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THE IMPLICATIONS OF SECURITISING HEALTH CRISES: THE CASE OF SOUTHEAST ASIA

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ABSTRACT

This article examined the consequences of linking health as a regional security issue. Securitisation Theory (hereinafter ST) is an innovative approach to understand how Non-Traditional Security (from now on NTS) is deemed as a posing threat to a referent object. Prioritising NTS issue as a security threat enables the issue to receive a higher degree of importance from policymakers, thereby gathering the resources needed in dealing with the threat. However, addressing NTS issues also bring negative implications; it can divert attention from more concerning issues. This article, therefore, investigated the consequences of securitising health issues at the Southeast Asian level. This was done through triangulating academic materials,

ASEAN's official statements, and semi-structured elite interviews on Southeast Asian health policy discourses between 1967 and 2010. This study argues that while there are some disadvantages to regional efforts in constructing pandemic disease as a regional security threat, the advantages of such a move outweighs the drawbacks, particularly in terms of establishing regional health mechanisms.

Keywords: Securitisation theory (ST), non-traditional security (NST) issue, health security, pandemics, ASEAN.

INTRODUCTION

The number of outbreaks of infectious diseases reported worldwide has tripled since 1980 (McNeil, 2017). In this interconnected world, an outbreak in one area can spread easily to other areas within a few hours, greatly affecting human health and economic performance throughout the world. The impacts of pandemics have taken their toll on all states, and states in Southeast Asia are no exception. The region is becoming a hotspot for emerging infectious diseases including those with pandemic potential (Lamy & Phua, 2012, p. 236) as it has already experienced a myriad of infectious diseases including SARS, H5N1, H1N1, Mers-Cov, and more recently, COVID-19. Hence, the proposal to securitise – move ordinary issues like migration, environment and health to the realm of 'emergency' politics. Health issues is said to be important as it would redefine the political and financial commitment of regional states to health issues.

Nevertheless, such a move linking health with security comes with consequences. Such steps are often said to have given greater attention to global political agendas, attracted more financial resources, generated new policy initiatives and benefited causes from the involvement of a wider range of stakeholders (Curley & Herington, 2011). On the other hand, in countries known for the 'absence of a meaningful state response', securitising HIV/AIDS at the international level has provoked action, domestically, as in some African countries (Elbe, 2006). This contradictory finding motivated this article to discuss whether the outcome of such a process is beneficial to the region or its negative impacts have strongly outweighed the positives. This article seeks to explore the impact of securitising infectious diseases in Southeast Asia through the methodology of process

tracing, document analysis and semi-structured elite interviews (from policy experts to high-ranking public officials) on Southeast Asian health policy discourses between 1967 and 2010 to elicit data.

BACKGROUND

Securitisation framework is viewed as an innovative approach to understand how health threat is deemed as a posing threat to referent objects. On the one hand, diseases with pandemic potential offer one important benefit: it accelerates an ordinary public health issue to the top of the political agenda and bypasses the normal processes or rules that would otherwise constrain the actors from acting effectively. In other words, by prioritising pandemic issues as a security threat, the issue receives a higher degree of importance from policymakers than other issues, thereby being able to gather the resources needed in dealing with the threat. For HIV/AIDS scholars, securitising the issue could be the most efficacious way to attribute a sense of urgency to it and consequently attract political support and garner urgently needed resources (Garrett, 2005). This is because all states value security regardless of their attitude to addressing normal political issues. Hence, they will provide considerable resources for the defence of people's well-being. On the other hand, such extravagant measures have also diverted priorities and resources away from other underlying health issues. Brown and Harman (2011, p. 774) argued that the securitisation of specific health risks has 'led to a distorted focus on key diseases'. Moreover, linking health and security could lead to the formulation of emergency measures that could bring more harm than good. Securitising pandemic influenza as a security issue could also lead to emergency responses that could be ineffective, counterproductive, and unjust because of the practical dangers that might arise (Enemark, 2009). Meanwhile, the excessive focus on the health-security linkage would only deviate from the reality of the international environment that health is already 'part of [our] daily life' (Nunes, 2015). In other words, health threats should not be framed in the language of security because we do not need the excessive focus on military crisis management and emergency preparedness as part of our daily routine (Nunes, 2015). Other authors suggest an alternative to overcome this debate by focusing on studying the value of securitization in a context. Flyod (2007) argued that securitization is neither priori positive nor negative; rather, it is issue-dependent. The importance of context in determining the

outcome of securitization has been agreed by other scholars. Nyman (2016) has emphasized 'the need for detailed empirical enquiry to see how different actors use security in different contexts and how individuals experience it'. In other words, in order to understand the value of security, we need to study how it works and what it does in different empirical contexts. Following this alternative, this research attempted to study how security was used and what occurred in the process in different empirical contexts by way of empirically testing it at the regional level.

It was only recently that literature on regional health security has reported on the advantages and disadvantages of such securitisation process. For instance, a paper by Kamradt-Scott (2018) focused on the benefits and drawbacks of Australia as the regional health security actor in the Indo-Pacific region while Youde (2018) demonstrated the negative and positive implications of framing health as a security issue during the Trump era. Generally, literature on regional health security consisted mostly of comparing two regional institutions such as between the EU and ASEAN (Lamy & Phua, 2012; Liverani et al., 2012; Maier-Knapp, 2011) or between the Association of Southeast Asian Nations (ASEAN) and the African Union (AU) (Haacke & Williams, 2008). Analysing regional health security in one region without comparing with other regions, especially regions that are located outside of the western realm is crucial as several scholars have claimed that ST is not applicable in non-Western context (Peoples & Vaughan-Williams, 2010; Wilkinson, 2007). The Copenhagen School of securitisation theory has begun to exhibit its presence in many places over the years (Bilgin, 2011). ST is the most widely applied theoretical framework in examining NTS threats in the Southeast Asia region (Jones, 2011).

Health issues were implicit in Southeast Asia, since the establishment of ASEAN in 1967. However, it was only 20 years later that health issues were discussed properly at the regional level. The ASEAN Health Ministers (AHM) Meeting held in 1980 marked the region's first step in organising collaboration between ASEAN member states (AMS) on health issues. However, the inconsistencies of ASEAN in organising AHM meetings indicated that health issues were not a priority in the regional agenda during the 1980s and early 1990s. Although a significant shift could be traced between the 1990s and 2000s when regional leaders recognised HIV/AIDS as a regional security threat in an ASEAN Summit, it did not last long as there

was no urgency among them to combat the communicable disease. The outbreak of SARS sparked a more active involvement of ASEAN in health-security linkage (Caballero-Anthony, 2006; Lamy & Phua, 2012) The emergence of H5N1 and H1N1 had further pushed health issues to be considered as a serious security threat to the region (Curley & Herington, 2011; Jones, 2011).

ASEAN elites appeared to gradually securitise the outbreaks of a series of infectious diseases and articulated them in security terms between 2003 and 2010. The threat posed by the series of infectious disease outbreaks was portrayed in regional declarations and communiqués as a threat to the well-being of the people and regional economic development. This indicated the urgency of the problem and led to political attention at the highest diplomatic level even though each AMS experienced different levels of threat with each outbreak. Nonetheless, there was a tendency to question whether such processes had been beneficial or, in contrast, detrimental to the Southeast Asia region. Hence, this article aims to examine the health crises in light of the process of securitisation, preceding it as a means of determining the consequences of securitising the health crises in a non-Western area—the Southeast Asia region.

THE COLLECTIVE SECURITISATION APPROACH

The idea of ST draws heavily on the theory of language, specifically from the branch known as 'speech act theory'. Through the theory of language, we can regard 'security' as a speech act. Wæver (1995, p. 35) indicated that 'security is not of interest as a sign that refers to something more real; the utterance itself is the act. By saying it [security], something is done (as in betting, giving a promise, naming a ship)'. In other words, labelling something as a security issue turns it into such, although this does not necessarily mean that a real threat is present (Buzan et al., 1998).

ST requires specific criteria in the process to change an ordinary issue into a security issue. Buzan et al. (1998) referred to it as a two-stage process. In the first stage, securitising actors (e.g., political leaders) must state that a reference object (something threatened, such as the state or the economy) is existentially threatened. This step is known as the securitising move. To ensure the issue is securitised, the audience should accept the move made by the securitising actor. Thus, in the second stage, for an issue to be regarded as a security issue, the

audience must accept the interpretation of events by the actor and recognise that extraordinary measures must be implemented.

Buzan, Waever, and de Wilde emphasised that securitisation requires all the criteria (securitising actors, reference object, existential threat, and emergency measures) to be successful. Such requirements also indicate that not all issues undergoing the securitisation process should automatically be securitised because securitisation is "essentially inter-subjective process" (Buzan et al., 1998, p. 30). Although the securitising actor managed to pose such an existential threat without the approval of the appropriate audience, the threat could not be securitised. Only with the consent of the audience can such a move be followed by putting a 'normal' political issue on the emergency political agenda. This highlights the importance of inter-subjectivity in determining the success of such a process.

COSTS AND BENEFITS OF SECURITISING REGIONAL HEALTH CRISES

Diverting Priorities and Resources

An obvious negative implication of linking health issue to a security issue is, instead of gathering the urgent resources needed throughout the emergency, securitisation is diverting the attention of the government from the 'real' issue. Focusing attention on a certain type of disease has diverted the states' attention towards a few specific infectious diseases while other more pressing health concerns will be ignored could be true in the case of Southeast Asia when a singular focus on the health crises has diverted attention in the region from more concerning diseases, such as non-communicable diseases (hereinafter NCDs).

Due to urbanisation and unhealthy lifestyles, NCDs such as cardiovascular diseases, cancer, diabetes and chronic respiratory diseases are becoming more common and deadly within the ASEAN bloc. A comparison between the morbidity rate of the health crises with NCD, revealed that the total number of deaths recorded in the region due to pandemic diseases, namely SARS, H5N1 and H1N1 was only around 1,000 (World Health Organisation [WHO], 2003, 2017a), whereas the epidemic of chronic NCDs is responsible for 14

million, or 60 per cent of deaths in the region, annually (World Health Organisation, 2017b). However, the rapid rise of morbidity and mortality from NCDs has not been accompanied by a similar reaction to the one meeting pandemic diseases, either in terms of attention or resources. Instead, constructing pandemic disease as a regional security issue has rather diverted the original plan of ASEAN's regional health agenda for NCDs.

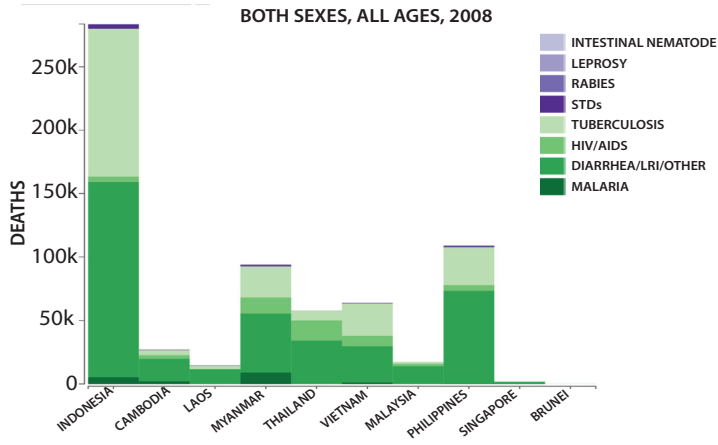
Before the SARS outbreak in 2003, ASEAN's agenda on health issues was to meet the challenges of the new millennium health issues including the emergence of NCDs. ASEAN unanimously agreed to the vision of a 'Healthy ASEAN 2020' – a mission where, by 2020, 'health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that their people are healthy in mind and body, and living in harmony in safe environments' (ASEAN, 2000, 2002). In working to achieve this aim, ASEAN Health Ministers had identified alcohol consumption, nutrition, physical activity, tobacco control and the prevention of NCDs as the regional priorities in achieving their goal. However, regional strategies for implementing the key guiding principles to overcome these issues were pushed aside as soon as SARS, H5N1 and H1N1 viruses were constructed as regional security issues, beginning in 2003. This concerned AMS, especially in recent years as the majority of deaths in the region were due to the NCD.

Although these pandemic diseases have created a major public health and economic burden, they represent only part of the health issues that have posed public health threats within the region. Other health issues are also threatening the region but these have received less attention and aid at the regional level. Based on data from Global Burden of Disease Study as shown in Figure 1, it is not surprising that diseases such as intestinal nematode, leprosy, rabies, tuberculosis, malaria, HIV/AIDS, and sexually transmitted diseases (STD) continue to be a major cause of morbidity and mortality in the region. Another strikingly, deadly disease is diarrhoeal diseases. Data on the Global Burden of Disease Study showed that the pandemic disease only caused a relatively minor number of cases with 219 deaths during the H5N1 outbreak between 2003 and 2008 (World Health Organisation, 2011) while diarrhoeal diseases together with lower respiratory and other common infectious diseases accounted for 381,390 deaths in 2008 (Institute for Health Metrics and Evaluation [IHME], 2016). The diarrhoeal disease is significant as this disease is actually preventable

and treatable through safe drinking water, adequate sanitation and hygiene. However, the high mortality rates recorded by some AMS indicated that the region is still experiencing low levels of health infrastructure.

Figure 1

The Burden of Communicable Diseases in Southeast Asia Countries, 2008



Source: Institute for Health Metrics and Evaluation, (2016)

For many lower-income states in the region such as Cambodia, Laos, and Myanmar, each disease had a more significant impact in these countries than the influenza pandemic. The outbreak of pandemic disease is just one of the multiple infectious disease threats. Yet, the pandemic disease security linkage would only result in 'countries lower down in the global economic and political pecking order are compelled to devote extraordinary attention and resources to issues that might not pose a grave threat to them' (Abraham, 2011, p. 784). Hence, securitising pandemic disease meant a diversion of resources away from other priorities which only privileged the interests of the state affected, causing public health issues to become under-resourced and underfunded.

The agenda to make HIV/AIDS the regional security issue received little attention despite efforts to securitise the disease through various regional declarations and communiqués since the 1990s. Southeast

Asia has the highest prevalence rate of HIV/AIDS in Asia (Caballero-Anthony et al., 2013, p. 20). Approximately 1.7 million people are living with HIV in the Southeast Asia region (ASEAN Secretariat, 2015) which represents an increase from 1.5 million in 2009 (ASEAN Secretariat, 2011). Yet, despite this alarming figure, very little progress has been made on the implementation of common measures for HIV/AIDS (Jagan, 2001)their purpose of securitization may be motovated by a desire to reinforce social control or legitimate policy to bureaucratic elites (it happen because of blurred definition between normal and emergency politics. The singular focus on certain types of diseases diverted the regional attention from HIV/AIDS. Evidence of this can be seen in Table 1. The HIV/AIDS issue was the epicentre of the regional health agenda from 1991 to 2002 but this attention was diverted when the region started to frame pandemic diseases in 2003. ASEAN neglected HIV/AIDS as only one meeting related to HIV/AIDS was recorded between 2003 and 2010. As a result, uneven securitisation of infectious diseases was observed. The nature of the securitising process has led the region to focus all of its attention on diseases that have caused only a relatively small number of cases compared with other diseases across this region.

Table 1

ASEAN related health meetings between 1990s and 2010

Year	Meeting	Main agenda of meeting
1991	4th ASEAN Health Ministers Meeting in 1991	Emphasis on AIDS and environmental health
1998	Ha Noi Declaration	Prevention of communicable diseases including HIV/AIDS
2000	5th ASEAN Health Ministers Meeting - Healthy ASEAN 2020	Establishment of guiding principles of Healthy ASEAN 2020
2001	7th ASEAN Summit on HIV/AIDS	Recognition of HIV/AIDS as an epidemic in the region
2002	6th ASEAN Health Ministers Meeting - Healthy ASEAN Lifestyles	Promotion of priority areas of health issues

(Continued)

Year	Meeting	Main agenda of meeting
2003	Special ASEAN Leaders Meeting on SARS	Information exchange on the treatment of SARS patients and prevention of the spread of the disease
2004	7th ASEAN Health Ministers Meeting	Technical cooperation and preventive measures for diseases like SARS and H5N1
2006	8th ASEAN Health Ministers Meeting - 'Unity in Health Emergencies'	The spread of H1N1 and regional strategies
2007	ASEAN Commitments on HIV/AIDS	Reaffirmation of the region's earlier commitment in 2001
2008	9th ASEAN Health Ministers Meeting – 'Trade liberalisation: Its adverse impact on our borderless health problems'	Discussion on the implications of globalisation and liberalisation and region preparedness for a pandemic
2009	ASEAN+3 Health Ministers Meeting on H1N1	The outbreak of H1N1 and regional strategies
2010	10th ASEAN Health Minister Meeting – 'Healthy People, Healthy ASEAN'	Information exchange on the development of H1N1 outbreak and formulation of new formula to create regional health cooperation

Source: This information was compiled by the author based on the agendas of ASEAN Health Ministers Meetings between the 1990s and 2010.

Focusing on single diseases has also diverted regional funds from other more pressing diseases. Across Southeast Asia, intensive livestock production has been increasingly prevalent, contributed

by four poultry sectors[1]. With diverse types of poultry production in the region, it has increased the risk of diseases, particularly poultry production in sectors three and four, due to their lack of appreciation for good hygienic, agricultural and manufacturing practices.

ASEAN re-prioritised its regional fund to address the pandemic challenges. In 2003, ASEAN established an ASEAN Animal Health Trust Fund (AAHTF) to enhance the effort of the institution in ensuring that the region would become a Foot and Mouth Disease (FMD) free zone by 2007. The initiative to create an FMD-free zone was critical since animal husbandry was an important component of food production activities in the region (Ahmad, 2007). However, as several member states in the region were not affected with the disease, ASEAN agreed that the eradication of the avian influenza (AI) would be prioritised rather than the FMD issue when the H5N1 virus struck the region in 2004 (ASEAN 2010, p.19). Dr Ronello C. Abila, regional coordinator of the Southeast Asia Foot and Mouth Disease Campaign of the World Organisation for Animal Health (OIE), said that 'the eradication of AI will be prioritised because it will be easier to solicit funds since several of its member countries have been afflicted with the disease that continues to spread across the globe' (Felix, 2006). Besides indicating that the framing of AI as a security threat had redirected the regional fund, her statement also revealed that securitisation only focused on issues that were supposedly more severe. In reality, of the 10 countries in the region, FMD is endemic in seven states: namely, Cambodia, Laos, Malaysia, Myanmar, the Philippines, Thailand and Vietnam have reported cases while the other three member states – Brunei, Indonesia and Singapore – are also vulnerable to the disease due to their close geographical proximity (Gleeson, 2002).

Framing the pandemic diseases in the language of security seemed to cause ASEAN to focus its energies on certain types of disease to the exclusion of other potential problems. They have neglected diseases like HIV/AIDS, communicable diseases, and NCD and placed more focus on pandemic diseases despite the fact that the total number of

[1]Based on the Food and Agriculture Organisation (FAO) classification, the poultry sector in the region is divided into four sectors: Sector 1, large integrated commercial poultry farms with high biosecurity; sector 2, small to medium commercial poultry farms with moderate to high biosecurity; sector 3, small commercial poultry farms with low biosecurity; and sector 4, backyard poultry withlittle or no biosecurity.

deaths from the latter was lower than the former. While it is clear that Southeast Asia has a daunting amount of health challenges, not all health issues represent security concerns as they do not carry the same level of risk. This must be kept in mind as we think about infectious diseases in the context of security. For instance, the problem of communicable diseases such as diarrhoeal diseases is a clear challenge to the AMS. However, the delayed impact of the microbial spread mitigated the sense of urgency that often drive policymakers in the region, preventing emergency actions such as allocating finances and resources needed to address the disease (Caballero-Anthony, 2006).

The notion of security might be used too loosely, lose its meaning, and no longer be able to play a useful role in political discourses if every health issue in the region is characterised as a security threat (Selgelid & Enemark, 2008, p. 458) therefore, it is important to limit the occasions upon which draconian disease control measures are implemented in the name of security. The term 'security', moreover, should not be used too loosely if it is to retain force and meaning in political discourse. It may be argued that the bar for disease securitization should be set high so that it is limited to contexts involving rapidly spreading pathogens. Such an approach, however, would rule out securitization of more slowly spreading, endemic diseases such as HIV/AIDS. An advantage of characterizing HIV/AIDS as a security threat in developing countries, where the burden of the disease is concentrated, is that this is likely to mobilize resources needed to improve the situation there. That is, if HIV/AIDS is convincingly framed as a security threat, then governments may recognize self-interested reasons to ramp up control measures. Following consideration of arguments for narrow (excluding HIV/AIDS. This logic could also be applied to diseases like NCD and HIV/AIDS, as member states are likely to treat the diseases as a domestic issue. This observation was also confirmed by several elite interviewees in the region: 'We do prepare for other communicable diseases like HIV, TB [tuberculosis] and other non-communicable diseases, but we address them as public issues as we are more concerned to address all the pandemic issues as a regional security issue' (Officer, 1 2016).

Securitisation as Raising Attention and Resources

This section examines whether framing health crises as a regional security issue brought possible benefits to ASEAN as expected.

Pandemic diseases have certainly caused many problems and numerous challenges to nearly every state in the region. However, it is entirely plausible that every AMS would pay sufficient attention and resources to the health crises, given their other health challenges and different levels of pandemic threat for each outbreak. Hence, securitising the health crises helps to push the issue to the attention of each state in the region, encouraging them to cooperate as national solutions are inadequate to combat the natural impact of transnational diseases. In line with Elbe's (2006, p. 131) argument, it was not the issue of ineffective measures that should be of concern; instead, it was the utter absence of a meaningful state response to the disease that ASEAN should worry about. As each state experienced different levels of threat, the term security in health challenges managed to grab the attention of the poor states, less affected and unaffected states in cooperating closely with the affected states.

The impact of such security framing of the health crises is particularly obvious in the decision of AMS when they agreed to enhance the commitment to cooperate in addressing emerging diseases by developing regional policies to face pandemics. Starting with the SARS outbreak, ASEAN has become more responsive in facing pandemic outbreaks as they managed to organise and coordinate containment measures across national borders. They also created infrastructures and information-sharing networks that can be, and have been, used in the event of other regional public health emergencies of international concern (Curley & Thomas, 2004) Following the outbreak of SARS and H5N1, ASEAN set up additional instruments in support of regional initiatives known as ASEAN+3 Emerging Infectious Disease Programme (EID) in 2004. The comprehensive ASEAN+3 EID Programme has become a reference point for regional coordination. Programmes under the regional policy are highly efficient in that they established the foundational elements of a regional system for emerging infectious diseases preparedness and response that has continued to be built on. The individual projects supported by the policy are among the most significant achievements of the ASEAN+3 EID Programme. ASEAN+3 EID has been highly efficient (Schierhout et al., 2017). The programme focused on four areas of collaboration among ASEAN+3 states.

Indonesia, as the Component Coordinating Country (CCC), for instance, managed to improve the capacity of ASEAN regional disease

surveillance, known as ADS-net, when member states agreed to sign an agreement that required them to transfer selected national data like results of the surveillance for selected diseases and the detection and investigation of outbreaks of infectious disease into the regional database maintained in the ADS-net (AusAID, 2007). Considering the adverse impact of sharing sensitive issues and the relatively enduring mistrust among AMS, the establishment of Ads-net (an open industrial realtime network based on Autonomous Decentralized System technology) has brought significant developments to regional cooperation (AusAID, 2007). Thailand took the lead role with WHO in planning the workshop for the national assessment of Early Warning Outbreak Recognition Systems (EWORS) in Bangkok in September 2004. Similarly, based on Thailand's direct experiences with the outbreaks of AI, its staff played the lead role in influenza-related activities in Phase 1, i.e. the teleconference before the meeting of Health Ministers and WHO, the influenza workshop in April 2005, and the regional consultation on influenza in October 2005 (AusAID, 2007).

Meanwhile, Malaysia as the CCC for strengthening regional laboratory capacity managed the inventory of laboratory services among member states (AusAID, 2007), developed twinning arrangements for laboratory support between the most advanced laboratories in Thailand, Singapore and Malaysia together with the less-developed laboratories in Brunei, Cambodia, Laos and Myanmar to reduce the development gap. Through this mechanism, Malaysia has twinned with Vietnam and Brunei, and Thailand with Cambodia, Laos and Myanmar (Philavong et al., 2009). As a result of receiving collaborative training of laboratory personnel by Malaysia, Brunei's laboratory capacity has significantly improved (ASEAN, 2010, p. 29). Malaysia also developed consensus for working towards a regional system of quality assurance and biosafety, as well as a laboratory-based system for the surveillance of selected pathogens. Strengthening the laboratory networks through the ASEAN+3 EID programme resulted in greater openness between countries in sharing information, peer support, and troubleshooting technical issues. Consequently, almost all member states are now capable of making a diagnosis and performing confirmatory tests for H5N1 virus infection (Hanvoravongchai et al., 2010).

Securitisation has attracted a regional response when more policy and institutional arrangements have been created in response to the health challenges, notably within the ASEAN Charter framework. For instance, haze mitigation has been problematic due to the ASEAN style of regional arrangement, which prioritises the maintenance of sovereignty (Varkkey, 2012). Compared with the ASEAN response to the issue, like haze, 'the threat of pandemic diseases drove ASEAN to act with alacrity with no less than 25 ASEAN instruments covering SARS, avian flu and H1N1' (Koh, 2012, p. 80). The change, including the recognition of health issues in the ASEAN Charter – an institutional framework, consists of a strong reporting system and an effective secretariat with monitoring powers. ASEAN Charter restructured its organisation around three interdependent, mutually reinforcing pillars: the ASEAN Economic Community (AEC) aims to create an economically integrated Southeast Asian regional production space and markets while the ASEAN Security Community (ASC) and the ASEAN Socio-cultural Community (ASCC), respectively, contribute to community building through cooperation on regional political and security matters as well as cooperation on social and cultural issues (ASEAN+3, 2003). Each pillar has its blueprint that forms a roadmap for the ASEAN Community 2025. Pandemic issues typically fall under ASCC within part B.5 (Improving capability to control communicable diseases) (ASEAN, 2009b).

Securitising pandemic diseases has positively caused the issue of pandemics to be elevated to an NTS approach under the newer version of ASEAN Political-Security Community (APSC) 2025. Pandemics are classified in Part II, section B.3.9 of the APSC blueprint 2025, as one of the NTS issues under the 'transboundary challenges' category, together with haze, transnational organised crime, irregular movements of persons, hazardous waste, oil spill incidents, trafficking in wildlife and timber (ASEAN, 2015). Despite the fact that the three pillars are interrelated and mutually reinforcing – one is not more important than the others – classifying pandemics as one of the NTS issues under the APSC blueprint is significant. It is significant in a way that it requires AMS to address NTS issues effectively and on time. For instance, under Part II, B.3.9, ASEAN (2015, p. 22) agreed to 'Strengthen existing ASEAN mechanisms to consider preventive management to effectively address these new challenges; and convene special meetings, as and when necessary,

at Senior Officials' level to address challenges of a transboundary or transnational nature'.

The provisions found within the APSC and the initiatives currently undertaken to tackle the NTS challenges are different from the usual practices of ASEAN. Under the new version of APSC, most ASEAN initiatives are focused on problem-solving measures. Bringing the dramatic connotation of the word 'security' into the pandemic issue has also positively caused ASEAN to enforce a pandemic-related agreement that is legally binding. The ASEAN Agreement on Disaster Management and Emergency Responses (AADMER) was ratified by all AMS in December 2009. AADMER can be considered as an important step in the region since it is the first binding agreement on managing disasters regionally. It covers all aspects of disaster management: before, during, and after a disaster.

Besides categorising pandemics under the role of the ASEAN Secretary-General, Articles 8 to 16 in the AADMER also focused on disaster preparedness and emergency responses related to the regional pandemic preparedness effort (ASEAN, 2005). The scope of work outlined in the AADMER as well as in the work programme, the third strategic component of AADMER, 'Preparedness and Response', has two activities that specifically target pandemics: namely, (i) to 'develop other appropriate SOPs to respond to specific disasters, such as pandemics, and link them to SASOP, if appropriate' and (ii) to 'develop systems and mechanisms needed to ensure the continuity of essential services when required in a disaster, such as severe pandemics, and link them to SASOP' (Towards a Safer World, 2014, p. 6). Under the AADMER, policies are established at the regional level while programmes are carried out at the national level by member states. This binding agreement shows that AMS have committed themselves to take a more proactive approach in response to pandemic outbreaks. Hence, constructing pandemic diseases as a regional security issue managed to stimulate several actions to be taken by member states in terms of preparedness and response.

One of ASEAN's greater achievements in planning and preparing for pandemic influenza have been their ability to support member states in preparing all relevant sectors for the impact of a severe pandemic. In contrast to the conventional method of pandemic preparedness planning which focuses solely on improving the animal and human

health sectors, ASEAN has gone beyond that by planning and coordinating a multisectoral pandemic preparedness plan. ASEAN's pandemic preparedness plan is unique as it requires the involvement of the whole society, the only example of a regional association working on multisectoral pandemic preparedness (Towards a Safer World, 2014). The inclusion of other non-health sectors in the pandemic preparedness plan is vital as a severe pandemic could have a significant impact on the operation of various services and sectors which could lead to additional problems for governments if unprepared.

In testing the efficiency of coordination among all parties in terms of their pandemic preparedness, ASEAN hosted a major simulation exercise, a first of its kind in the world, focusing on managing the impacts of severe pandemics on societies, governments and organisations in the region. This simulation exercise marked another remarkable achievement of the ASEAN approach in strengthening the multisectoral pandemic preparedness of their member states as it also managed to attract the attention of high-level participation from governments, UN agencies, international bodies and non-governmental organisations (Xinhua General News Service, 2010). This simulation exercise strengthened the ASEAN collaboration in terms of response. As a result of ASEAN's intensive efforts in dealing with the preparedness planning together, ASEAN has been cited as 'one of the most advanced regions for pandemic preparedness including multisectoral preparedness' at the UN Senior Official Meetings on H1N1 (ASEAN, 2009a).

Many governments decided that in the event of a pandemic, the best line of defence would be the extensive use of pharmacological interventions like antiviral and new vaccines. While developed countries can sign advance purchase agreements with pharmaceutical companies and stockpile large amounts of vaccines that they ultimately would not use (Deshman, 2011, p. 1096). Gostin (2009, p. 106) noted that such a move has deprived the poorer states: 'Stockpiling by the rich, of course, leaves poor countries in Africa, Asia, and Latin America much more vulnerable'. This happened to most of the AMS as they faced some trouble accessing the antiviral drugs during the H5N1 outbreak. Thus, member states agreed to contribute five per cent of their Tamiflu stocks to the regional stock to

overcome this situation. An ASEAN officer explained their purpose in contributing the antivirals: 'All these efforts are aimed at ensuring member states are equipped to face the flu epidemic' (Hashim & Ron, 2005). Following the incident, ASEAN has set up a regional network of antiviral-drug stockpiles to help poor countries. ASEAN is the only regional organisation which has been able to set up and manage a regional stockpile (Asia-Europe Foundation, 2010, p. 16) since 2007. This regional stockpile is a significant step as it can ensure that every country in the region will have access to limited supplies of the treatment needed during the outbreak. As a result, ASEAN has become more prepared and vigilant in facing the outbreak of H1N1. ASEAN's stockpiling initiative has also reduced the dependence of the region on wealthy countries to obtain limited supplies while helping poor states to secure access to expensive drugs.

In regard to financial support, besides managing to gather contributions from all member states, securitisation has also led to ASEAN changing their usual practice of contribution. ASEAN established AAHTF when faced with the bird flu outbreak. Unlike the EU, whose institutional budget is shared based on the gross national income of member states; the ASEAN budget is based on the principle of 'equal contribution'. This means that each member state needs to provide the same level of financial support despite their different levels of economic status (ASEAN Secretariat, 2008).

However, the establishment of the AAHTF indicated an important change in the institution's common pattern. Surprisingly, ASEAN leaders agreed on the proportion of the contribution being based on member states' production of livestock and the capacity of the states to contribute. In other words, states which have large poultry industries and more stable economic capabilities need to contribute more than other states. As a result, this effort managed to help poor governments to fund projects they could not pay for and at the same time provides equity to other, less-developed, and unaffected states in the region.

Table 2

Amount of Contribution by Member Countries to AAHTF based on Category

Category	Definition	Amount	State
Category 1	Countries with very productive livestock industry and capacity to contribute based on the status of their economy	USD 300,000	Indonesia, Malaysia, the Philippines and Thailand
Category 2	Countries with medium livestock productivity	USD 200,000	
Category 3	Countries with very productive livestock, but may not be able to contribute as much as countries form Category 1	USD 100,000	Cambodia, Laos, Myanmar and Vietnam
	Countries with very little livestock		Brunei and Singapore

Source: ASEAN (2006)

Based on Table 2, states such as Indonesia, Malaysia, Thailand and the Philippines are placed under Category 1, where they need to contribute US$ 300,000 while states like Cambodia, Laos, Myanmar and Vietnam are under Category 3 - a category where the states

have very productive livestock, but may not be able to contribute as much as states in Category 1, only need to contribute US$ 100,000 (ASEAN Secretariat, 2006). What is more interesting to note is that, despite states like Brunei and Singapore which have little livestock, they still need to contribute the same amount as states which have more livestock due to their high Gross Domestic Product (GDP). Furthermore, the ratification of this agreement is significant as it was adopted under the ASEAN Economic Community (AEC) as one of the main pillars of the ASEAN Charter. Compared with the other pillars, the AEC was the first blueprint adopted by the ASEAN Community, which indicated the importance of the AEC as the main programme of the three communities (Shimizu, 2011). Thus, the adoption of the AAHTF under the AEC indicated how serious and committed the region is about eradicating H5N1 and other animal-related diseases. The implementation of the AAHTF indicated the importance of securitising AI in the region as the execution of the AAHTF suggests that the usual practice of the region could be changed during a regional emergency.

What is interesting to note on the impact of securitising health crises is that ASEAN initiatives to tackle infectious diseases are significantly different from ASEAN's usual process-oriented and confidence-building modalities. This is because ASEAN has initiated various types of mechanisms that can be categorised as problem-solving measures. Among the initiatives is the creation of a regional disease surveillance website (ADS-net), regional stockpiles, and the regional laboratory twinning programme. If we look closely, most of these regional programmes aim to help the less-developed states in preparing themselves in facing the pandemic diseases. For instance, the establishment of ASEAN's regional stockpile has reduced the issue of the ability of poor states to access expensive antivirals, while the ASEAN laboratory twinning programme has helped less-developed states to upgrade their staff expertise. An AMS's elite officer was quoted in the interview, 'We are AMS. We always help each other. We must help others when they call' (Officer 3, 2016).

CONCLUSION

This article contributes to the advancement of knowledge on the positive and negative impacts of securitization in relation to health

issues, in this case by way of empirical perspectives and experiences from the non-Western context in particular, the Southeast Asia region. Although public health challenges are a global phenomenon, how they are addressed varies across geographical regions, and Southeast Asia is often associated with a particular political culture which shapes its governing norms. Although such security framing brings certain negative impact, the positive impact outweighs the negative. Securitising pandemic type diseases has diverted ASEAN's attention from other pressing health issues. NCDs and communicable diseases received relatively less attention from the region despite record-high mortality rates. HIV/AIDS met the same fate as NCDs and other communicable diseases. Before the series of pandemic outbreaks, the regional agenda focused on issues related to citizens' lifestyles and the spread of HIV/AIDS. However, ASEAN diverted its attention to pandemic diseases shortly after ASEAN started to frame pandemic diseases as a regional security issue. Moreover, financial support for animal health issues was also diverted to assist in the work on securitisation processes.

On the other hand, securitisation of pandemic diseases helped to highlight the issue to the attention of each state in the region to seek their cooperation as national solutions were inadequate to combat the natural impact of transnational diseases. As each state experienced different levels of threat, the term security in health challenges managed to seize the attention of the poor states, the less affected, and unaffected states to closely cooperate with the affected states. Securitisation has also brought about positive implications as it managed to draw attention and mobilise resources needed to ensure that regional health cooperation could operate. For a region that has previously ignored pandemic issues, framing pandemics as a regional security threat managed to create policy outcomes that have garnered regional attention and resources, and altered political priorities urgently needed to address complex health issues as national solutions are often inadequate to address transnational challenges. Securitising has encouraged AMS to pay more attention to pandemic disease issues. Consequently, an increasing number of regional mechanisms have been observed. Their health strategies have been praised as one of the most advanced in the region in terms of confronting diseases. Moreover, ASEAN's willingness to set up and contribute to the regional fund based on the level of economic status of its member

states is regarded as a remarkable achievement in constructing disease as a security issue.

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