2 Countering Emerging Infectious Diseases and COVID-19

The Development of ASEAN's Institutional Arrangements and International Cooperation

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Abstract

This chapter argues that ASEAN's mechanisms to tackle emerging infectious diseases (EIDs) have been developing gradually since the declaration made at the ASEAN Health Ministers Meeting (AHMM) in 1980. While the 2003 SARS crisis significantly enhanced ASEAN's cooperation to counter EIDs, ASEAN had already laid a foundation for such cooperation before 2003. This chapter shows that ASEAN has tended to focus on the regional rather than global level due to a lack of financial and technical resources and ASEAN's long-standing institutional norms. The recent intensification of great power rivalries, particularly between the United States and China, means that relying on external actors for medical support would entrap ASEAN in great power politics. As such, ASEAN needs to make efforts to build its capacity to respond to EIDs.

Keywords: emerging infectious diseases (EIDs), ASEAN, regional cooperation, SARS, COVID-19, institutional norms

1 Introduction

The Association of Southeast Asian Nations (ASEAN) was established in 1967 as a multi-purpose regional institution that facilitates social, economic, and political cooperation in Southeast Asia. Despite the severe regional strategic environment during the Cold War era, when great powers competed with

each other for influence in the region, ASEAN was able to maintain its relative autonomy and promote economic development by strengthening intra-ASEAN cooperation in a comprehensive manner (Acharya 2014, 43-78; Koga 2017, 28-76; Emmers 2018, 349-370).

ASEAN's areas of cooperation include health cooperation. This is because ASEAN has a 'comprehensive' concept of security, which not only focuses on the military but also the economic and social aspects of security. The approach aims to support ASEAN member nations' socio-economic development to increase their domestic regime security, which can also contribute to regional security through the enhancement of national stability (Emmers 2009, 161-163). However, health governance mechanisms have been underdeveloped in ASEAN. Given its limited resources, ASEAN has consistently needed to prioritize some issues over others. Health was not top of the organization's agenda in its nascent days. During the Cold War era, ASEAN made little effort to advance health-related cooperation or to create a mechanism that could manage regional health issues.

This trend somewhat reversed in the post-Cold War era, particularly after the start of the new millennium. The end of the strategic rivalry between two global superpowers generated globalization, which facilitated the economic and social interconnectedness and increased the salience of transnational security issues. These trends contributed to a shift towards ASEAN placing greater attention on health cooperation. Further, the emergence of severe acute respiratory syndrome (SARS) in Southeast Asia in 2003, which had a serious negative socio-economic impact on different ASEAN member nations, facilitated regional health cooperation. During the 2003 SARS outbreak, national governments in the region, the World Health Organization (WHO), and epistemic communities securitized health issues and facilitated the creation of regional cooperation programs (Caballero-Anthony 2018, 61-66). However, the development of ASEAN's health governance mechanisms did not occur overnight. Instead, it was a gradual process through which ASEAN created its own mechanisms, enhanced its communication links with international organizations, and facilitated regional cooperation.

This chapter argues that ASEAN's emerging infectious disease (EID) mechanisms have been developing gradually since the declaration made by the ASEAN Health Ministers Meeting (AHMM) in 1980. While the SARS outbreak significantly enhanced ASEAN's cooperation to counter EIDs, ASEAN had laid a foundation for such cooperation before this, and it continued to develop the cooperation afterwards. ASEAN created institutional linkages with the WHO in 1997. It also institutionalized regional cooperation mechanisms after the 2009 H1N1 outbreak.

Furthermore, ASEAN has tended to focus more on cooperation at the regional rather than global level. This is due in part to a lack of financial and technical resources and ASEAN's long-standing institutional norms, such as the non-interference principle. Regional states are more familiar with these institutional principles and norms – the so-called 'ASEAN Way' – and have significant interests in its aims of increasing regional economic and security stability. The recent intensification of great power rivalries, particularly between the United States and China, means that relying on external actors for medical support would entrap ASEAN in great power politics. As such, ASEAN needs to make efforts to build its own capacity to respond to EIDs.

This chapter is divided into three sections. The first section outlines the three phases seen in the development of ASEAN's health governance, which were caused by three pandemic shocks, namely SARS in 2003, H1N1 in 2009, and COVID-19 in 2020. The second section examines ASEAN's global, regional, and national level cooperative frameworks, highlighting the salience of regional frameworks. The third section discusses the future implications of ASEAN's management of COVID-19, analysing the extent to which it can facilitate regional cooperation amid the ongoing strategic confrontation between the US and China.

2 The Development of ASEAN's Health Governance

ASEAN's health governance efforts were initiated during the Cold War. In fact, since the organization first made a declaration about health governance at the second AHMM in 1980, ASEAN has gradually consolidated its health-related institutions (ASEAN 1980a). One of the main aims of ASEAN when it was established was to further socio-cultural development in the ASEAN region. It was believed that this kind of domestic development would contribute to the enhancement of 'self-reliance and self-determination' (ASEAN 1980b). Functional cooperation, such as exchanges of 'information, experience, and expertise' and 'identification of specific regional projects,' was thus endorsed as a first step of institutional development on health (ASEAN 1980b).

In the 1990s, ASEAN also strengthened its ties with global health institutions. Most notably, ASEAN signed a Memorandum of Understanding (MOU) with the World Health Organization (WHO) in 1997 (ASEAN, 1997). One of the most important reasons for concluding such an MOU was because the member states included in the different WHO regional offices do not correspond with the member states of ASEAN. Specifically, the WHO's

Regional Office for South East Asia (SEARO) includes Indonesia, Myanmar, and Thailand. However, seven other ASEAN member states belong instead to the WHO's Regional Office for the Western Pacific (WPRO). Because these different geographical demarcations would create redundancy and inefficiency, the memorandum signed by ASEAN and the WHO was an attempt to ensure policy coordination among these groupings.

Admittedly, ASEAN's institutional consolidation did not go smoothly. After the second ASEAN Health Ministers Meeting was held in 1980, it then took sixteen years to hold the next three ministerial meetings. The third meeting was held in 1984, the fourth in 1991, and the fifth in 2000 (ASEAN 1991). This demonstrates the relatively low priority placed on health by ASEAN. However, this trend changed in March 2003, when SARS spread in Southeast Asia, disrupting economies and societies in the region. Since then, the development of ASEAN's health governance has moved forwards in three phases; these were prompted by the outbreaks of SARS in 2003, H5N1 in 2005, H1N1 in 2009, MERS in 2012, and COVID-19 in 2020.

First Phase: *Ad hoc* Responses

The first phase started in 2003, when SARS emerged in Southeast Asia. Its economic impact was significant, albeit short-term. For example, the number of tourists and visitors to Malaysia, Thailand, and Singapore dropped by approximately 30% between March and May 2003. This affected various business sectors in the countries and cost around US\$40 billion (Barua 2020; Caballero-Anthony 2020, 222). In response to this, ASEAN began to seriously discuss its coordinated responses to the pandemic. However, at this time ASEAN lacked financial resources, expertise in countering EIDs, and medical infrastructure to implement measures that could cover all of Southeast Asia. As a result, ASEAN began to coordinate its policies and operations with external actors.

ASEAN explored utilizing two institutional frameworks: the ASEAN Plus Three (including ASEAN members, namely Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Singapore, Vietnam, Thailand, with China, Japan, and South Korea) and the ASEAN-China framework. Given the geographical proximity and deepening economic interconnectedness of states in these two cooperation frameworks, their interests were relatively congruent. The ASEAN Plus Three (APT) framework was a particularly useful tool for ASEAN to receive external assistance because the framework included the regional economic powers of Japan and China. Indeed, in April 2003, soon after the SARS outbreak, this group

held a special meeting. The states involved issued a joint statement calling for a coordinated work plan, namely the ASEAN Disease Surveillance Net and the ASEAN Epidemiologic Network (ASEAN 2003a). In 2004, the group created the APT Emerging Infectious Diseases (EID) programme to discuss effective surveillance capacity as well as early warning and rapid response mechanisms (ASEAN 2006). ASEAN and China also held a meeting and issued the Joint Statement of the Special ASEAN-China Leaders Meeting on SARS. Both actions aimed to coordinate measures taken to counter SARS by exchanging information, creating a 'hotline' network, and facilitating research collaboration (ASEAN 2003b). However, the two initiatives were not entirely successful. Their shortcomings stemmed from a lack of general institutional mechanisms. The cooperation of the APT and ASEAN-China frameworks only facilitated *ad hoc* responses to SARS. These mechanisms did not create longer-term institutions to tackle EIDs.

The trend for limited cooperation on tackling infectious diseases persisted in East Asia (geographically covering both Northeast Asia and Southeast Asia) because not all regional states were equally negatively impacted by SARS. Admittedly, EIDs were seen as a regional issue to some degree. For example, participants in the East Asia Summit (EAS) in 2005, including three APT members, Australia, India, and New Zealand, expressed their concerns about the emergence and the spread of the H5N1 virus, also called Avian Flu (ASEAN 2005). As a result, the summit created five priority areas for regional cooperation which included avian flu. However, EIDs were also considered sub-regional specific issues. It was not until the sixth East Asia Summit in 2011 that the scope of EID management was broadened. This modified the objective to 'enlarge cooperation in the fight against avian flu to encompass broader global health issues and pandemic diseases' (ASEAN 2011). In this sense, ASEAN-led organizations were not compelled to create a general framework to tackle infectious diseases in the first phase.

Second Phase: Institutionalization

The second phase began around the year 2009, as the frequency of infectious diseases affecting the region was gradually increasing. After experiencing SARS in 2003, and then H5N1 in 2005, Southeast Asian states faced a novel influenza H1N1, also called Swine Flu, in 2009 (CDC 2009). In 2013, the Middle East Respiratory Syndrome (MERS) coronavirus emerged. Then in 2015, South Korea faced a MERS outbreak which also created fear across the region (CDC 2015; WHO 2015). The series of pandemics in Asia propelled ASEAN to establish general mechanisms to counter EIDs within ASEAN-led

institutions. The aim was that these mechanisms would allow ASEAN to rapidly respond to such events by monitoring and analysing situations. Since APT had past experiences in dealing with regional infectious diseases, it became the basic platform used to facilitate the establishment of such functional cooperation.

In fact, APT created more functional mechanisms in addition to its previous effort to implement an EID programme. In 2010, it created the ASEAN Plus Three Partnership Laboratories (APT) to carry out laboratory surveillance and regional networking (ASEAN 2010b). This was supported by the National Institute of Infectious Diseases of Japan (NIID). In 2012, APT health ministers decided to focus on 'Communicable and Emerging Infectious Disease, Pandemic Preparedness and Response' and produced the ASEAN Strategic Framework on Health Development from 2010 to 2015 (ASEAN 2012b). At the same time, the APT also established the 'ASEAN+3 Field Epidemiology Training Network' (FETN; ASEAN 2012a). The ASEAN Emergency Centre (EOC) Network for public health emergencies, which aimed to promote information-sharing among the Public Health Emergency Operations Centres (PHEOCs) of the ASEAN member states, was also established in 2016 (Disease Control Division, Ministry of Health Malaysia 2016).

Alongside these APT functional mechanisms, the ASEAN Secretariat and the WHO signed a Memorandum of Understanding to form a strategic partnership in 2010 (ASEAN 2010a). ASEAN and the WHO, however, needed to resolve a perception gap about disease control. ASEAN suggested that the WHO's pandemic alert levels did not necessarily match the reality in the ASEAN region and needed to be updated (ASEAN 2010a). This shows that information dissemination and sharing were not only the responsibility of global institutions but also that of regional institutions and states (as well as non-state actors). Strategic partnership status would be able to facilitate these activities by more concretely institutionalizing the inter-organizational interactions.

Third Phase: Activation

The third phase in the development of ASEAN's health governance began in December 2019, when the world saw the first cases of COVID-19 appearing in China. This phase presents more continuity with the second phase than change. However, COVID-19 is the first case where it has been necessary to activate the mechanisms to handle EIDs that ASEAN had established, to assess their utility and to improve them. Indeed, in its response to the COVID-19 crisis, ASEAN has both utilized existing health governance

mechanisms and created new ones. Admittedly, they did not necessarily function smoothly. During the initial phase, ASEAN was uncertain about how to collectively respond to the virus. In January 2020, China's government said that there was 'no clear evidence of human-to-human transmission' of COVID-19. The WHO cautiously stated the necessity for additional investigation (WHO 2020). Because of such ambiguous information as well as socio-economic differences among the ASEAN member states, these states responded differently to the COVID-19 outbreak. Until 30 January, when the WHO declared COVID-19 to be a 'Public Health Emergency of International Concern (PHEIC)', ASEAN did not take serious political and social measures to respond to the virus. This slow response from ASEAN has been criticized by some scholars and policy-makers (e.g. Djalante et al. 2020).

However, several mechanisms had been activated to fight against COVID-19. For example, on 24 January, the ASEAN EOC Network and the ASEAN Biodiaspora Virtual Center (ABVC) launched its 'Risk Assessment for International Dissemination of 2019-nCoV across ASEAN' (ABVC 2020). This report provided information about the situation regarding the coronavirus in Southeast Asia. It warned about a possibility of human-to-human transmission spreading all over Southeast Asia because of the extensive travel between China and the region (ABVC 2020). Furthermore, the ASEAN EOC Network and ASEAN+3 FETN were actively utilized to share local situational updates (ASEAN 2020a). The ASEAN Defense Ministers' Meeting (ADMM) also agreed to use military resources for information-sharing and best practice sharing through the ASEAN Centre of Military Medicine and the Network of ASEAN Chemical, Biological and Radiological Defense Experts (ASEAN 2020b). After the WHO announcement declared COVID-19 a Public Health Emergency of International Concern, ASEAN also held COVID-19-related meetings on a regular basis. Meetings were held at least four times in February, with China, Japan, and South Korea also participating.

After the WHO declared COVID-19 a 'pandemic' on 11 March, ASEAN diplomatic efforts intensified. This resulted in ASEAN and APT summits as well as a number of foreign ministers' meetings with external states and actors, including the United States and European Union. Because the negative impacts of COVID-19 on member states were cross-sectoral, ASEAN organized a broad range of ministerial meetings in areas such as economics, agriculture, and transportation, allowing the different member nations to coordinate their policies on COVID-19 (ASEAN 2020c). A special APT Summit was held on 14 April and decided to establish the COVID-19 ASEAN Response Fund for public health emergencies (ASEAN 2020d). Since

April 2020, ASEAN has worked with member states and external actors to gain technical assistance, such as medical equipment and media and information literacy.

Because of the tremendous impact of the ongoing COVID-19 pandemic, it has been difficult for ASEAN to further consolidate its general cooperation mechanisms for combating EIDs. However, in April 2020 Vietnam, which was the chair of ASEAN in 2020, proposed that ASEAN create its own standard operating procedure. As a result, in November 2020, ASEAN formulated its 'Strategic Framework for Public Health Emergency' (ASEAN 2020b; ASEAN 2020e; Koga 2020, 141-143). This framework sets up comprehensive guidelines for the responses to EIDs of member states. Essentially, the 2020 guidelines aim to further enhance regional cooperation and policy coordination. Given ASEAN's continuous emphasis on the importance of the WHO's International Health Regulations (IHR), ASEAN has incorporated these principles in order to maintain coherence with existing international laws (WHO 2005; ASEAN 2020e, 3). This has created a more structured coordination mechanism between national and regional levels, incorporating the existing frameworks in the field of disaster management and humanitarian assistance. In this strategic framework ASEAN proposed the creation of the ASEAN Centre for Public Health Emergencies and Emerging Diseases (ACPHEED) to coordinate member states' responses, which was formally established in November 2020 with the financial and human resource support of the Japanese government (ASEAN 2020e; ASEAN 2020f).

As such, ASEAN has steadily developed its institutional mechanisms for pursuing effective and efficient measures to tackle emerging infectious diseases. It has especially made efforts to develop these mechanisms at those times when it has faced external shocks – SARS in 2003, H5N1 in 2005, H1N1 in 2009, MERS in 2012, and COVID-19 in 2020.

3 ASEAN's Cooperation to Counter EIDs: Regional Focus

ASEAN's health governance mechanisms function at global, regional, and national levels. At the global level, ASEAN has institutional ties with other international organizations, particularly the WHO. The WHO's expertise, information dissemination, and guidelines help ASEAN formulate its own countermeasures in response to EIDs. Despite the US criticism of the WHO, where it accused the organization of being politically too close to China and of having delayed its response to COVID-19, ASEAN has closely worked with the WHO. However, the WHO's advice and protocols, when adopted

by ASEAN, have often remained as 'guidelines' that do not obligate states to follow them. This is because ASEAN recognizes the existing capability gaps among member states which limit their ability to implement these protocols (Tan 2020). The WHO's International Health Regulations (IHR) are legally binding agreements, created in 2005, that aim 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' (WHO 2005; WHO n.d. (a)). The capacity to implement these nevertheless depends on each state's financial, technical, and political resources, and some states require external assistance to build their capacities.

At the same time, ASEAN's institutional principles, or the so-called 'ASEAN Way', often prevent the organization from taking enforceable measures at the national level. The ASEAN Way consists of several norms, such as the non-interference principle, a consensus-based decision-making process, and non-use of force. More importantly, the great emphasis on protecting state sovereignty makes ASEAN generally reluctant to pressure member states to change their behaviour in the domestic realm. Because of this, persuasion is often employed (Acharaya 2014; Koga 2018, 50-51; Tan 2013, 237-240). This *modus operandi* partly explains the incongruence in the responses to EIDs that is seen among the ASEAN member states.

To overcome these difficulties, ASEAN has nurtured institutional arrangements that draw external assistance and has simultaneously created inter-state coordination mechanisms. More specifically, ASEAN has focused on the enhancement of regional cooperation, which revolves around ASEAN itself and APT. This is well illustrated by several of the existing mechanisms that have been established to counter EIDs. These include the ASEAN+3 FETN, the ASEAN EOC Network, and the ABVC. The ASEAN+3 FETN was established in 2011 for facilitating capacity building programmes, narrowing the gap in the capabilities of ASEAN member states to manage EIDs, and promoting networks of experts in the region (ASEAN+3 FETN 2012a). The financial resources are voluntarily contributed by the member states, but as the mechanism is under the APT framework, China, Japan, and South Korea are the main contributors (ASEAN+3 FETN 2012b).

The ASEAN EOC Network is not under the APT framework, but is located within ASEAN's own mechanism. This network 'serves as the central location in monitoring disasters and coordinating ASEAN's collective response to disasters' (AHA Centre n.d.). Each member state's Public Health Emergency Operations Centre (PHEOC) can exchange information with others through

this communication channel (Disease Control Division, Ministry of Health Malaysia 2017). In response to COVID-19, daily communication among the member states has been conducted through *WhatsApp*, a commercial text messaging mobile application. This has meant that member states can exchange information in a timely fashion and allowed the communication channel to compile contact information about health centres in each member state (ASEAN 2021). This mechanism is financially supported by an external state, the Canadian government, which offered US\$11.6 million in 2013 for its initial establishment (Disease Control Division, Ministry of Health Malaysia 2016).

The ABVC is responsible for conducting big data analysis and data visualization. It is also responsible for disseminating information about the ongoing health situation to the member states and the international community. The idea to establish this centre was adopted in 2019, but the centre became visible in 2020 when it functioned to raise member states' awareness about COVID-19, particularly through its risk assessment reports. The centre has two computer programmes – the Explorer Tool and the Insights Tool. The former tool aims to track trends of infectious diseases, to find out about local transmissions, and to enable users to communicate with each other (ASEAN n.d.). The latter tool helps health centres in the analysis of the threat posed by different EIDs, sorting out the most significant events that would pose health risks at the national and regional levels (ASEAN n.d.). This centre was also financially supported by the Canadian government in 2019 (ASEAN 2019).

The characteristics of ASEAN's health governance mechanisms are therefore mainly shaped by ASEAN's institutional principles, norms, and rules. These mechanisms are made to be compatible with the ASEAN Way and with the idea of receiving external assistance to build member states' capacity. Because today EIDs have become one of ASEAN's and the world's top non-traditional security issues, ASEAN has been able to build its own mechanisms with external assistance. There are also other ASEAN mechanisms, such as the ASEAN Risk Assessment and Risk Communication Centre (ARARC) and Regional Public Health Laboratories Network (RPHL). These mechanisms facilitate laboratory readiness and the combating of fake news. They are supported by external actors, such as the United States (US Mission to ASEAN 2020).

ASEAN makes the most of its institutional weaknesses to attract assistance from regional states while emphasizing the importance of the ASEAN Way to prevent external actors from interfering excessively. In so doing, ASEAN has been relatively successful in utilizing these institutional frameworks in countering COVID-19 since January 2020.

4 Three Challenges to ASEAN's Collaboration in Countering Infectious Diseases

There is no guarantee that ASEAN can sustain the development model it has adopted in the future. At the global level, in April 2020 the Access to COVID-19 Tools (ACT) Accelerator was launched by the WHO, the European Commission, France, and the Bill & Melinda Gates Foundation. This aims to ensure diagnosis investment, equal distribution of treatment, and access to vaccines in developing states including some ASEAN member states (under the so-called 'COVAX' programme; [WHO, n.d.(c)]). Nevertheless, the international community has yet to find an effective way to contain COVID-19. Many countries have experienced second and third waves since late 2020 and the spread of mutated COVID-19 variants has also occurred in numerous places. In this context, there are three main challenges to ASEAN's health governance.

The first is to reduce ASEAN's dependence on external actors for materials, particularly for financial assistance. ASEAN effectively created its own institutional system to establish health governance mechanisms with external assistance from regional major powers. However, the negative impacts of COVID-19 have severely affected the financial capabilities of some states in the region. In the short-term, these states will continue to offer ASEAN a certain amount of assistance. However, if the situation worsens, it is not clear how sustainable their assistance will be and the degree to which ASEAN's health governance mechanisms can maintain their operations.

The second challenge is to manage the normative constraints that are created by ASEAN's adherence to the ASEAN Way. To be sure, the ASEAN Way has been a useful tool for the member states to maintain their political autonomy and independence in Southeast Asia. Nevertheless, given the high degree of trade interdependence among ASEAN member states, the mishandling of COVID-19 or another EID by member states, through such things as the imposition of trade restrictions, would affect the entire region (e.g., Pitakdumrongkit 2020). It is not realistic to see any radical change in ASEAN's traditional norms and rules in the near future, and ASEAN's 'Strategic Framework for Public Health Emergency' has advanced its own coordination mechanism. However, ASEAN's emphasis on state sovereignty would make it difficult for the association to manage complex emergency situations, such as those where a national government collapses or becomes dysfunctional because of EIDs.

The third challenge is to balance ASEAN's geostrategic position in the context of intensified US-China great power rivalry. While regional health

cooperation in Asia is based on transnational interests, such cooperation is still influenced by regional politics. At the heart of the Indo-Pacific region, ASEAN is located in a geo-strategically important area. Its multilateral frameworks have been, and continue to be, a source of political legitimacy in East Asia, which attracts many regional powers, including the United States, China, Japan, India, and Australia (Koga 2019, 288, 300). These regional powers are important for ASEAN member states, because they help to provide technical and financial resources to enhance ASEAN's capacity in countering EIDs. However, if the strategic rivalries between these powers continue to intensify, ASEAN will have to carefully and collectively assess its position. It will need to determine from which regional powers, and under what conditions, it can accept financial and medical resources. This is because if the United States and China, in attempting to expand their spheres of influence, drive a wedge between different ASEAN member states by offering them economic, medical, and technical assistance, then the organization will face difficulties in maintaining its unity. This will then in turn affect ASEAN's ability to collectively respond to EIDs.

These three challenges are inherently related to each other. It is not possible, or even advisable, for ASEAN to pursue complete autonomy. However, it is important to mitigate the negative impacts that may come from external factors. Essentially, prevention is the most cost-effective means of managing EIDs, and thus, the enhancement of ASEAN's preventive capabilities is imperative for national and regional security.

5 Conclusion

ASEAN has seen relative success in formulating its health governance mechanisms in the post-SARS era. By consolidating its political cooperative frameworks during the 2000s, ASEAN gradually nurtured functional cooperation in countering EIDs. This involved the creation of the ASEAN ECO Network and ASEAN+3 FETN. Facing the COVID-19 pandemic, ASEAN utilized these mechanisms and activated new ones, such as ABVC. This culminated in the production of the 2020 'Strategic Framework for Public Health Emergency', which included a set of standard operating procedures, as well as the establishment of ACPHEED in 2020.

This became possible because ASEAN constructed its own regional institutional system. Through this system, ASEAN can maintain its own political autonomy, provide political legitimacy in East Asia by promoting regional multilateralism, and gain political support and material assistance

from regional powers, including the United States, China, and Japan. This is partly why ASEAN has been able to utilize regional arrangements, particularly the APT, in facilitating its health governance mechanisms. Nevertheless, it is not clear whether ASEAN can sustain this institutional advantage in the future. It faces the challenges of intensifying US-China strategic competition and the ongoing negative consequences of COVID-19.

The year 2020 clearly shows that international relations in East Asia are shaped not only by power politics, but also by transnational security issues, such as threats which the COVID-19 pandemic poses. ASEAN's institutional focus on non-traditional security issues has thus far provided venues for Southeast Asian and Northeast Asian states to coordinate their policies and collectively respond to the COVID-19 pandemic. However, in the future, ASEAN's success ultimately depends on how member states build their own capacity to adequately respond to EIDs without significant assistance from external actors.

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