

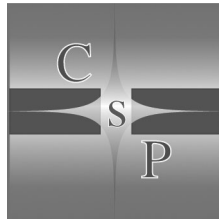
# Culture, Identity and Religion in Southeast Asia



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Edited by

Alistair D. B. Cook



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I dedicate my efforts to my parents, family and friends and to the memories of my grandma and godmother, Myra Leeke and Iris Ayres whose belief in me provides continued inspiration.



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## PREFACE

Ongoing institutional, cultural and regional developments in Southeast Asia prompt many and varied questions amongst scholars and practitioners alike, both within and outside the region. The establishment of the ASEAN Regional Forum (ARF) in 1994 saw the creation of a space to encourage debate and tackle ongoing security issues in Southeast Asia. It comprises the ten ASEAN members and a host of other partners with security interests in the region. The ARF promotes dialogue between these partners and seeks to strengthen civil society involvement in policymaking. Surrounding the ARF is an increasingly active scholarly community, which organises conferences, fora and other avenues for policy discussion. The National University of Singapore organised their first graduate forum on Southeast Asia studies for the end of July 2006. The interest generated by this forum prompted the creation of a mirror session at The University of Melbourne to enable interested scholars in Australia to congregate and share ideas. With the cooperation of the Singapore organisers I got in touch with those in Australia who were interested in the Singapore forum and within a few days was receiving abstracts from around Australia.

Thanks to the assistance of Antigone Vasilopoulos the forum attained an academic activity grant from the School of Graduate Studies (SGS). Antigone's experience and wealth of knowledge of such opportunities is truly remarkable. Her enthusiasm and support for this project helped every step of the way. Once details of the SGS academic activity grant emerged match funding was obtained through the Asia Institute. Thanks are due to Michael Leigh, the Institute's director, and Linda Poskitt for their enthusiasm, advice and support. I also had indebted to my colleagues Chris Freise, Tracey Churchill-Page and Tony Wilson who helped the day run smoothly. In addition to this support Derek McDougall provided key guidance and was an integral part of the forum. The Melbourne ASEAN forum also received support from the Melbourne Research Office and the experience of the Associate Arts Dean (Research) Professor Leslie Holmes. I also received support in kind from the ASEAN secretariat.

The preparation of this edited book brings together researchers from across the region and facilitates the discussion of pertinent political issues that affect Southeast Asia. This book would not have been possible

without the continuous backing and encouragement of many colleagues, friends and family to whom I am enormously grateful. I also thank the contributors to this volume for their support and ability to respond without delay to my many and varied requests. I am very grateful for the feedback provided by Hashim Abdulhamid, Bligh Grant, Amarjit Kaur, Coral Kee, Matthew Killingsworth, Michael Leigh, Ian Metcalfe, Derek McDougall, Ralph Pettman, Lily Rahim, and Jonathan Symons. Finally, I thank all those who worked on this manuscript at Cambridge Scholars Press, with special thanks to Amanda Miller.

Alistair D. B. Cook

# CHAPTER ONE

## INTRODUCTION

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The framework of the international security environment has always received much attention from all schools of thought. Each decade faces its own crises of confidence between various actors that make up the international system and no less is the Southeast Asian case. With Southeast Asian domestic and international security challenges taking place in its many forms whether it be between sovereign states such as the Indonesia-Malaysia *Konfrontasi* (armed confrontation) between 1962 and 1966; within sovereign states such as the independence of Timor Leste (East Timor) from Indonesia in 2002 and sustainability concerns such as population renewal; regional challenges such as the discovery of avian ‘flu in the 1990s and its subsequent (and continuing) spread or the mass internal displacement of people within Burma and its regional destabilising implications; the cross-level challenges of human rights, the Aceh peace process, the 2004 Indian Ocean tsunami with local and international non-governmental agency projects; the revival of some religious movements and their roles in national political processes, regional organisations and indeed international interactions. All of these concerns have had a continuous affect on the regional makeup of Southeast Asia and have significant implications internationally and for greater understanding of Southeast Asian internal interactions.

The new challenges that face Southeast Asia bring with them varied responses from different actors and create another forum of debate for scholars and practioners. In this book, many current challenges are discussed in detail to further the conversation initiated by the emergence of the various security challenges. These all arise as the world adapts to the globalisation processes in all their forms, whether it is the current neo-

liberal economic globalisation agenda or the increased interaction of individuals, peoples, communities and other forms of identity. Whilst these two forms of globalisation frequently confront one another, their effects on the world have significant affects both locally, regionally and internationally.

The way in which states interact has grown more complex as these new challenges emerge. The significance of the ongoing avian 'flu epidemic is testament to that with the obvious need for greater attention to developing appropriate responses to a deadly virus. In the second chapter of this edited book, Tracey Churchill-Page tackles this issue and how the recent changes to the way in which world health is governed and what the interactions are between the mandated international body and the local responses to it. Churchill-Page argues that the recent avian 'flu epidemic and the 2003 emergence of Severe Acute Respiratory Syndrome (SARS) have challenged the way in which international health is governed. The significance of Southeast Asia as the region under study lies in its place as a historically significant region of origin and subsequently predicted to reoccur. As the true spread of avian 'flu is realised there is a greater need to coordinate between different actors and stakeholders in the region of origin and ensure that future outbreaks are dealt with in the best possible way.

Churchill-Page further analyses the role that the state plays in operationalising the Global Health Security Framework (GHSF) and the impact that identity, culture and human behaviour have on ensuring GHSF success. Furthermore, Churchill-Page recognises the financial burden that the GHSF has and points to the international community as the source of help for a combination of self-interest and idealistic goals and aspirations. The ongoing development of the Association of Southeast Asian Nations (ASEAN) may well provide itself as a forum for greater interaction and better regional response mechanisms. Indeed, the future direction of ASEAN has many implications for regional security.

In the third chapter, Cook and Freise map out Southeast Asian forced migration and terrorist incidents and focus on how these human security challenges impact upon regional interactions. They approach both forced migration and terrorism in the region using an historical analysis. It maps the development of Southeast Asia from a region dominated by European Colonial powers up to more recent attempts at shaping its own identity. They identify the fragility of the Westphalian state system and how it has brought together different peoples in a way that has led to forced migration and terrorism in the region.

The authors suggest whilst the 1990s saw the prevalence of the self-determination norm, the twin challenges of forced migration and terrorism remain more likely to be intra-state than inter-state concerns; however, the increasingly transnational effects present considerable political and institutional challenges to ASEAN. Whilst these twin challenges pose non-traditional security concerns for states and regional institutional development, there remains significant interaction which occurs outside of this realm. The non-governmental sector both within and across states are significant actors and how they perform equally affects people in the region. How small non-governmental organisations and other civic networks interact with the large international non-governmental sector is the subject of the fourth chapter.

In the fourth chapter Zeccola focuses on the interactions between these two forms of non-governmental actors to evaluate how they influence one another. Zeccola demonstrates this interaction through focusing on post-tsunami Aceh and the sometimes irreconcilable differences between local and international nongovernmental organisations (NGOs). On the one hand, local NGOs possess the necessary local understanding of a conflict scenario but are without the necessary funds. Whereas, on the other, international NGOs are restricted by governments and funding agencies on where they initiate projects. This scenario leaves a gap between what can be offered to an affected community and what is wanted and needed.

Zeccola examines the development of the situation in Aceh looking at the historical, cultural and economic roots of the conflict alongside the development of human rights within humanitarianism. Whilst there are greater resources available for international NGOs, the smaller local NGOs outside of the international NGO and funding system are better equipt to respond to Acehnese issues as part of a broader social movement. The development of grass-root social movements occur in various forms responding to issues of identity whether they take the form of human rights, religion or cultural movements to name but a few. In the fifth chapter, Bustamam-Ahmad traces the development of both the Islamic revivalism and radicalism movements in Malaysia. This examination highlights the roots and responses of the movement to current phenomena in Malaysian domestic political arena and highlights its international connections. The development of Islamic revivalism in Malaysia saw the establishment of greater faith based educational institutions and better provisions for those of the Islamic faith.

However, this development did not stop the rise of Islamic radicalism in Malaysia but rather the indigenous development of Islam through

Islamic revivalism ensures that there is less reliance of educating Islamic leaders in the Middle East where many become radicalised and bring these ideas back to Malaysia on their return. Bustamam-Ahmad differentiates between the two forms of Islamic teachings as ways to better understand these two divergent areas. Creating a regional identity in its various forms has undoubtedly been spurred on by but not limited to the impact of globalisation and regionalisation. What emerges is a mixture of both global and local ideas being taken into account in the development of a regional identity.

In the sixth chapter, Hinton looks at the development of Singaporean welfare policies to combat its ongoing demographic challenges. In his analysis he compares the development of many theories of welfare identity and demonstrates how Singaporean welfare identity emerges. The delicate balance between the prevalent conservative authoritarianism and the neo-liberal market orientated economic policies constantly provide a tension in Singaporean policymaking. Hinton examines family payments in the welfare system and how they provide a new method of provision, which does not fit into the broader logic of the Singaporean welfare system. Whilst the economic and political implications are played out through a response to demographic challenges in Singapore, other Southeast Asian states are susceptible to policy challenges and social developments that can alter the course of policymaking in any given state.

In Indonesia the post New Order era has brought about many changes to the structure of the Indonesian state. In the seventh and final chapter, Karim evaluates the changing nature of *Pesantrens* – Islamic residential schools – from a cultural to a more overt political actor. Karim evaluates the transition of their impact over the 2000 and 2005 elections in Sumenep, Sumatra. During these elections, the *Pesantren* played a significant role in the recruitment of political candidates and the author demonstrates the significance of this development. Each of the chapters in this volume tackles significant challenges to Southeast Asia and provides analysis of the various contexts in which they occur. These chapters attempt to demonstrate and characterise Southeast Asian developments.

## CHAPTER TWO

# THE GLOBAL IS THE LOCAL: GLOBAL HEALTH IN SOUTHEAST ASIA

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### **Introduction**

The 2003 emergence of Severe Acute Respiratory Syndrome (SARS) and the ongoing avian Influenza (bird flu) epidemic highlight the dark-side of globalization, as these diseases spread rapidly to all four corners of the globe. The spread of emerging and re-emerging infectious diseases however have also performed another function, as they have served to highlight the increasing significance of the role of international health governance in a rapidly globalizing world. Until the advent of these novel diseases the field of international health had been largely marginalized by academia, governments and the mass media, whose main interests were predominantly focused on the global political economy and the global war on terror. However, as the 2003 SARS outbreak highlighted, international health governance is only as effective as its weakest link, thus the field of international health and international health governance has shifted from the periphery to a more central position within international relations. This has also resulted in a shift away from the Westphalian model of state-centrism with the World Health Organization (WHO) acting as the

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<sup>1</sup> This chapter has greatly benefited from the incisive feedback provided by Dr. Timothy Marjoribanks of the University of Melbourne, and Dr Susan Park, Deakin University. Sections of this paper were first discussed in April 2004 in the author's MA Thesis, 'Responding to SARS: A Comparative Study of China and Canada (International University of Japan, Niigata). All other material and research are part of the author's ongoing PhD thesis, 'Redrafting the IHR: WHO Benefits?'

coordinating and collaborating agent in international health governance, to that of a model of pluralism and diversity involving non-state actors such as NGOs, private corporations, banks, philanthropic organizations, and inter-state initiatives. Another example of this shifting attitude towards international health governance was the momentum gained in implementing revisions to the International Health Regulations after the outbreak of SARS, which places greater emphasis on national capabilities such as surveillance and response mechanisms, and reduces the risk of Member States hiding outbreaks within their borders.

The frequent, and at times alarming, predictions of the emergence of a highly pathogenic influenza pandemic, as virulent as the 1918 Spanish flu, which was estimated to have killed as many as 50 million people globally, has firmly placed Southeast Asia and South China in the global spotlight, as it is from this region that previous outbreaks have occurred, and where the next highly pathogenic influenza pandemic is predicted to emerge (Fidler 2004, 72; Layne 2006, 564). This increased attention has highlighted the inequities between the developed and developing worlds, and most significantly for international health governance, the serious lack of capabilities within Southeast Asia. The realisation that infectious disease surveillance capabilities are essential to international health governance (Fidler 2004, 72) has seen the creation of public-private partnerships and funding frameworks, such as the International Partnership on Avian and Pandemic Influenza (WHO 2006b; Sun and Chang 2006). Thus it would seem armed with the re-drafted International Health Regulations, and with multi-donor partnerships providing the funding essential for developing surveillance frameworks in Southeast Asia, when the predicted influenza pandemic hits, we will be ready for it...or will we?

This chapter analyses the changing nature of international health governance, from its origins as a Westphalian strategy to prevent the spread of exotic or Asiatic diseases with the minimum disruption to trade, to the contemporary Global Health Security Framework established by WHO, the purpose of which is to contain infectious diseases, respond to unexpected events, such as bioterrorism, and improve the capability to detect, contain and manage infectious diseases at national levels. The Global Health Security Framework is only as strong as its weakest link, and one region that has been identified as a weak link is Southeast Asia. While much effort and funding has been focused on this region, there are determining factors which will, if left unaddressed, continue to undermine such efforts. Through the analysis of the Malaria Eradication Programme, the 2003 SARS outbreak, and the current ongoing bird flu

epidemic, this chapter seeks to explain how not only inadequate state capabilities undermine the Global Health Security Framework, but also how identity, culture and human behaviour can all act as impediments to establishing effective surveillance capabilities within States in Southeast Asia, and thereby undermining the Global Health Security Framework.

## **International Health Regulation History**

The origins of international health regulation can be traced back to 14th century Europe with the introduction of quarantine practices. However the adoption of quarantine by many of the major European powers at that time was problematic, as the measures implemented were unregulated, arbitrary and corruptible, and often incurred serious losses for maritime trade. The practice of quarantine continued until the 19th century, by which time several developments converged and forced many European States to reconsider the unilateral and disorganized systems of quarantine. These converging factors which culminated in the first attempts at international health regulation were the emergence of a bourgeois merchant class; European colonialism of the New World, and the resultant epidemics of novel, exotic diseases; the industrial revolution; and scientific/medical advances in the aetiology and transmission of infectious diseases (Goodman 1971; Rosen 1993).

The emergence of the bourgeois merchant class was as a result of increased levels of trade and commerce. As this class gained more wealth, it also gained more political power, and was able to bring pressure to bear on governments to address the issue of irresponsible and unregulated quarantine practices in order "to relieve trade of these burdens or, if they could not altogether be abolished, to render them less irksome and particularly more stable and uniform"(Goodman 1971, 36).

The major western European maritime powers began to travel great distances to undiscovered territories with the advent of technological developments such as improved navigational systems. These voyages were devastating, both for the indigenous populations, as well as for the European explorers, as these different gene pools were each introduced to novel diseases for which there was no natural immunity. Thus many indigenous populations were decimated by influenza, smallpox, measles and typhus, whilst the European explorers also succumbed in large numbers to novel, endemic diseases such as cholera and yellow fever.

However it was not until the advent of the industrial revolution that these diseases were able to reach the distant European shores. The industrial revolution gave rise to many important technological

developments, however the most significant from a health perspective being that of transportation. These advancements facilitated not only increases in travel and trade, but increased the distances covered and concurrently reduced the time required. This gave rise to a series of epidemics in Europe of non-endemic diseases such as yellow fever and cholera. A major cholera outbreak that spread from India, to Europe and the United States, from 1828 until 1832, and another major cholera pandemic in 1847, confronted States with the realization that the existing multilateral and unregulated quarantine measures were ineffective in containing and preventing epidemic outbreaks. As a consequence, States had little alternative but to develop coordinated and collaborative strategies to combat infectious diseases whilst protecting their economic interests (Goodman 1971, 36). Thus the major driving force for international health regulation at this time can be characterized as Westphalian, as European powers sought "the removal of hindrances to trade and transport, and ... "the defence of Europe" against exotic pestilences" (WHO 1958, 14).

From as early as 1834, calls for an international conference for diseases and quarantine were made throughout Europe, although the first international sanitary conference was not held until 1851. The outcome of this intergovernmental International Sanitary Conference was the drafting of the International Sanitary Convention, which cited 137 regulations in the management and containment of infectious diseases. Nevertheless the Convention was a dismal failure as, of the twelve signatory States only three ratified the Convention in 1852, and two of whom, Portugal and Sardinia subsequently withdrew in 1856. Notwithstanding, these Conferences and the International Sanitary Convention are extremely significant, as these attempts at regulation were the precursors of the International Health Regulations today (Goodman 1971; Siddiqi 1995).

It was not until scientific and medical advancements, most significantly the discovery of the *cholera vibrio*, and *intermediate vectors*, such as mosquitoes, that any degree of international health regulation began to develop concretely (WHO 1958, 9-14). Earlier Conferences lacked medical technical expertise or scientific knowledge, as there was significant disagreement over the aetiology and transmission of exotic infectious diseases. Without scientifically based knowledge or universal consensus, the establishment of coordinated and standardized practices of international health regulation was not possible (WHO 1958, 9-14). The 1903 Conference held in Paris was significant, as finally, scientific data about cholera, the plague and yellow fever, achieved consensus and

became accepted facts. In understanding the aetiology and transmission of these diseases, the possibility of implementing the necessary measures became a reality. As a result of this scientific breakthrough, the establishment of an international public health office was proposed at the Paris Conference, although it took another four years before the Office International d'Hygiene Publique (OIHP) was established in 1907, under the auspices of the Treaty of Rome (WHO 1958, 9-14).

Attendance at the International Sanitary Conferences grew exponentially, and by the twelfth convocation in 1912, the Conference was attended by medical and diplomatic representatives of forty-one countries. By 1926, sixty-five States and territories were represented by Member State delegates, as well as representatives from the Health Organization of the League of Nations, the International Labour Office and the OIHP, culminating in the signing of an amended International Sanitary Convention. Part I of this re-drafted Convention translates that all signatory states agreed to comply with the codes of conduct and cooperate within the arena of international health through the collaborative management of quarantine measures and through the notification of infectious diseases, or conventional diseases, such as typhus, smallpox, cholera, yellow fever, plague and relapsing fever (Goodman 1971).

With the exception of the addition of regulations for aerial navigation in 1935, the International Sanitary Convention continued to provide the framework for international health regulatory practices until after the Second World War, when WHO adopted them in 1951, at which point they were redrafted and renamed the International Sanitary Regulations. They were renamed again - International Health Regulations - and further amendments were made in 1969, with the removal of typhus and relapsing fever, although cholera, yellow fever, plague and smallpox remained on the list of notifiable diseases (WHO 2007a). In 1980, the Global Commission for the Certification of Smallpox Eradication presented its findings to the thirty-third World Health Assembly, namely that smallpox had been globally eradicated. As a result of these findings, smallpox was removed from the list of notifiable diseases (WHO 1983).

## **Contemporary International Health Regulation**

The International Health Regulations (IHR 1969) have not been amended or updated since this time. However, in response to the exponential growth of re-emerging communicable diseases, such as tuberculosis, and the emergence of new infectious diseases, such as Ebola haemorrhagic fever, WHO's 48th World Health Assembly (WHA) in 1995

raised concerns about new and re-emerging communicable diseases within the context of globalization. Furthermore it was agreed that the primary defence against rapid and international dissemination of infectious diseases was the "strengthening of epidemiological surveillance and disease control activities at [the] national level" (WHO 1995). WHA Resolution 48.7 was passed, charging the Director-General with the task of drafting a report on the revision of the IHR (1969). Concurrently, the 48th WHA passed Resolution 48.13, which mandated the Director-General to provide the Assembly with proposed strategies for detection and response mechanisms for the emergence and re-emergence of communicable diseases (WHO 1995).

As a result of these Resolutions, in 1997 WHO established an Outbreak Verification System (OVS) as a surveillance mechanism to globally monitor disease outbreaks. In collaboration with Health Canada, WHO now has access to over 600 sources of information through the Canadian electronic web-crawler - the Global Public Health Information Network (GPHIN). WHO also accesses information through additional collaborations at the global and regional levels: ProMed-mail is "an Internet-based reporting system dedicated to rapid global dissemination of information on outbreaks of infectious diseases" (ProMed-mail 2001); PACNET is a weekly e-newsletter "designed to facilitate communication on timely and fast breaking events in the region and to serve as a vehicle for sharing research results and analyses" (PACNET 2007; TravelMed 2007) is an electronic discussion board hosted by the International Society of Travel Medicine (Grein et al 2000, 99).

From the information received from these different sources, WHO's OVS team assesses data on previous outbreaks and endemic foci, as well as any other relevant background information, in order to assess the significance of an "event" (an outbreak of disease) and its potential to impact upon the welfare of international public health. The OVS team also assesses whether an event meets the criteria of an outbreak, for example whether the "observed number of cases exceeds expected number of cases in a given population for a given period" (Grein et al 2000, 99). It then disseminates the data collated from the information provided through a variety of media: A subscriptions based e-mail Outbreak Verification List; WHO's Disease Outbreak news Website - which is accessible to the general public; and through the publication of its Weekly Epidemic Report (Grein et al 2000, 99). The OVS affords WHO the opportunity of a quicker response time to outbreaks and enabling it to provide technical and procedural assistance and WHO field personnel to the originating country of an event more effectively.

In 2000, the former Communicable Disease Surveillance and Response of WHO convened a meeting on “Global Outbreak Alert and Response”, the outcome of which was the establishment of the Global Outbreak Alert and Response Network (GOARN), which represents a "major pillar of global health security aimed at the detection, verification and containment of epidemics" (WHO 2004a). The Network "interlinks, in real time, 110 existing networks which together...keep the international community alert to outbreaks...[and] magnifies the resources of individual partners considerably" (Kinderhauser 2003, 58). The coordinated approach of OVS and GOARN in disease outbreak and surveillance also greatly reduces the risks of States not reporting an event within its borders, and to some extent gives WHO advance warning of unusual events prior to the uncontrolled spread of an infectious disease outbreak. WHO was further augmented in its global outbreak and alert programme by the passing of WHA51.14 Resolution during its 54th WHA, which, in addition to reiterating its commitment to the revision of the IHR (1969), called for the "development of a global strategy" (WHO 2001c) in order to achieve an effective management system of potential and actual global epidemic outbreaks.

Thus the CSR was restructured and mandated to meet the growing demands of re-emerging and newly emerging communicable disease and the result was WHO's Global Health Security Epidemic Alert and Response. The IHR are an integral and fundamental component of the Global Health Security Framework, as they provide the overall legal authority. Subsumed under the IHR is WHO's Global Health Security strategy which is a three-pronged approach to Epidemic and Pandemic Alert and Response (EPR). This triadic strategy iterates the following initiatives: To *contain known communicable diseases*, such as cholera, yellow fever and plague, which requires the development of surveillance and response mechanisms at the national level, as well as laboratory and diagnostic facilities (WHO 2001a). The second initiative is to *respond to unexpected events*, such as newly emerging diseases, for example SARS, and the accidental and/or intentional release of biological agents and acts of bioterrorism. This is achieved through the collaboration of OVS, GOARN, WHO Collaborating Centres, other UN Agencies, and Member States through epidemic intelligence networks in order to contain epidemics (WHO 2001c). The third prong of the Global Health Security strategy is that of *improving national preparedness*. For instance, in Southeast Asia for States to develop national preparedness plans for emerging infectious diseases outbreaks and implement national surveillance and verification systems will require medically and

technically trained personnel, thus EPR "provides tools, expert assistance and carefully-tailored training to enhance multidisease skills in laboratory diagnosis, field epidemiology and public health mapping" (WHO 2001b).

Another component to the establishment of WHO's Global Health Security Framework was the redrafting of the IHR, which at first glance seems to be a response to the changing nature of health within the context of globalization, such as the emergence of new infectious diseases such as HIV/AIDS, Ebola Haemorrhagic Fever, Severe Acute Respiratory Syndrome (SARS); the re-emergence of infectious diseases, such as tuberculosis (TB), cholera and plague. However, the redrafting of the Regulations was not solely in response to these changes, the IHR (1969) contained serious inherent weaknesses, and without significant revision, would undermine WHO's new Global Health Security Epidemic Alert and Response framework. One major flaw of the IHR (1969) is the list of notifiable diseases, of which there are only three, cholera, yellow fever and plague, which Member States are legally obligated to report to WHO under the Regulations. The IHR (1969) mandates that Member States notify WHO of "a disease subject to the Regulations" (WHO 1983), thus there is no obligation on the part of Member States to notify WHO of diseases that are not subject to the Regulations. It is hard to imagine that a Member State would not report or notify WHO of a disease which had the potential to become a global epidemic. However, the issue of notification highlights another inherent weakness of the IHR (1969), namely the negative effects of reporting a disease outbreak can have. Two diseases which exemplify these negative effects are plague and cholera. In 1994, Surat, India, experienced an outbreak of pneumonic plague. Media sensationalism caused panic, and in one night alone, 600,000 people fled Surat to escape the plague (Ramalingaswami 2001). The high level of panic was exacerbated by the international community's response to the outbreak, as "countries throughout the world [responded:] airports were closed to aeroplanes arriving from India and imports of foodstuffs were blocked" (Kinderhauser 2003, 58). These measures and irresponsible media coverage of the outbreak was estimated to result in economic losses of US \$2 billion (Kinderhauser 2003, 58). However, the reality of the situation later became apparent, as the Head of the 1994 Technical Advisory Committee wrote:

Between August 26 and October 5, 1994, 5,150 suspected cases of pneumonic or bubonic plague were reported from eight states of India, including 2,793 from Maharashtra state, 1,391 from Gujarat state, 749 from Delhi, and 169 from five other states. A total of 167 cases were confirmed

by serology by October 5, and there were 53 deaths, 49 from Surat (Ramalingaswamin 2001).

Another example of the negative effects to Member States of reporting infectious diseases under the IHR (1969) is cholera. From 1817 until today, there have been a total of seven pandemics. The current and ongoing seventh pandemic originated in Sulawesi, Indonesia, in 1961, gradually spreading to Bangladesh in 1963, India in 1964, and the Soviet Union, Iraq and Iran during 1965 to 1966. By 1970 it had spread to West Africa, and spread rapidly throughout most of the African continent (WHO 2000). It reached Peru in 1991, and over the period of a year travelled to a further eleven Latin American countries, resulting in 400,000 cases and 4,000 deaths from cholera. By 2001, the same pandemic had appeared in 58 countries that saw a further 184,311 reported cases, and 2,728 deaths: "In Peru alone, the highly publicized arrival of cholera is estimated to have cost the country's economy up to US \$ 770 million in lost trade, and tourism" (Kinderhauser 2003, 77). From such examples, it is possible to recognize that the international community's response, in the form of embargoes, affecting not only trade but international traffic; and the impact on tourism and related industries, act as serious disincentives for Member States to promptly and accurately report event outbreaks within their borders. Thus, the redrafted IHR (2005) has been revised to remove these weaknesses and introduce protocols which attempt to remove disincentives in notifying WHO of events which may develop into epidemic or pandemic outbreaks.

Moreover the emphasis of the purpose and scope of the Regulations has also changed significantly. IHR (1969) states that "[t]he purpose of the International Health Regulations is to ensure the maximum security against the international spread of diseases with a minimum interference with world traffic"(WHO 1983), which reflects the earlier Westphalian model of security of State's borders against infectious disease and the protection of trade. However, IHR (2005) emphasizes the importance of the purpose and scope of the Regulations through the inclusion of these issues as an Article, rather than in the previous Foreword of the IHR (1969). Article 2 states that: "The purpose and scope ... are to prevent, protect against, control and provide a public health response to the international spread of diseases in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade" (WHO 2005a). Whilst there are still echoes of its Westphalian heritage, the IHR (2005) clearly broaden the roles and responsibilities of the WHO. To elaborate, the primary function of WHO at its inception was to "act as the directing and coordinating

authority on international health work" (Goodman 1971, 46-47), whereas it now plays a leading role in Global Health Security, interacting and directing a multitude of State and non-state actors in detecting and verifying outbreaks, as well as providing guidelines, logistical technical support and recommendations to Member States in helping them to develop standardized national core capacities.

The IHR (2005) also places greater emphasis on national based surveillance and verification systems than its earlier counterpart. Article 5.1 (Surveillance) mandates that all Member States "shall develop, strengthen and maintain, as soon as possible but no later than five years from entry into force of these Regulations ... the capacity to detect, assess, notify and report events in accordance with these Regulations..."(WHO 2005a). Every Member State is also legally mandated to develop its core capacity requirements at the national, community and intermediate public health levels, with Annex 1 of the IHR (2005) iterating exactly what these capacities should be:

The local community level should be able

- (a) to detect events involving disease or death above expected levels for the particular time and place...
- (b) to report all available essential information immediately to the appropriate level of health-care response...essential information includes the following: clinical descriptions, laboratory results, sources and type of risk, numbers of human cases and deaths, conditions affecting the spread of the disease and the health measures employed;
- (c) to implement preliminary control measures immediately (WHO 2005a, Annex 1).

The intermediate public health level should have the capacities:

- (a) to confirm the status of report events and to support or implement additional control measures; and
- (b) to assess reported events immediately and, if found urgent, to report all essential information to the national level ... urgent events include serious public health impact and/or unusual or unexpected nature with high potential for spread (WHO 2005a, Annex 1).

The national level should have the capacities:

- (a) to assess all reports of urgent events within 48 hours;

and

- (b) to notify WHO immediately through the National IHR Focal Point when the assessment indicates the event is notifiable (WHO 2005a, Annex 1).

The public health response capacities are listed as able:

- (a) to determine rapidly the control measures required to prevent domestic and international spread;
- (b) to provide support through specialized staff, laboratory analysis of samples (domestically or through collaborating centres) and logistical assistance (e.g. equipment, supplies and transport);
- (c) to provide on-site assistance as required to supplement local investigations;
- (d) to provide a direct operational link with senior health and other officials to approve rapidly and implement containment and control measures;
- (e) to provide direct liaison with other relevant government ministries;
- (f) to provide, by the most efficient means of communications available, links with hospitals, clinics, airports, ports, ground crossing, laboratories and other key operational areas for the dissemination of information and recommendations received from WHO;
- (g) to establish, operate and maintain a public health emergency response plan, including the creation of multidisciplinary/multisectoral teams to respond to events that may constitute a public health emergency of international concern; and
- (h) to provide the foregoing on a 24-hour basis (WHO 2005a, Annex 1).

Each Member State will also be responsible for designating or establishing a National IHR Focal Point (NFP). The NFP is to be accessible to WHO at any and all times. According to WHO's National Focal Point Guide:

While the exact structure and organization of the NFP are left to the State, IHR (2005) define the role, functions and operation requirements for real-time management of information and for efficient communications ... NFPs will need clearly established links and coordination mechanisms with existing national health emergency committees and mechanisms, within or outside the health sector (WHO 2005b).

All signatory Member States to the IHR (2005) will be expected to establish or designate the NFP and ensure core capacities by a five year time limit from June 2007, when the IHR (2005) come into force.

Article 11, *Provision of information by WHO* is also noteworthy. As the outbreaks in India and Latin America highlight, timely and accurate notification of disease outbreaks can be undermined by the potential disincentives of severe economic loss and social unrest and panic. Article 11.2 ensures that if a Member State notifies WHO of an event that has the potential to develop into "a public health emergency of international

concern" (PHEIC) (WHO 2005a), the notification will be treated in confidence. However, there are certain conditions attached to the confidentiality rule. Confidentiality will be broken if the event is deemed a PHEIC; if containment of the event is not possible due to the nature of the event; the Member State experiencing the event is unable to implement the necessary operational measures or contain the disease from spreading further. In addition, according to Article 10 Verification, if a Member State is invited to collaborate with WHO over an event that may constitute a PHEIC, and the Member State does not accede, WHO may share information with other Member States, if doing so is justified by the magnitude of the event (WHO 2005a). In principle, close collaboration with WHO should minimize the negative impacts of reporting an outbreak, as WHO has access to technical resources, laboratory services and medical expertise and capabilities that many Member States lack.

Despite the fact that the IHR (2005) does not come into force until June 2007, implementation of the Regulations has already begun. Resolution WHA59.2, which was passed in May 2006, calls for all Member States to implement, on a voluntary basis, aspects of the IHR (2005) which will help in combating avian influenza and developing preparedness for a human influenza pandemic (WHO 2006a).

The 2003 SARS outbreak played a major role in the redrafting process of the IHR (1969), in defining the parameters of WHO's power as the leading institution of international health governance, its roles and responsibilities, and that of its Member States. It achieved this in two ways, firstly SARS saw the application of the Global Health Security Framework in a real-life situation, and secondly this application drew a line in the sand of how far States were prepared to go in allowing WHO to halt the outbreak in its tracks.

In addition to "leading and coordinating the investigation and containment of an international epidemic" (Fidler 2004, 79), WHO implemented a virtual laboratory, by electronically connecting eleven laboratories from nine different countries, in an effort to "improve diagnostic precision and move forward on the development of a diagnostic test" (WHO 2003a) for SARS, and coordinated an electronic conference of "80 clinicians from 13 countries" (WHO 2003a) which was convened for the purpose of sharing clinical features and treatments of SARS. However, most significantly, WHO began to issue travel advisories, via its internet site and the mass media, directly to the general public instead of its Member States. The issuance of a travel advisory was based on three criteria: the severity of the outbreak - the number of probable cases; transmission - whether the disease spread via the general population or

was confined in transmission, for example, amongst health care workers, and thirdly, a Member-State's ability to contain the outbreak from spreading beyond its borders. During the SARS outbreak there were three levels of travel advisories, the first alerted international travellers of the outbreak, and provided guidance on the early symptoms of the disease; the second travel alert made the "recommendation that people who have possibilities of postponing travel to these areas do so" (WHO 2004c), and the third level recommended postponing all but essential travel to the identified areas. On April 23, 2003, WHO imposed level three travel advisories on Beijing, Shanxi Province and Toronto. In issuing these travel advisories WHO had acted beyond its mandate as the IHR (1969) makes no provision for such actions, and the health organization had not consulted with Member States prior to issuing these statements directly to the press. Perhaps most remarkable however was the absence of objection to the introduction of these travel advisories from Member States, whilst there were complaints, the most vociferous coming from Toronto, rather it was the level of travel advisory under which they were placed that caused complaint (CTV 2003).

However, analysis of the IHR redrafting process clearly highlights Member States' concern over WHO's ability to act independently of its Member States, and to implement policies, such as the travel advisories, that impacted deleteriously on State's economies. One such example is the definition of "temporary recommendation", which in an earlier intergovernmental working group on the revision of IHR read: "means advice issued by WHO ... for application on an ad hoc, time-limited, risk-specific basis, as a result of a public health emergency of international concern" (WHO 2004b); by the final draft of the IHR (2005) the definition of temporary recommendation now reads: "means non-binding advice issued by WHO ... for application on a time-limited, risk-specific basis..." (WHO 2005a); thus limiting WHO's ability to improvise, as it had during the SARS outbreak, and concurrently removing any authority to enforce temporary recommendations, which will not be legally binding under the IHR (2005). WHO has always been constrained in any actions within a Member State's borders, requiring a formal request of assistance before it can dispatch any representatives to any given country. In earlier drafts, Article 10.3 stated: "In the absence of such a request WHO may offer assistance to the health administration of a State ... and the health administration shall collaborate with WHO ... and, when necessary, in conducting on-the-spot studies by a team sent by WHO, with the purpose of ensuring that appropriate control measures are being employed" (WHO 2004b). Interestingly in the finalized draft, the term "health

administration” has been replaced with “State Party”, and paragraph 10.3 has been completely removed. This is particularly significant and potentially detrimental to future containment measures of infectious disease outbreaks, as the SARS epidemic highlights: Despite repeated offers of technical support (in the form of epidemiologists being dispatched), China did not request assistance from WHO until March 17, 2003, a full three months from the first recognised incidence of the disease in Guangdong Province, in November 2002, and over a month after WHO began to receive information through GOARN and GPHIN, (WHO 2004d) and it was during this interim period that SARS began marching across the globe (WHO 2003b).

WHO's Global Health Security framework during the SARS outbreak was without doubt extremely successful, and it certainly gained a degree of power previously unavailable to it, through the incorporation of GOARN and GPHIN into its global surveillance strategies, as "[s]overeign states no longer monopolize information flows related to infectious disease events" (Fidler 2004, 136). However, it should be remembered that SARS was a newly emerging infectious disease, and as such Member States were galvanised into action by the unknown, and had little alternative but to follow WHO's leadership. Nevertheless, as this chapter has shown, once that panic faded, notable changes were made during the revision process of the IHR to ensure that WHO could not circumvent or subordinate state sovereignty again.

Fortunately SARS only killed 916 people globally during its 2002/3 emergence, the common garden variety of influenza on the other hand, accounts for between 250,000 and 500,000 deaths annually (Radford 2003). There are three categories of influenza viruses, Influenza A, B and C. Of these, Influenza A is a particularly virulent pathogen, of which the Spanish Flu of 1918-19 (H1N1) is but one, another well known Influenza A strain is the bird flu, or avian flu (H5N1) and whilst it "is not easily spread from human to human... health specialists fear it could mutate into a virulent form like the Spanish flu" (Webb2007). Furthermore, there is a strong likelihood that avian influenza is now endemic to Asia (Smolinski 2005). Moore identifies that from 1727 until 1968 there have been ten influenza pandemics, which "suggests that we are due a pandemic any time now" (Moore 2001, 107). That a pandemic of a highly virulent strain of Influenza A could mutate at any time to become a global epidemic, raises major concerns about the state of readiness of States to respond to such an outbreak.

For many States in the developing world, both in Africa and Asia, the legally mandated requirements of the IHR (2005) will place tremendous

pressure on national governments, on fiscal and health policymaking, and national health systems, in order to meet these obligations. In recognition of such pressures, WHO will extend an additional five year grace period to States who will need a longer time to restructure their national health systems, train public health and medical personnel and develop epidemiological surveillance, detection and verification systems. Yet this begs the question of what happens during the interim? It also raises the issue of what will happen to Member States who cannot meet their obligations, and are seen to be losing control or containment of an infectious disease outbreak will they be assisted or sanctioned by the international community?

## **International Health Regulations 2005 and Local Contexts**

WHO has established its Global Health Security Framework to prevent global pandemics, Member States have signed on to uphold these measures within the legal framework of the International Health Regulations (2005), and governments, corporations, non-governmental organisations and charitable organisations have all committed to funding these initiatives, but there is one dimension neglected in adopting a global approach: people.

The National Academy of Sciences Institute for Health (2005) identifies thirteen factors that can contribute to the emergence of infectious diseases, such as economic development and land use, human demographics and behaviour, and the breakdown of public health measures, of these, "human behaviour, both individual and collective, is perhaps the most complex factor in the emergence of disease" (Smolinski 2005, 2). This is not to say that we should throw our arms up in despair, or resort to draconian measures to enforce compliance to adopted strategies, conversely it is possible to look at different programmes, events and behaviours and learn valuable lessons, which can then be adapted and applied to current and future strategies, for the benefit of all.

One such programme from which lessons can be learned was the Malaria Eradication Programme (MEP) established in 1955 and was a dismal failure. It was not solely as a result of human behaviour that the MEP failed, factors such as a lack of knowledge of the disease and programme design were also responsible. To elaborate, lack of knowledge regarding the mosquito-vectors significantly impeded progress in eradicating the mosquitoes, of which there are many different species, all of whom behave differently. For example some species flourish during rainy season, "some breed in the shadows, some in sunlit pools, and some

in tin cars and discarded automobile tires ... some feed at night; some during the day" (Needham and Canning 2003, 39). Consequently the attitude towards malaria eradication resulted in a highly inflexible programme and one-size-fits-all strategy which Needham and Canning liken to a military exercise (Needham and Canning 2003, 27). With hindsight, it is clear that a more elastic approach to mosquito control was needed, which could be adapted to suit the diversity of local vectors. Human behaviour was another factor that at the time was not taken into consideration, but retrospectively can be seen to have had serious negative consequences for the programme, on both the part of the donor health workers and the recipient populations. To elucidate, "because the MEP treated malaria as a single problem with a single solution, it proceeded as if the people who had the disease did not exist" (Needham and Canning 2003, 23). This contributed to the programme's failure, as the indigenous populations' attitudes towards malaria and beliefs were largely ignored. Malaria is a major killer, however, for those who do survive initial infection, and continue to live with malaria, as have their parents, and their parents' parents, "further back than anyone can remember - such a person may not view malaria as the greatest challenge in her life. Other diseases, such as infectious diarrhoea and tuberculosis" (Needham and Canning 2003, 24) were seen to be more serious. Malaria workers were ejected by villagers in Malaya, after DDT-immune caterpillars munched their way through the roofs of the villagers' homes. MEP lacked both cultural sensitivity and the necessary indigenous knowledge and experiences that would have assisted in the implementation of the programme and in gaining cooperation, instead of resistance, from the indigenous population.

A more contemporary example is that of Kampot province in Cambodia, which has one of the highest incidences of local transmission of malaria. After heavy landmining of the forests during the Khmer Rouge occupation, forests became no-go areas. Now that the forests have been cleared, "[m]any poor rural Cambodians, mostly men, have started venturing into forest areas to work as loggers, gem miners or to hunt" (Chatterjee 2005, 191-192). Unfortunately for these workers, they have no natural immunity to the mosquitoes inhabiting the forests, and while many use the insecticide treated nets, this only protects them during the night while they are sleeping, whilst they are sat around camp fires during the evening, they have no protection whatsoever. Chatterjee posits that transmission rates could be higher than the Malaria Information Registers list, as people continue to elude malaria officials, either as a result of belief systems such as bad spirits causing malaria or that malaria and mosquitoes are unrelated, to continued fear of visiting government-run