UNISCI Discussion Papers

SARS: NEED FOR SECURITY PRIORITY*

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While the threat of Severe Acute Respiratory Syndrome (SARS) continues to spread across the globe, many countries have been bracing themselves to cope with one of the worst health epidemics that have hit several parts of the world. To date, SARS has spread to 28 countries with 7, 864 infected cases and 642 deaths. With no known cure in sight, medical teams have been working feverishly to contain the problem as the clock ticks away with more reported casualties, while government authorities have been deploying various strategies to cope with the silent killer.

In the Asian region, hard-hit Asian governments have quickly set in place mechanisms to prevent further the spread of the disease.These mechanisms ranged from quarantine of infected patients including their families and friends who may have had close contacts with them, issuing travel advisories to SARS-affected countries, strict immigration checks and border controls, massive public information programme and even closure of schools. Singapore, one of the badly hit countries in Southeast Asia, has been commended for its hands-on, pro-active approach in containing the disease—even to point of adopting stringent quarantine measures labelled by some media as "draconian". Within a month after the outbreak of the disease in the Southeast Asian region, Singapore also prompted its neighbours in ASEAN to convene a special meeting of ASEAN + 3 Health Ministers (which would also include Health Ministers of Korea, Japan and China) and ASEAN Heads of Government to discuss regional mechanisms to deal with the crisis. The meetings were held in the ASEAN capitals of Kuala Lumpur and Thailand, respectively at the end of April 2003.

But while Singapore and the other affected countries were prompt to act, some were not. China, for example, had been severely criticised for initially playing down the seriousness of the problem and its delayed response. In particular, in what seemed to be the height of the outbreak, China was censured for its slowness to respond to the request by the World Health Organisation (WHO) to allow its medical team to go to Guangdong where the infectious pathogen was said to have started. In a press statement in mid-March, WHO's Director-General, Gro Harlem Brundtland, confirmed opinions that had the Chinese authorities acted earlier and with more openness, the outbreak of the disease would have taken a different course.

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China's belated response has been perceived as due to the authorities' concern about economic fall-out if the information about SARS is leaked. But the slow process of silence-denial to acknowledgement and cooperation is not really surprising given the prevailing attitude towards infectious diseases. Most, if not all countries—China included—treat infectious diseases as medical problems, thus receiving/meriting a medical response. The fact that it apparently took four-and-a half months after the first known case of SARS before the Chinese authorities alerted the WHO is reflective of this kind of conventional approach. The delay was reportedly due to bureaucratic procedures to first classify SARS as a Category B disease and only then would local health authorities be required to report this to the central government. Yet, there still remained the problem of how to handle this type of disease, i.e. whether this would fall under the framework of the International Health Regulations (IHR) wherein reporting of infectious diseases becomes imperative.

The IHR, which was introduced by the WHO in 1969 and later revised in 1981, is a global disease surveillance system which require member states to notify WHO within 24 hours of outbreaks of infectious diseases. The WHO, however, does not have any enforcement power and instead relies mostly on persuasion and recommendation to encourage countries to comply. Moreover, the present IHR covers only 3 diseases—cholera, yellow fever and plague and does not cover all other emerging or re-emerging infectious diseases that may have potential for international spread. Given the shortcomings of this system and the lacunae of multilateral arrangements to deal with global health emergencies, the lack of coordination at both local and national level in alerting the international community comes as no surprise. Yet the consequences can be severe if these are not addressed. There are several factors that account for these shortcomings, two of which are highlighted below.

- *Attitudes and Approaches*

As noted earlier, infectious diseases have been conventionally regarded as medical problems. But in a rapidly changing global environment, the threats brought on by infectious diseases are no longer confined to medical/health risks alone. With the outbreak of SARS, the disruption of business activities, its impact on travel and tourism industries and more importantly—on economic growth are among the serious repercussions that necessitates defining the SARS problem in strategic terms.

The SARS outbreak has already hit many economies hard across the region. Three months after the reported outbreak, national and regional growths are now under threat as tourism and other travel related industries have taken a nosedive. Estimates of the financial cost of SARS have varied, from a conservative figure of US$30 billion according to the WHO to US$50 billion and to a high of US$150 billion globally. As one Asian analyst, Gurinder Shahi of the BioEnterprise Asia, has noted in the 24 April 2003 edition of the Far Eastern Economic Review, the figures of US$150 billion are only "back-of-the envelopes" figures and are likely to be gross underestimates. Thus, the SARS that has hit the Asian region is now regarded as the region's own "September 11" and the aftershocks of such episode are still unfolding.

It has been noted that with globalisation, the scale, speed and reach of movement of people and goods have been unprecedented. These movements in turn have shaped the appearance, spread and distribution of infectious diseases not just in humans but also in

animals and other species. The SARS case is instructive. There are speculations that the infectious pathogen may have come from an animal (e.g. chicken) and has managed to get into humans. In a densely populated Chinese province of Guangdong where human and animal contact is extremely close, transmission and spread of infection is much more rapid while containment of the disease becomes more difficult. Compounded by the massive movement of people in and out of China and the ease of international air travel, the reach of the SARS disease to cover more than 28 countries is not unexpected. Meanwhile, other countries are bracing themselves for the possibility that the virus could reach their community. Indeed, in a globalised world, no community can be entirely immune from these contagious diseases.

SARS is certainly not the first case that illustrates the nexus between movement of people and goods with the nature and spread of infectious diseases. Much has already been said and written about the HIV/AIDS pandemic and threats associated with it. But it bears reiterating that there is still a wide gap between the extent of the HIV/AIDS threat and an adequate and cohesive international action. Within a few years after its discovery, HIV/AIDS had spread to every continent and to every country. So far, 25 million people have died of AIDs and the about 3 million people a year continue to succumb to the disease. In Asia, the current statistics paints an alarming picture: UN estimates for example have noted that China has about 1 million AIDS cases, while in India about 4 million people are reported to have been infected with the HIV virus; by 2010 China could have more than 10 million HIV/AIDS patients while in Cambodia more than half a million of the country's 11.5 million population will suffer or either die from AIDS. These grim scenarios do not include the death toll from other infectious diseases like tuberculosis (TB) and malaria which kills about 3,000 people daily.

In 2000, the United Nations Security Council declared AIDS as a national security threat, followed by similar political endorsements at the G-8 meetings in Okinawa and Genoa. But despite these initiatives, AIDS, tuberculosis, malaria and now SARS are still seen by many countries as health diseases/problems, not as human security threats. It is interesting to recall that when the United States first pushed for HIV/AIDS to be discussed in the Security Council, many nations protested for procedural reasons—many felt that the Security Council was not the appropriate forum for what are perceived as "social and economic issues". However, unless the linkage between infectious diseases and human security is recognised, most countries will still "medicalise" infectious diseases like SARS rather than "securitise" them until the outbreak of the disease(s) reaches alarming proportions. The experience of Sub-Saharan Africa with AIDS reveals that the socio-economic and political effects are more devastating than the effects of war.

Thus, going beyond the medical approach to securitising infectious diseases must become more of a norm rather than an exception. In the case of SARS, this requires more than official pronouncements that SARS is a national security issue. An integrated approach with the participation of various ministries, government agencies and the medical sector in coping with SARS is an important step. Singapore has adopted such an approach while others like Malaysia, Indonesia, the Philippines and Thailand have followed suit.

- *Iceberg of Poverty*

While the linkage between infectious diseases and human security has been forcefully validated by the SARS outbreak, understanding the risks and vulnerabilities posed by infectious diseases is just the tip of the iceberg. There are underlying challenges that also need to be addressed to cope with the threats of infectious diseases. These are the absence and/or lack of basic health care and the poor health infrastructure. These types of health environment are prevalent in many developing countries.

Yet, the most vulnerable to infectious diseases are the poor who are clearly at a disadvantage in protecting themselves. The burden of HIV/AIDs for example, is overwhelmingly concentrated among the people in the poorest regions of the world. One just has to look at the typical health-seeking behaviour among the poor to see why this is so. They resort either to non-treatment or self-treatment in case of illness. Such patterns are not surprising considering that the financing of health care for the poor comes mostly from their own meagre resources, thus a traditional method of cure frequently is sought first, and more often than not, referrals to tertiary health facilities are made at very late stages.

Poverty and infectious diseases are fellow travellers—each feeding on the other. The risks of poverty-related diseases are compounded by malnutrition and environmental threats, especially the lack of clean water and sanitation. Add in crowded conditions and poor hygiene, these become perfect breeding grounds of infectious diseases.

Strategies for Protection and Empowerment

Coping with infectious diseases therefore requires multi-dimensional responses. Among the imperatives is the importance of building a good mechanism for global disease surveillance and control. The Global Outbreak Alert and Response Network was initiated by the WHO in 1997 and maintained by Health Canada. It has a network of 100 existing laboratory and disease reporting systems. However, for this to be successful, cooperation at both local and national level is crucial. For new infectious diseases like SARS that has several unknowns in epidemiology and treatment—the race to discover these things requires multilateral coordination at many levels. But as discussed earlier, the problem is not simply one of getting countries to cooperate. Unless certain mindsets and attitudes are changed to regard infectious diseases as more than a health problem, it would be difficult to get certain governments to act promptly and decisively. As we have seen in the case of SARS in China and more recently in Taiwan, mismanagement of health crisis can destroy the credibility of governments.

It can therefore be argued that health issues are too important to be left solely in the hands of medical professionals and bureaucrats. Hence, health must be a security priority at all levels. But health matters, as noted by an ASEAN bureaucrat, have always been regarded as belonging to national domains. However as illustrated in the SARS unfolding episode, governments must be made accountable to both the local and international community in ensuring health and security. The globalisation of health risks also means that leadership must be exercised by the United Nations with the support of the global public. Reducing health threats to security will therefore require comprehensive cooperation among diverse actors and nations.

The other equally important issue is the need to develop the public health system, especially among the poorer communities who are the most vulnerable. The greatest paradox of our times is that given the world's existing knowledge, technologies and resources, more than 40% of 56 million deaths annually are avoidable. The WHO Commission on Macroeconomics and Health has reported that of the 17.7 million people who die every year from infectious diseases, about half could actually be saved had basic health care been provided. The study goes on to highlight the fact that the way to save lives in the future is not dependent on discoveries today but more about "getting the basics right, e.g. getting tetanus shots for children…and providing safe drinking water for more villages." Perhaps this situation is best encapsulated in the remark of a Cambodian physician who said that the "in our country, the real killers are poverty, ignorance, fear and corruption…disease just administers the coup de grace."