases, including five fatalities (*Vietnam News Briefs* 2003–21 October).

As was the case with other countries affected by the outbreak, the impact of SARS quickly moved beyond a health issue, to become a political and economic threat as well as major foreign policy challenge. In addition to the health protocols enforced at the French Hospital in Hanoi, the Vietnamese government moved quickly with a public information campaign. While official sources claimed that this campaign had reduced public concerns, regional press reported that Hanoi residents were being discriminated against, while ethnic Chinese tourists were being shunned. (*Vietnam News Briefs* 2003–22 April) In fact, once China was identified as the index country, additional troops were placed on the border to prevent the unchecked entry of any infected Chinese persons (*Channel News Asia* 2003)

Economically, no sector of Vietnam's economy was left unscathed by the virus, with hospitality and tourism-related operations the most affected. Since the first case of SARS was discovered in Hanoi in late February, the country's tourism and air travel sectors have been badly affected. Vietnam's economic loss was estimated to be in excess of US\$220 million, which was compounded by an estimated 120,750 redundancies. In GDP terms this meant that SARS cut 1.1 percent from Vietnam's economic growth in 2003 (*Vietnam News Briefs* 2003–21 October).

The main lesson that can be drawn from the Vietnamese experience with SARS is that hospital staff need to be trained to make informed decisions, and have the authority to act on them in a preventative manner. Further, it is essential that hospitals have good lines of communication with relevant health ministries, and are not afraid to issue alerts when required. Finally, the decision by the Vietnamese government to create an inter-ministerial committee, capable of coordinating policy responses across different sectors was a key tool in the government's fight against SARS.

Singapore

The SARS outbreak in Singapore presented the government with a major social, economic and political challenge, at a time when the country was distracted by other economic and security issues. In reviewing the SARS outbreak in Singapore a number of important issues stand out. First, Singapore's location as a major regional transport hub makes it particularly

exposed for rapidly transmitted, human-borne diseases. At a practical level, there is little the local authorities can do to prevent further viral outbreaks. Despite this exposure, Singapore dealt with a major medical crisis and managed to avoid the travel sanctions imposed on other affected areas, thereby partly protecting the economy; though many travellers simply stayed away. It should be acknowledged that Singapore was in a better position than either Vietnam or Hong Kong in that there was a transmission lag between the severity of the virus being realised and SARS arriving in Singapore. That caveat aside, the Singaporean government was quick to implement political, medical, economic and public relations strategies to counter the virus.

Even with the time lag, the first three SARS cases were confirmed on 13 March, all of whom had stayed in the Metropole Hotel. Less than two weeks later the first death had been recorded and the government was forced to close all schools and issue quarantine orders for 740 people, amid rising public concern. In late March, the Singaporean Health Ministry invoked the Infectious Diseases Act (IDA), to isolate everyone known to have been in contact with anyone who had fallen sick with SARS. This was quickly followed by the Home Affairs Minister, Wong Kan Seng, heading a ministerial-rank task force to deal with all aspects of the SARS outbreak. As with Vietnam, the power delegated to the cross-ministerial committee to decide policies that cut across individual departments was an important factor in helping Singapore stem the SARS outbreak. In addition to the public policy and quarantine programs, in late April the government also began restricting the movements of health workers, during office hours as well as at home.

In terms of medical responses, the government moved swiftly to designate hospitals for quarantine, and to disseminate guidelines to private doctors and clinics on how to handle suspected SARS cases. At the height of the outbreak it went further, creating barriers against cross-hospital transmission by requiring hospital staff to reside only with other staff from the same hospital. However, it is unclear how effective this policy was, as it was slow to be implemented and the virus was largely contained by the time it was being properly enacted.

In an effort to address the economic impact of the SARS virus, in April the Singapore government unveiled a S\$230 million rescue package for those sectors most affected; namely tourism and the transport-related industries. Of the S\$230 million, S\$155 million was used to help tourism-related businesses like hotels, travel agents, retailers and restaurants—with almost S\$74 million set aside for airlines, cruise operators and taxi drivers, who saw fewer passengers. The Singapore Tourism Board (STB) also announced a short-term financing programme for local SMEs in SARS-affected tourism-related sectors. Domestic reaction to the SARS outbreak was calm, relative to public sentiment witnessed in mainland China or Hong Kong. To a large extent this was due to two factors: (1) the public control of the outbreak agenda by the government, and (2) the close relationship between the local media and the

government, which allowed the government to direct the information flow. There were a number of instances where members of the local population did not heed the numerous warnings and advice regarding appropriate SARS behaviour. Such breaches were dealt with increasing severity as the crisis unfolded. Outside these two factors, the government also engaged social organisations, in the dissemination of information and home detection kits (Hooi 2003b), and the private sector, in the daily testing of employees (Hooi 2003a).

In sum, Singapore's responses were aided, from the bottom up, by highly effective channels of communication between frontline medical staff, hospital management, and health officials. In turn, the rapid creation of a ministerial-level committee to provide oversight for all SARS-related government activities, on a daily basis, ensured that top-down management of the crisis across all political, economic and social sectors was efficiently implemented. This whole-society approach was more necessary in Singapore than in Vietnam because the geographical area was much smaller, allowing the virus easier access to all areas of the country. The higher threat to Singapore from SARS is reflected in the final toll, 33 people dead from the virus out of 238 infections. (Ling Chang Hong 2003).

Thailand

Thailand is a good example of how the perception of a threat can—in some instances—be as damaging as the threat itself. During the regional outbreak of SARS, Thailand reported only eight cases, with two reported deaths and no domestic transmission of the disease. Thai Prime Minister Thaksin was, from the outset, acutely aware of the potential damage the outbreak of SARS could do to the Thai economy. As the crisis unfolded, Thaksin made much effort to promote Thailand as a 'SARS zero-transmission country' in an attempt to limit the damage to the tourism industry and the wider economy.

The most obvious impact of SARS virus on the Thai economy was a downturn in tourist arrivals, flowing into the retail sales and hotel/entertainment sectors of the economy. Despite the fact that Thailand was not as severely affected by the virus, its tourism industry nevertheless suffered considerably by regional association. March tourist arrivals declined by 12.5 year-on-year, April by 46 percent, while the number of arrivals to late May was down by nearly 55 percent. As a result, the government launched a range of measures to reinvigorate the tourism sector, focusing on promoting Thailand as a 'SARS Free' destination. While these measures included the standard hotel and airfare discounts, and subsidised holiday packages, it also included the more controversial program to offer US\$100,000 in compensation to any foreign tourist who was infected with SARS in Thailand and subsequently died (*Financial Times Information* 2003).

Thailand's understanding of the regional nature of the crisis pushed it to

call for regional responses to the crisis. Thailand was very active in pushing other ASEAN members to approach the threat from a regional perspective, with the accompanying recognition that the region was now increasingly interconnected in sectors beyond economics, trade or politics.

Regional responses

Regional responses to the SARS outbreak were not as rapid as those taken by individual Southeast Asian countries. While both ASEAN and, to a lesser extent, APEC attempted to develop coordinated multilateral strategies to address the threat posed by the SARS virus, two issues emerge. First, at least with this particular crisis, states were the main agents of prevention and response. Second, stemming from this, both regional organisations were very passive actors, unable to enforce a collective will on states that did not agree with the policies under discussion.

The ASEAN + 3 (ASEAN plus China, Japan and South Korea) Ministers of Health Special Meeting on SARS was held in Kuala Lumpur on 26 April. The ministerial meeting agreed that a comprehensive cross-border approach was required to contain and prevent the spread of the disease but that such measures should take the form of 'isolate and contain' strategies rather than blanket bans. The ministers also agreed to: (a) request the ASEAN Expert Group on Communicable Diseases (under the ASEAN Senior Officials Meeting on Health Development), in collaboration with their counterparts from China, Japan and South Korea, to develop a work plan for regional cooperation as well as evaluating the setting up of an ASEAN centre of excellence for disease control; (b) request Indonesia, as coordinator of the ASEAN Disease Surveillance Net, to look into using the Web to support the exchange of information among the ASEAN + 3 Countries; (c) request Thailand, as the coordinator of the ASEAN Epidemiologic Network to strengthen regional capacity for epidemiological surveillance; and (d) request Malaysia to implement the ASEAN project on Strengthening Laboratory Capacity and Quality Assurance for Disease Surveillance (*New Straits Times* 2003a). While critics of ASEAN often deride its meetings as little more than talk shops, the difference with this meeting was that it was focused on practical outcomes rather than a reiteration of regional ambitions.

The Special ASEAN Leaders' Meeting on SARS on 29 April 2003, initiated by Singapore, was the first such meeting since the group's creation. The Heads of ASEAN states and the leaders of the + 3 countries, as well as Hong Kong, met to exchange information and approve initiatives drawn up earlier by regional health ministers and senior officials to address the SARS outbreak. The leaders approved the establishment of an ad-hoc ministerial-level Joint Task Force to follow-up the decisions made and the creation of an ASEAN SARS Containment Information Network to share information. The meeting also endorsed pre-departure health control procedures for travellers, 'despite

some initial objections from Cambodia, Laos and Myanmar who feared that tourism would be affected' (*New Straits Times* 2003b).

Although the summit reaffirmed ASEAN as the most relevant group to combat SARS, it was unable to enforce a uniform approach among its members. Malaysia insisted on placing a 10-day quarantine on foreign students entering Malaysia from SARS-affected areas and Filipino migrant workers to prevent them from spreading the SARS virus. Other regional countries also imposed a range of other unilateral measures (*New Straits Times* 2003b).

The annual ASEAN Labour Ministers meeting held on 8–9 May in Mataram discussed the challenges of SARS on labour-related issues. The ministers agreed to ask the senior officials to convene a special meeting to discuss among other things the impact of SARS on labour, employment, human resources and occupational safety and health. The ASEAN Labour Ministers also had a separate meeting with their +3 counterparts on this issue the day after their main meeting (*Borneo Bulletin* 2003).

ASEAN + 3 Airport Officials met in Pampanga in the Philippines on 15–16 May. Responding to a Philippines proposal, ASEAN + 3 airport officials agreed to adopt standardised prevention and immunisation measures and procedures in order to prevent the spread of SARS through civil aviation. These measures included the use of health declaration cards for all departing and arriving passengers and for temperature screening at both ends of any route that touched a SARS affected area, starting from 15 June. Starting from 15 August, all officials, except Japan, agreed that all departing passengers and passengers arriving from countries and regions affected with SARS would have their temperatures taken. The airport authorities had also agreed that all passengers suspected of having SARS would not be denied entry into the country of arrival, but rather would be provided with appropriate medical treatment in that country (*Xinhua* 2003).

However, soon after these agreements were made, Singapore was criticised by Malaysia, for turning back a Malaysian man entering Singapore at their common land border on 18 May. Singapore replied that the agreement among ASEAN members not to refuse entry to SARS cases and treat them in the country where they arrive in applies to travellers who land at the airport and said the Malaysian official 'might have mistakenly referred to the common protocol agreed upon for air travel' (*Agence France Presse* 2003).

The APEC Trade Ministers met between 2 and 3 June in Khon Kaen in Thailand, where they approved an emergency plan to protect their economies from SARS and terrorism. Regarding the SARS-related outcomes, a public relations campaign was suggested to boost regional tourism. Members also agreed to establish common health screening measures at borders and airports, while exchanging information about SARS cases (*Deutsche Presse-Agentur* 2003). Though this was simply a reflection of what was already being done within the ASEAN and ASEAN + 3 group and, given the timing of the meeting, it was of little use to the region.

ASEAN + 3 countries then met again for a high-level symposium on SARS in Beijing on 2–6 June, designed to exchange information between ASEAN + 3 experts as well as international organisations and researchers (Wang Qian 2003). Ahead of the Beijing meeting, China and ASEAN signed a joint action plan to strengthen quarantine measures at border checkpoints to control the spread of SARS. Under the agreement, travellers from China and ASEAN member countries are required to undergo temperature checks, answer medical inquiries and complete a health declaration form when passing through customs. When a SARS suspect is detected at the border checkpoint of a country other than his own, the passenger's country of origin will be notified immediately. China and the ASEAN countries also agreed to set up effective communications channels; facilitate customs clearing for medicines, remedial equipment and other goods used for the prevention and treatment of SARS; and allow ships carrying a SARS suspect to stop at the nearest port for emergency medical help. Finally, any country intending to temporarily close its border checkpoints due to SARS has to notify all the other countries concerned in advance (*Asia Pulse* 2003).

In sum, these meetings covered the period of greatest impact from the SARS virus, from April to June 2003. Although the decisions reached in the ASEAN and ASEAN + 3 meetings were largely reactive, they have created an information-sharing network that can be utilised in the event of another regional public health threat. Beyond the network is an increased capacity of regional states to protect themselves against other health or biosafety threats. Further, the speed with which these meetings were called and the decisions reached is unprecedented in the history of ASEAN; an indication that the organisation has learnt from the mistakes of the Asian Financial Crisis to respond in a timely fashion. However, inasmuch as ASEAN was able to respond relatively quickly to the crisis, the delay in an institutional response from APEC only serves to highlight its irrelevancy to region-building processes that, by their very nature, must be both responsive to regional needs and go beyond a narrowly-focused agenda. Additionally, the outcomes from these meetings show that self-interest from regional states can still prevent collective action being taken.

Lessons learned

When reviewing the programs implemented in the affected countries a number of factors stand out in their successful eradication of the virus. Indeed, seldom 'have intersections between politics, economic development, and public health been more graphically demonstrated' (Breiman *et al.* 2003). First, there were good channels of communication. Especially in the cases of Vietnam and Singapore, there were clear and effective channels of communication between medical staff and authorities. Good lines of communication were also established between the government and the people. These lines of communication

and support were also extended to the domestic private sector. Second, within the governments there was a rapid response in creating a high-level body able to coordinate information and policies horizontally across all government departments. In some cases these bodies met daily, sometimes twice daily, sometimes weekly or as needed. Together, these two factors helped foster a third factor: the maintenance of public trust and state legitimacy. In other words, even as states were under attack from an unforeseen threat, with an unknown pathology, they undertook measures to strengthen their capacities. With the state as the lead actor, markets and societies were engaged in an effort to ensure that any sectoral failures stemming from the SARS virus were isolated and did not become systemic.

Going beyond the state, it is clear that as states engage in regional (or even global) processes of engagement they must simultaneously protect themselves against threats that are more intense as geographical areas become smaller. Southeast Asia had already experienced this intensity at the regional level during the 1997–98 Asian Financial Crisis, as well as with the environmental ‘haze’ threat, which emerged at the same time. With the SARS virus, a major public health threat crossed national boundaries to challenge the security of regional states, economies and societies. Therefore, given this intensity, it could be concluded that, in a regional setting, states have a self-interested obligation to their counterparts to act in such a manner as to not threaten regional stability and prosperity.

It follows that, as part of this obligation, states have to act to ensure that their processes of governance do not fail or, if they do, that the processes are sufficiently transparent for neighbouring states to take preventative actions to address any potential threats that may subsequently arise. In the example of the 2003 SARS outbreak, China’s failure to ensure that its public were protected by the timely provision of information relating to the virus only served to start a failure that cascaded through its bureaucratic, market and community sectors. With the transborder movement of people, it was only a matter of time before an infected person took the SARS virus outside mainland China. At this point, China’s internal inadequacies unwittingly created a human security threat of regional and global proportions. Thus, one of the key lessons to be drawn from this crisis is that, while it is still may be a matter of debate to what extent states benefit domestically from good governance, it is clear that there are tangible benefits—in the form of enhanced security and prosperity—to be gained at the regional level for enacting such processes.

Conclusion

SARS was the latest crisis to engulf Southeast Asian states—domestically as well as at the regional level. Unlike the Asian Financial Crisis or the ‘haze’, SARS originated outside Southeast Asia and was not the result of any pre-existing systemic weakness in the regional states’ structures. However, as

with the two earlier crises, what began as a problem in one area of one state quickly spread across boundaries to challenge the ability of other regional states to engage in their normal daily operations. It was at this point that a failure due to one state's internal inadequacy became a human security threat. Further, as also occurred in the last two crises, the threat perception was so great that even states not seriously affected by the virus, suffered by association. This perception not only served to increase the magnitude of the threat—and, hence, the difficulty in addressing it—but also served to underline the regional nature of contemporary Southeast Asia.

In understanding such crises, traditional, state-dominant conceptions of security are insufficient to meet the international community's needs. What is required is a reformulation of what it means to be secure, and then an understanding of how such security can be achieved. This article has argued that security can be achieved by acknowledging the role market groups, civil society organisations, and even individuals can play in both detracting from and enhancing a nation-state. Beyond a single state, this article has also argued that such actors can also both cause insecurity or create greater security in secondary states. Such an effect is stronger where the geographical area is smaller. Thus, the effect is most intense at the domestic level, and weakest at the global level. In the case of regions, the intensity can be said to depend on the level of integration, both real and perceived.

If the diverse threats that are now seen to threaten the security of states (for example, economic, food, environmental, or health insecurities) are to be properly met, then a security model that, at least, attempts to consider how and why such threats emerge should be advanced. The human security concept offers one possible model that can equitably meet the analytic needs of the international community without devaluing or distorting its myriad elements.

In conclusion, there is an old saying that 'no man is an island'. I believe that none of us can afford to exist in isolation. We must build bridges between us, we must communicate and support each other. If we do this now, we will be better able to respond to the next challenge.—*Mr Stephen Ip, Secretary for Economic Development and Labour, Hong Kong SAR. 15 July 2003.*

Notes

1. During Thai Foreign Minister Surin Pitsuwan's time in office, Thailand strongly promoted human security. Since then, the regional dialogue has preferred non-traditional security approaches over human security models; largely because of the latter's individual-centrism.
2. For more information refer to: *Financial Times Information*, 2003 (15 June). The Chinese idiom and its interpretation were provided by a Chinese scholar in the wake of the sackings.

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