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Health and human security challenges in Asia: new agendas for strengthening regional health governance

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ABSTRACT

The role of regional organisations in dealing with global health challenges cannot be understated. Against current and emerging health threats, strong and effective regional collaboration in health security provides a critical pillar in advancing global health governance, allowing for significant interventions in building health systems capacity at national and regional level, improving disease surveillance and response, and strengthening international efforts in responding to a wide spectrum of global health challenges. While regional health cooperation in Asia has come a long way since the 2003 Severe Acute Respiratory Syndrome crisis and the establishments of regional frameworks in East Asia in fighting pandemics and infectious diseases, more can certainly be done to improve collective efforts to deal with emerging health issues such as climate-related diseases and antimicrobial resistance, as well as rising incidence of non-communicable diseases. The expanding regional and global health agenda should compel ASEAN to work closer toward a more comprehensive human security approach to health—one that does not prioritise pandemics over other health threats, while continuing to strengthen public health systems.

KEYWORDS

ASEAN; global health security agenda; global health governance; regional frameworks; climate change

Introduction: changing patterns of health risks

Much has changed in Asia's security environment as new security challenges emerge. This change can be clearly seen in the area of health security where new patterns of communicable and non-communicable disease are changing the regional and global health agendas. These health trends pose complex challenges to national and regional health systems to address new health challenges and how best to ensure health security for all.

Such trends are pertinent to Asia, particularly the East Asian region, that had to face one of the most serious health emergencies in modern times. In 2003, the outbreak of Severe Acute Respiratory Syndrome (SARS), an unknown highly pathogenic infectious virus, caught the region by surprise. What started as an infectious disease outbreak in China's Guangdong province quickly evolved into a global health crisis which spread across the globe and reached as far as North America and Europe. Since then, much attention has focused on preventing the outbreak of highly pathological influenza pandemics

and spread of similar virulent viruses such as the avian influenza strains of H1-H5N1, and Middle East Respiratory Syndrome Coronavirus (MERS-CoV).

More recently, emerging climate-related health risks pose new challenges to global health. Given its geography and climate change, the region's vulnerability to natural disasters is growing in frequency and intensity. Its demographic trends coupled with rapid urbanisation and migration movements have also increased the regional community's risks to water-borne diseases such as severe diarrhoeal diseases, typhoid and cholera, to vector-borne diseases such as Zika and Lyme disease. In 2016, Zika was declared by the WHO as a 'public health emergency of international concern' (PHIEC). Added to these new trends in human health risks are also the changing patterns of infectious diseases like tuberculosis which are drug resistant, as well as the rising threat of antimicrobial resistance (AMR).

Juxtaposing these new trends in communicable diseases with the rising prevalence of non-communicable diseases (NCDs) such as diabetes, cardiovascular diseases, cancer and strokes have significantly expanded the global health agenda that seriously impact the state of regional health security in Asia. To be sure, all these emerging health trends and the increasing burden of diseases present new challenges to regional health governance.

Against this background, the aim of the paper is to analyse the impact of new challenges to regional health governance in East Asia. It examines the extent to which current regional frameworks and approaches are able to deal with the speed of change in the burden of diseases in a highly interconnected and integrated community. As most analyses of regional health governance focus largely on the role of the Association of Southeast Asian Nations (ASEAN) which has been regarded as an important actor in managing regional security, this paper will analyse the evolving nature of regional governance to health security, paying close attention to the way health issues are framed and the norms that define the nature of regional cooperation in health security.

The paper argues that ASEAN's approach to regional health governance must go beyond the current efforts to strengthen cooperation in fighting pandemic influenza and epidemiological surveillance. As a more mature regional body, more efforts must be made to collectively address the emerging challenges to health security such as climate-related diseases and AMR, as well as help strengthen national public health systems to achieve inclusive health security.

The paper further argues that while ASEAN's progress in regional health cooperation has been defined and framed around the language of 'security' that tends to privilege the security of the state, re-framing health security as also development, global public goods, human rights, etc and bringing back individuals and people as the security referent allow for a more comprehensive, human-centred approach toward health security. The current agenda of ASEAN's health governance should therefore adequately reflect a plurality of frames that aim to achieve the well-being and security of its people. In confronting the challenges of bringing back human security into the framing of health security, ASEAN also needs to revisit its normative practices in advancing regional health governance.

Following the introduction, the paper is organised as follows: part two briefly discusses ASEAN's framing of health security and how this has shaped the nature of its regional cooperation in health. It also examines key issues that define the nature of regional health governance. Part three then moves to examine whether the extent to which the

ASEAN approach to regional health governance is adequate to deal with emerging health challenges. The paper then concludes with some observations on the future of regional health cooperation and its impact on global health governance.

Regional health governance in ASEAN: which frame matters?

In the literature on global health governance, how issues are framed and the attendant narratives significantly influence how states approach health in their foreign policies (Rushton 2010). Labonte and Gagnon also noted that the language used to frame health security helps one to understand how states see health issues in terms of their national interests. States therefore employ different words such as security, development, global public goods, trade, human rights and ethics to reflect how they approach global health in their foreign policy agenda (Labonte and Gagnon 2010). Similarly, McInnes and Lee argue that each frame is indicative of the privileging of certain ideas, interests and institution, which consequently shapes the nature of power relations among actors (McInnes and Lee 2012, 18; Amaya, Vincent, and Kingah 2015).

Narratives of health security also provide insights on agenda setting by actors. It further explains how and why certain norms and practices are institutionalised¹. In brief, the way issues are framed significantly influence the way relevant actors deal with an issue. This is particularly relevant when applied at the regional level as we examine how regional organisations like ASEAN address regional health issues, how these are governed and why certain norms promote or impede deeper cooperation and collaboration in health. Suffice it to say that from the perspective of framing and its impact on global health governance, the current discourses on global health agenda make for an interesting background on understanding developments in regional health governance in East Asia. The global health agenda has urged states to a global partnership to, among others, reduce poverty, improve health and education, and promote peace, human rights, gender equality, and environmental sustainability. It also gives particular attention to investments in building strong and resilient health systems and universal access to health care (UHC) which is also a key target of the Sustainable Development Goals (SDGs) (WHO 2017a, 3).

Locating ASEAN's governance approach to health

How health is framed is very relevant in understanding the ASEAN story of regional health governance. At the outset, while ASEAN declarations on regional health governance reflect a plurality of frames being used to promote (regional) cooperation in health—i.e. development, economic growth, and more recently, human rights (Amaya, Vincent, and Kingah 2015), where ASEAN was successful in generating collective response was when the framing of national security was deployed (Caballero-Anthony 2005, 2008b).

Historically, ASEAN was formed to enhance economic cooperation and promote peace and security in the region. Since its establishment, the focus of regional cooperation in ASEAN has been mainly in promoting economic development and avoiding political conflicts. Its member states have assiduously promoted the so-called ASEAN norms of sovereignty and non-interference in domestic affairs. High in the agenda of ASEAN then were regional programmes geared to promote deeper economic cooperation and integration, socio-cultural exchanges, education and technical cooperation, and closer

political cooperation through building mutual trust and confidence among member states. Following the Bangkok Declaration in 1967, the ASEAN Treaty of Amity and Cooperation (TAC) was adopted in 1976 which codified the normative framework for intra-regional relations starting with the peaceful settlement of disputes, respect for sovereignty and non-interference in domestic affairs (Caballero-Anthony 2005). The TAC also outlined several areas of cooperation, but made no mention of health.

It was not until the early 1980s when health cooperation featured in ASEAN's agenda (ASEAN Declaration on Health Ministers on Collaboration on Health, 1980). But, for most of the period until early 2000, the agenda of health cooperation was focused mainly on identifying areas of common interest such as access to health care, promotion of healthy lifestyles, improving capacity to control communicable disease and ensuring drug-free ASEAN (ASEAN 2000). But even then, there were no visible efforts to put health as an agenda for regional governance. The prominence of national-level over regional framework for health cooperation was largely due to two factors: one is the prominent role of the WHO as the global institutional body that is in charge of health issues and in developing health regimes. Until the mid-1990s, it was essentially the WHO that managed and coordinated health-related issues with national governments globally, including the ASEAN region. The other factor is the institutional arrangement that splits the membership of ASEAN states in the institutional structure of WHO. WHO's South-East Asia Regional Office (SEARO) brings together—Indonesia, Myanmar and Thailand; while its Western Pacific Regional Office (WPRO) groups the other seven ASEAN members. The dominant role of the WHO in global health issues as compared with the limited technical expertise of ASEAN in health, at least during the formative years after the organisation was established, meant that national sovereignty largely defined the nature of regional health governance (Stevenson and Cooper 2009; Lamy and Puah 2012). Thus, at best ASEAN played a passive role in regional health governance and the regional activities around health were mostly facilitative.

It was not until the outbreak of the SARS influenza in 2003 when ASEAN began to proactively institutionalise some form of regional framework to manage health issues. The region's experience has shown that viruses do not recognise any borders. And, as peoples' mobility is increasing in leaps and bounds, so too are the rising risks of transmission of communicable disease within and across borders. The SARS crisis therefore underscored the need for more vigilance and surveillance of disease outbreaks among ASEAN countries. More importantly, the crisis stressed the importance of instituting deeper regional cooperation—not only among health officials but also across different sectors and agencies of governments to combat the spread of infectious diseases.

As noted earlier, whereas health was implicitly framed as integral to development, it was the significant shift to framing health as a security issue that prompted the push for closer regional collaboration and cooperation in health. Many ASEAN leaders had framed SARS as an issue of national security issue. The 'securitisation' of health led ASEAN during the SARS outbreak to convene a special Health Summit between ASEAN leaders and Japan, China and South Korea to decide on a coordinated response to manage the spread of the disease and establish the necessary arrangements that addressed the related issues such as border controls and immigration (Caballero-Anthony 2005; Thomas and Curley 2004). Following the Summit, a number of key

ASEAN frameworks were established to monitor and respond to further pandemic outbreaks. These included the ASEAN Diseases Surveillance Network in 2003, the ASEAN Highly Pathogenic Avian Influenza Task Force and the ASEAN Plus Three Emerging Infectious Disease (EID) Programme, the ASEAN Partnership Laboratories, and the Field Epidemiology Training Network among others.

One would note that most of the current regional health security initiatives started off as responses to influenza outbreaks during their course from 2003 to 2009, which explains the high number of frameworks addressing emerging and re-emerging infectious diseases with pandemic potential, including but not limited to SARS (2003), H5N1 (2005–2006), H1N1 (2009) and H7N9 (2013)². Since then, a variety of mechanisms and networks have emerged to address different aspects of health security from regional surveillance and risk communication to capacity building. The frameworks include bilateral arrangements between ASEAN and its dialogue partners (e.g. Japan, China, South Korea). These are summarised in [Table 1](#) and mapped out in [Figure 1](#).

In sum, one would observe from the table and figure below that it took the language of ‘security’ to raise the urgency of institutionalising health governance in ASEAN. Clearly, ASEAN spent a lot of effort to develop several institutional arrangements to build regional capacity to prevent the outbreak and spread of infectious diseases. Health also began to feature in many ASEAN declarations and documents, most recently in the ASEAN Political and Security Community (APSC) and the Socio-Cultural Community (ASCC) Blueprints (ASEAN 2009).

Beyond securitisation

Over the last few years, a shift can be noted from the preoccupation on pandemic preparedness to a much broader approach to regional health governance. As reflected in its post-2015 ASEAN Health Development Agenda, more efforts are now being put to promote a more holistic approach to health security in Southeast Asia. ASEAN’s 2016–2020 health agenda incorporates the elements highlighted in the global SDGs more broadly, and in particular SDG goal 3 which is on good health and well-being. The health priorities outlined in its regional health cooperation agenda are clustered into four areas namely: (1) promoting healthy lifestyle, including prevention and control of NCDs, (2) responding to all hazards and emerging threats, (3) strengthening health system and access to health care and (4) ensuring food safety which includes access to safe food, safe drinking water and sanitation (ASEAN 2017a).

Table 1. Regional health frameworks and areas of cooperation.

Regional frameworks	Areas of health security cooperation			
	Emerging infectious diseases with pandemic potential	Infectious diseases: HIV/AIDS, malaria and tuberculosis	NCDs	Health systems strengthening
ASEAN-China	✓		✓	
ASEAN-Japan	✓		✓	✓
ASEAN-Korea	✓	✓	✓	✓
ASEAN Plus Three Health Cooperation Framework	✓	✓		
East Asia Summit	✓	✓		

Source: ASEAN Secretariat.

Figure 1. Regional frameworks on health cooperation in ASEAN. Source: ASEAN secretariat.

With the changing patterns of infectious diseases and burden of diseases, ASEAN's cluster approach presents a more comprehensive agenda aimed at translating these areas of cooperation into actionable programmes and policies in order to address multiple threats to health security. Cluster 2 on responding to all hazards and emerging threats is timely given the possibilities of outbreaks of new types of viruses such as Zika and re-emergence of highly pathogenic diseases like Ebola. Cluster 3 complements and provides critical support to cluster 2 as it aims to strengthen health systems to combat new health threats like AMR and improve means of implementation through the One Health Approach that engages other sectors beyond human health. Similarly, clusters 1 and 4 emphasise the seamless relationships between food security and nutrition, food safety and disaster health management and the importance of promoting healthy lifestyle. In sum, while ASEAN's evolving frameworks in regional health governance started out with a strong focus on security, particularly fighting pandemics and other infectious diseases, the more recent frameworks reveal a more expanded framing, using a plurality of frames to now include human rights, equity, protection, social welfare and justice (Amaya 2015:237–238, ASEAN ASCC 2009).

The goal of institutionalising UHC and addressing NCDs are indeed important given that despite the rapid economic growth that ASEAN countries enjoy, there remain wide economic disparities among ASEAN countries and within its own population that significantly impact on peoples' health security. The institutionalisation of UHC is certainly considered as a means to reduce the impact of income disparities across the populations in the region that seriously hinders their access to health care. Indonesia, for example, rolled out one of the world's largest single-payer health care programmes in 2014, which expanded to guarantee comprehensive health insurance for 165 million citizens and residents by 2016 (Emont 2016).

UHC has also gained global momentum in recent years in the wider East Asian region with China and India undertaking this relatively new wave of government-funded programs for health care. Despite the criticisms of its implementation such as the lack of access to quality health care and lack of qualified health personnel, the idea of UHC is now gaining more traction as governments face up to their fundamental obligation to protect people's health and address different health problems (Ahoobim et al. 2012).

Similarly, the current attention to NCDs is timely given the rapid demographic changes seen globally. For instance, a recent study published by the Council on Foreign Relations in 2017 notes that countries with the fastest increase in NCDs are the least prepared, most of which are poor and developing nations found in Asia such as Vietnam, Bangladesh, India, Pakistan, Indonesia, Philippines and Myanmar (Bollyky and Shendruk 2017). Despite this, one notes that external support continues to be skewed towards containing the spread of infectious diseases and addressing pandemics, as only 2% of overall global health aid goes to addressing NCDs despite making half of the entire global burden of disease (Bollyky and Shendruk 2017). Laurie Garrett further notes that most NCDs continue to be left out from UHC schemes today despite their rising numbers (Garrett 2012, 12).

The notable emphasis on NCDs was seen during the 13th ASEAN Health Ministers Meeting (AHMM) held in September 2017, where ASEAN health ministers and heads of delegations reiterated the primary concern over the increasing cases of NCDs in South-east Asia, particularly obesity and diabetes. Health officials called for the need to institute more interventions and promote best practices, while putting more effort in preventing risk factors and to promote health through the delivery of relevant health services. Some ASEAN countries such as Malaysia, Singapore and Brunei have already been reported to put a lot of effort in tackling NCDs (Ismail and Koh 2014; Mustapha et al. 2014; Choo 2018a, 2018b).

Regionally, ASEAN has also recently been promoting the notion of ‘culture of prevention’. Vongthep Arthakaivalvatee, Deputy Secretary-General of ASEAN Socio-Cultural Community (ASCC), highlighted the importance of fostering this ‘culture of prevention’ and stressed the fundamental role of the region’s health sector in building this norm to achieve health security for the peoples in the region. Consequently, the ASEAN Declaration on Culture of Prevention (CoP) for Peaceful, Inclusive, Resilient, Healthy and Harmonious Society was soon after adopted by the Member States during the 31st ASEAN Summit held in Manila on 13th November 2017 (ASEAN 2017b). Additionally, the CoP was further emphasised at the 19th Meeting of the ASEAN Socio-Cultural Community on 21st March 2018, where Ministers discussed strategic issues on the development of preventive policies and programmes to address poverty, gender inequality, racial and religious discriminations, lack of access to education and employment opportunities, lack of access to a sustainable, safe and clean environment, as well as deprivation of physical and mental well-being—key issues deemed as obstacles to sustainable development (ASEAN 2018).

The introduction of ASEAN’s ‘culture of prevention’ approach to health security is a significant development, particularly if viewed from the perspective of the broader regional approach to security. Since the adoption of the notion of ASEAN Community in 2003, anchored on the three pillars of political and security community, economic community, and socio-cultural community, security has always been framed in a comprehensive manner. More recently, ASEAN’s *Vision 2025* envisions a regional community that is ‘... [an] inclusive community in which (our) peoples enjoy human rights, fundamental freedoms and social justice, live in a safe and secure environment with enhanced capacity to respond effectively to emerging challenges ...’ (ASEAN 2016, 1). Such framings are indicative of ASEAN’s preference for a broad, multi-faceted approach to security that have been consistently taken in dealing with all types of security challenges—both

traditional and non-traditional. The extent to which this has been implemented, however, remains to be seen.

Filling in the gaps

While ASEAN's health agenda may indeed be comprehensive, there remains concerns about the capacity of individual countries to deal with emerging health threats. That questions are raised about the abilities of ASEAN states to deal with new health challenges reflect the nature and complexities of emerging health threats: one is the rising incidence of climate-related health threats, and the other is the growing threat of AMR. More importantly, these new types of health challenges bring to the forefront the need to re-examine the modalities of regional health governance in ASEAN.

Climate-related health threats

In a recent UN FCCC report entitled, *Human health and adaptation: understanding climate impacts on health and opportunities for action*, health and climate change experts highlighted how climate change can exacerbate health problems that already pose a major burden to vulnerable populations—children and elderly, pregnant women, the socially marginalised (to include poorest of the poor, indigenous groups, refugees), and those with existing health conditions like HIV (UN FCCC 2017). According to the report, the socioeconomic costs of health problems for these vulnerable groups are considerable. The report further noted that heatwaves can severely impact working conditions, increasing the risk of cardiovascular, respiratory and renal diseases. Moreover, human displacement caused by climate and weather-related disasters are expected to increase significantly, which in turn results in higher socioeconomic costs and affects mental and physical health. With the visible impacts of climate change already felt in the region, this would make for more compelling reasons for ASEAN countries to re-assess current health frameworks and put more effort in boosting capacity of health systems in line with climate adaptation and mitigation strategies done in other sectors. In fact, the WHO in 2014 had already identified strengthened public health services as one critical component in the building blocks of climate-resilient health systems.

This agenda is particularly challenging for most countries in the region that are still struggling with healthcare delivery, access and affordability, especially for the poorer and more vulnerable segments of the population. With these realities, it is hard to tell whether existing health systems are in fact ready and robust enough to withstand potential health fallout of the changing climate. Despite the comprehensive nature of ASEAN's post-2015 health agenda, it is interesting to note the absence of climate change in ASEAN's 4-clustered agenda. While concerning, one can argue that this is not really surprising given that climate change work puts a lot of emphasis on adaptation and mitigation, and often require modelling of future projections and scenarios. In this regard, within the context of being 'climate-ready/prepared', it is therefore logical to pay more attention now to the status of national health systems of respective ASEAN states and how this can further impact on regional health security. When it comes to adaptive capacity of the health sector, the WHO has in fact already stressed that 'strengthening a well-known and well-tested public health and health service interventions such as public education,

disease surveillance, disaster preparedness, vector control, food hygiene and inspection, nutritional supplementation, vaccines, primary and mental health care, and training' (WHO n.d.) will enable protection from the impact of climate change on health.

In assessing whether regional health frameworks are adequate to respond to climate-related health issues, a good starting point is to examine the performance of national health systems. The 2005 International Health Regulations (IHR) has specified 13 core competencies to assess the capacity of health systems³. In the 2017 World Health Statistics Report (WHO 2017b, 73), ASEAN members generally reported optimistic measures of their average IHR core competency between 2010 and 2016, as follows: Malaysia (100), Indonesia and Singapore, Vietnam (99), Thailand (98), Brunei Darussalam (92), Philippines (87), Myanmar (84) Lao DPR (75) and Cambodia (55). On paper, the scores suggest that their respective health systems are relatively strong. Despite the scores, however, other studies point out that health systems in more countries in the region are still struggling with healthcare delivery, access and affordability, especially for the poorer and more vulnerable groups (Chongsuvivatwong et al. 2011). It is therefore hard to accurately tell whether existing health systems are in fact ready and robust enough to withstand the potential health impact of a rapidly changing climate. Building robust health systems is particularly important to the health and human security of many vulnerable communities in the region that are already facing the burden of diseases, and which are expected to be compounded with the multiple impacts brought on by climate change.

The fight against AMR

The importance of having in place robust health system in ASEAN countries becomes even more critical in the global fight against AMR. Given the complexity of the health threat and the interconnectedness between animal health, human health and agriculture, being able to achieve a more holistic, collaborative intersectoral approach requires a strong foundation of a country and the region's public health systems.

Following the United Nation's General Assembly (UNGA) meeting on AMR on September 2016, where all UN members unanimously committed to addressing AMR, ASEAN developed the 'ASEAN Regional Strategy on Antimicrobial Resistance Communication and Advocacy' in October that year. The regional strategy was subsequently adopted in September 2017 at the 39th ASEAN Ministerial Meeting on Agriculture and Forestry (ASEAN and UN FAO 2017). The regional strategy highlighted the lack of awareness within the region, across government, animal health specialists, producers and traders, on AMR. It also noted that 'there has been no systematic studies undertaken in the Southeast Asian Region to understand antimicrobial use or extent of antimicrobial resistance' (ASEAN and UN FAO 2017). Based on a report by the UK government, though, the death toll in Asia could increase to 5 million annually by 2050, making up half of the global estimate of 10 million annually and a 100 trillion USD 'cost of inaction' (O'Neill 2016).

As per ASEAN practice, the grouping set forth a vision, of 'An ASEAN community promoting and practicing responsible and prudent use of antimicrobials. Prudent use of antimicrobials and good farming practices contribute to slowing antimicrobial resistance in ASEAN' (ASEAN and UN FAO 2017). Components include technical activities ('To design and implement evidence-based communication and advocacy activities'),

awareness and education programmes (“To raise awareness by fostering knowledge exchange and understanding of AMR among key stakeholders”), networking collaboration (“To strengthen cooperation and collaboration among AMS in promoting prudent use of antimicrobials”) and resource mobilisation (“To ensure a sustainable and efficient approach to AMR education, communication and advocacy.”). The primary responsibility is given to members of the ASEAN Communication Group on Livestock (ACGL) and the ASEAN National Focal Points on Veterinary Products (ANFPVP) (ASEAN and UN FAO 2017). Over a two-year period after being adopted by the ASEAN Sectoral Working Group on Livestock, the strategy sought to align with the 38th ASEAN Ministers of Agriculture and Forestry’s call to action on AMR, to be implemented by each ASEAN member state according to its current cultural and political norm, and with openness to technical assistance from international partners. A logical framework is also to be developed for monitoring and evaluation (M and E) purposes.

By November 2017, the ‘ASEAN Leaders’ Declaration on AMR: Combating AMR through One Health Approach’ was adopted in Manila (ASEAN 2017c). This called for ASEAN member states to formulate and execute national plans aligned with the one health approach. (ASEAN 2017c). An important aspect of the November 2017 ASEAN Leaders’ on AMR declaration is the recognition that ‘that the scale of the AMR situation extends beyond public health with socio-economic and environmental health impacts which threatens global health security and the achievement of the Sustainable Development Goals (SDGs)’, and its demand for ‘urgent, concerted, multi-sectoral and multidisciplinary collaboration at the national, regional and global levels’. This led to specific recommendations, pertinent among which involve formulating and executing national plans in line with the One Health approach, that includes comprehensive multi-sectoral responsibility and governance and effective monitoring and evaluating mechanisms (ASEAN 2017b, 1).

Among the means for achieving these include: awareness and advocacy (echoing the October 2016 ASEAN Regional Strategy on Antimicrobial Resistance Communication and Advocacy) and training and education programmes. Towards ‘(ensuring) equitable, timely and sustainable access to safe, efficacious, affordable and quality antimicrobials, environmental management of antibiotic residues and impacts’, it also declared commitments to strengthening regulatory systems, pharmaceutical and food supply chain management, health financing mechanisms, and agricultural value chain management (ASEAN 2017b, 2).

On the healthcare side, the regional strategy also echoes the global objective of greater antimicrobial stewardship. It seeks to ‘(implement) antimicrobial stewardship programs and infection prevention, control and treatment measures at all levels of healthcare and the community’ (ASEAN 2017b, 3) to reduce disease burden, and in a related manner, moving towards requiring prescriptions before being able to access antibiotics. On veterinary practice, the Declaration also called discouraged use of antibiotics for growth promotion purposes, in the absence of risk analysis.

An overarching recommendation, regardless of sector, was to have greater capacity for integrated surveillance and monitoring of AMR, the consumption and use of antimicrobials, and drug residues, and to promote research (ASEAN 2017b, 4). Equally important is the need to strengthen regulatory capacity, and this hinges on research on AMR’s impacts. The responsibility for this was placed on the ASEAN Health Ministers Meeting, with

support from the Senior Officials Meeting on Health Development as well as related subsidiary bodies and sectors ‘to develop and monitor the implementation of the ASEAN strategic plan to combat AMR’ (ASEAN 2017b, 4).

To what extent has ASEAN complied? Since the adoption of a massive workplan in 2016, and based on self-assessment reporting, none of the ASEAN countries had completed the rather complex process of having in place a multi-sectoral national AMR action plan, with funding sources identified, implemented and with monitoring capacity. Although four countries were seen as being ahead, in particular, Cambodia, Malaysia, Philippines and Singapore, with multi-sectoral AMR action plans that meet the requirements of the Global Action Plan objectives, the rest of the ASEAN members lag far behind. See Table 2 below.

Based on available reports, progress on AMR preparedness in ASEAN is uneven with member countries reporting progress in different areas. Vietnam was highlighted for its commitment to stop the use of antibiotics in animal feeds by 2018, and to ban its use for livestock altogether by 2020. The Philippines also drew praises for its launch of its One Health-based National Action Plan in November 2015. Thailand has also developed its national strategic plan in end-2015, endorsed by the government in August 2016 after consultation with ‘several hundred stakeholders’. Malaysia, on the one hand, has convened a National Antimicrobial Resistance Committee (NARC in March 2017, under a national framework referred to as ‘Malaysian Action Plan on Antimicrobial Resistance (MyAP-AMR) 2017-2021’ (Ministry of Health and Ministry of Agro-Based Industry, Malaysia 2017). Singapore has also launched its national action plan on National Strategic Action Plan on AMR in 2017, emphasising five core strategies to implement: education; surveillance and risk assessment; research; prevention and control of infection; and optimisation of antimicrobial use. Multisector collaboration among relevant ministries have also been outlined (Ministry of Health et al. 2017).

But the rest of the ASEAN members have not gone beyond organising meetings on AMR awareness (UN FAO 2017). In Myanmar, for instance, signs of plans being put into action include a document from the Ministry of Health’s website likewise showing that a SWOT analysis has been conducted, which notes the challenge of insufficient public awareness, segment surveillance systems, and insufficient resources for implementation. The study also shows national studies being done to develop profiles of which antimicrobial agents are susceptible to AMR (Tin 2018). In brief, one can observe that regional

Table 2. 2016 Self-reporting by ASEAN countries, on 5.1 country progress with development of a national action plan on AMR.

A—No national AMR action plan.	Brunei Darussalam
B—National AMR action plan under development or plan involves only one sector or ministry.	Lao People’s Democratic Republic
C—National AMR action plan developed that addresses human health, animal health and other sectors.	Indonesia Myanmar Thailand Viet Nam
D—Multi-sectoral AMR action plan approved that reflects Global Action Plan objectives, with an operational plan and monitoring arrangements.	Cambodia Malaysia Philippines Singapore

Source: WHO, FAO and OIE (2018).

response has been fragmented with ASEAN countries implementing it at their own pace and with the less developed countries lagging far behind. Clearly, more work has to be done to get the region to work collectively in order to scale up preparedness in dealing with complex health risks. To a large extent, the pace at which the region is moving towards addressing the AMR challenge reflect either lack of prioritisation at country-level, and/or that the complexity of the issue requires new modes of national and regional collaboration which are relatively new to ASEAN practices.

Conclusion

ASEAN has come a long way in developing its regional mechanisms to deal with health issues. Through its various regional health frameworks, ASEAN has been relatively successful in dealing with several cases of infectious diseases such as H5N1 and SARS. The shift from a largely security-focused approach to regional health governance to one that includes development and human security concerns of equity, protection and justice reflects ASEAN's recognition that regional health security is not only about preventing outbreaks and spread of infectious diseases but also about ensuring peoples' well-being and safety.

Moving forward, the immediate tasks to improve regional health governance is to be more proactive in mainstreaming climate change related issues in the agenda of health cooperation among ASEAN members. This requires greater efforts both at the national and regional level to strengthen public health systems. This means that at the ASEAN level, there should be more time and resources invested in helping build the capacity of public health systems of ASEAN countries that are in need of support. One could argue however that the tasks of building capacity and improving health systems should not only be limited to states. Given stretched resources and the multiple demands on state action, ASEAN must be able to tap on the resources of non-state actors and the private sector in order to provide quality health care and inclusive access to health provision.

Moreover, the global health security agenda on prevention, detection and ability to respond further necessitates stronger health systems at the national level to address the gaps in regional pandemic preparedness and other health emergencies. Building on the existing frameworks of cooperation, this is now an opportune time for ASEAN to re-examine current regional modalities in information and data sharing arrangements with the aim of further improving disease surveillance and regional response. But in order to take these initiatives forward, sustained funding for building more capacity in scientific and technical expertise, laboratories and diagnostics, and training of more qualified healthcare workforce among others need to be addressed. Targeted assistance in capacity building inevitably requires more transparency in dealing with national level constraints so appropriate intervention at the regional level can be done. In this regard, the extent to which the norm of non-interference in domestic affairs must be upheld would need to be recalibrated. Similarly, a timely review of the modalities of decision-making processes and implementation would be critical if a more collaborative and integrated regional health governance framework were to be achieved.

Attending to all these issues underscore the fact that one cannot simply push ahead with more robust regional health governance without confronting the normative impediments to closer regional cooperation. Certainly in the case of ASEAN, this challenge must

be addressed in tandem with that of strengthening health systems if the region were to be equipped to deal with emerging health challenges ahead and truly evolve into a people-centred regional body.

Notes

1. For the literature on norms, see among others, Finnemore and Sikkink (1998, 243–244), Fukuda-Parr and Hulme (2009) and more recently, Davies, Kamradt-Scott, and Rushton (2015).
2. This trend has also been noted by Fidler (2013, 208) when he identified infectious diseases, HIV/AIDS, SARS, avian influenza and H1N1 as examples of health cooperation issues in APEC and ASEAN.
3. 13 core capacities defined by the WHO International Health Regulations (IHR) include: (1) National legislation, policy and financing; (2) Coordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; (13) Radionuclear emergencies. Countries self-assess their implementation and report their scores (WHO 2017b).

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