**11. Pandemic Response in the Asia-Pacific: Risk and Opportunity in PRC’s International Relations**

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Appearing at regular intervals, three to four times a century, globe spanning pandemics have long existed as a threat to humanity. However, the rapid expansion of globalization has greatly enhanced that threat. Often described as “artificial disease force-multipliers”, attributes of globalization such as expanded global trade and tourism, the movement of goods, services and people across the planet in ever increasing numbers, and rapid urbanization, have exacerbated human vulnerability to pandemics.[[1]](#endnote-1) It has become widely accepted in the public health community that a novel or re-emergent virus which is highly virulent and easily transmissible among humans is inevitable and long overdue.[[2]](#endnote-2) Recognizing this threat, the World Economic Forum in its 2006 Global Risks Report ranked pandemics and natural disasters among the gravest risks confronting the international community.[[3]](#endnote-3)

This paper explores efforts to effectively respond to pandemic disease within the Asian-Pacific community. It argues that pandemics represent a significant threat to human life and well-being, while simultaneously providing a unique opportunity for international cooperation in the sphere of pandemic prevention and control that is essential to effective pandemic response. Such cooperation may also represent a point of departure for expanded trust and cooperation in other spheres of international relations. However, how we frame pandemics in political terms can have a significant effect on successful pandemic response. Does the movement towards framing pandemic threats as a form of high politics/non-traditional security increase or decrease the likelihood of successful global pandemic response?

The paper opens by exploring the debate on how to frame pandemics in international politics. It then describes growing global awareness of the threat pandemics represent for the international community while focusing on the PRC’s uniquely important role as a focal point of pandemic development, spread, and potentially, control. The paper then explores the nature and development of international cooperation on pandemic response, with a focus on the PRC and its interaction with key actors in the Asia-Pacific, including the Association of South-East Asian Nations (ASEAN), the World Health Organization (WHO) and the United States Centers for Disease Control (USCDC). While making the case that pandemic response offers a real opportunity for international cooperation on a relatively “safe” issue, the paper draws on Taiwan as a case study of the impact which framing may have in undermining effective public health cooperation and by extension, resulting in less effective pandemic response with the potential for enormous human and economic repercussions.

**Framing Pandemics within the Security Debate**

In international relations, a distinction is often drawn between high and low politics. High politics normally refers to sovereignty and security-related issues; developments that might impact on the survival of the state, its identity and self-image as relates to diplomacy, defense and national security.[[4]](#endnote-4) By contrast, low politics refers to the many ways governments and NGOs interact over issues lacking “great, manifest political or military import”, such as improving mail service or halting epidemics.[[5]](#endnote-5) Because high politics are fraught and highly visible, compromise is both difficult and potentially undesirable. Rare is the country that will willingly sacrifice its sovereignty or security.

By contrast, in the sphere of low politics, opportunities for cooperation are far greater. In the case of pandemic response, pandemics do not normally pose a military security threat to states nor can they normally be viewed as initiated by an enemy to threaten vital state interests.[[6]](#endnote-6) Like environmental challenges such as cross-border pollution, pandemics are perceived as a different threat level and therefore cooperation is more likely.[[7]](#endnote-7)

Another approach to incorporating pandemics within the security debate is through the distinction between traditional and non-traditional security. Here traditional security is similar to the above described conception of high politics. However, the conception of security is expanded to incorporate an additional component: non-traditional security. Non-traditional security describes issues that challenge the survival and well-being of people (human security) and states that are non-military in nature, including environmental degradation, pandemics, and illegal immigration, among others. Proponents of this approach argue that by framing pandemics as non-traditional security concerns – “securitizing the issue” – greater attention, prestige, and resources will be allocated to researching and resolving them.[[8]](#endnote-8) However, there exist potentially serious drawbacks to securitizing pandemics. Defining pandemics as security issues conflates them with issues like state sovereignty and national security. If pandemics are a security issue, compromise and cooperation – key aspects of pandemic response effectiveness - may actually become more difficult. In addition, since pandemics are unlikely to trigger violent conflicts, the concept of “security” as traditionally conceived will be diluted, requiring new vocabulary for more immediate threats to the state.[[9]](#endnote-9) Thus, while on the one hand, “securitizing” pandemics may draw attention and resources to resolving a significant threat, if the goal is to enhance global cooperation to overcome pandemics, framing initiatives that decrease the likelihood of cooperative behavior should be considered with caution. As the next section illustrates, global cooperation is essential to effective pandemic response.

**Emerging and Reemerging Pandemic Diseases as a major global concern**

Emerging and reemerging infections are “infections that have newly appeared in a population or have existed previously but are rapidly increasing in incidence or geographic range”.[[10]](#endnote-10) Important historical examples of emerging infections include the 1348-1351 Black Death which was responsible for between 20-40 million worldwide deaths, the 1918-20 Spanish influenza which infected approximately one third of the world’s population with total deaths estimated at between 50 and 100 million and a thirty-three percent case fatality rate, and the Asian flu of 1957-58, responsible for 2 million worldwide deaths.[[11]](#endnote-11) Of great concern is the fact that incidences of pandemic disease have increased over the last few decades, not only in frequency, but also in terms of impact. In 2002-03 the SARS (Severe Acute Respiratory Syndrome) pandemic caused a relatively small number of deaths, fewer than one thousand, and yet its economic cost has been estimated at between $40 and $60 billion, having the heaviest impact on the PRC, Hong Kong, Taiwan and Canada.[[12]](#endnote-12)

It remains premature to evaluate the impact of the 2009 H1N1 (swine flu), however preliminary estimates attribute an approximate loss of 0.3 percent of Mexico’s (the likely source of the outbreak) GDP.[[13]](#endnote-13) According to Margaret Chan, Director-General of the World Health Organization (WHO), between twenty percent and forty percent of the world population was infected with H1N1, and that in responding to this pandemic, “… we have been aided by pure good luck. The virus did not mutate during the pandemic to a more lethal form,” and vaccines proved effective and safe.[[14]](#endnote-14) And yet “pure good luck” nonetheless involved infections reported in more than 214 countries and overseas territories or communities, and over 18,500 deaths worldwide as of 1 August 2010, despite a low case fatality rate estimated to be between 0.0004 and percent to 0.06 percent.[[15]](#endnote-15)

Perhaps the source of greatest concern for a dangerously disruptive and damaging pandemic is Highly Pathogenic Avian Influenza (HPAI), H5N1. According to the UN Food and Agriculture Organization, since 2003, sixty-two countries have reported H5N1 cases in poultry and wild birds. The fatality rate up to this point among birds is one hundred percent, with efforts to control the outbreak relying on vaccination in advance of outbreaks, and mass culling where outbreaks have occurred.[[16]](#endnote-16) According to the WHO, there were 507 cumulative cases of confirmed human infection with H5N1 through September 2010, of whom 302 died.[[17]](#endnote-17) This reflects a case fatality rate of well over fifty percent, though were the disease to extend to regular human-to-human transmission, mortality rates would likely decline as the disease became less virulent to enable more efficient transmission. Increased risks for spreading H5N1 include geographic and cultural factors. Thus, studies have found that H5N1 thrives in agro-livestock farming systems combining paddy rice production, domestic water birds and poultry in river deltas.[[18]](#endnote-18) These are conditions that are prevalent in South-East Asia and in the PRC’s south-east. Indeed, according to a U.S. Government, *National Intelligence Estimate*, “…particularly Chinese agricultural practices place farm animals, fowl and humans in close proximity and have long facilitated the emergence of new strains of influenza that cause global pandemics.”[[19]](#endnote-19) In other words, H5N1 in particular, but emerging infectious diseases in general, are most likely to appear in regions with very specific conditions including high human population densities; rich diversity of wildlife; and warm climates.[[20]](#endnote-20) Therefore it is perhaps not surprising that the PRC is home to one seventh of the global disease burden measured in years of healthy life lost.[[21]](#endnote-21)

To this point, H5N1 has largely followed a bird-to-bird or bird-to-human transmission pattern. Once it infects humans, H5N1 dies along with its host. However, influenza strains easily mutate and health officials anticipate that human-to-human transmission will eventually arise (and has seemingly done so in a small number of cases). Human-to-human transmission may result if a person ill with H5N1 is simultaneously ill with another form of influenza. In such a situation, the two forms of influenza may interact, resulting in a new, more easily transmissible form of H5N1.[[22]](#endnote-22) If and when this mutation occurs, thirty to fifty percent of the global population will likely fall ill.[[23]](#endnote-23) The resulting cost in human lives and to the global economy would likely dwarf that of past pandemics.

A WHO study of human-to-human transmissible influenzas based on past pandemics predicts that in a future pandemic, approximately 1.5 billion people will seek medical attention, while deaths will range between two and seven million people. The Asia Development bank, focusing on the impact of an infectious H5N1 pandemic in East Asia, identifies two scenarios – one a mild pandemic, one more severe. Based on these two scenarios, the economic cost to Asia alone would range between $99 and $283 billion.[[24]](#endnote-24) Meanwhile, a 2005 World Bank study estimates the economic cost of a severe worldwide influenza pandemic at $800 billion, and tens of millions of lives lost.[[25]](#endnote-25) In the US alone, deaths are estimated at between 207,000 (US Centers for Disease Control) and 1.9 million (Department of Health and Human Services), with an initial cost to the economy of between $166 billion and $200 billion. Long term costs would, of course, be far greater.[[26]](#endnote-26)

What will be the likely global response? Tamiflu, the anti-viral of choice, has proven ineffective against H5N1, and because humans have never experienced an H5 type virus, we are highly vulnerable to its effects. In general, vaccines are difficult to produce and must be constantly adapted as the targeted virus undergoes rapid mutation. Furthermore, vaccine production is very costly and exposes the producers to potential litigation. As a result, there are only a limited number of vaccine manufacturers worldwide, and their combined vaccine production capacity is approximately 300 million doses per year, which is clearly insufficient to meet demand during a pandemic. We can therefore anticipate that millions will likely become infected well before a vaccine is available. In less developed countries, it is likely that few people will be given the opportunity to be vaccinated.

However, perhaps even more urgent than developing and producing anti-virals and vaccines is the need for a globally coordinated, cooperative response. As the US CDC asserts, “the scope and intensity of global health challenges ensures that no single country or agency can work alone to meet them”.[[27]](#endnote-27) The second of six WHO Global Agenda items echoes this assertion, stating that “shared vulnerability to health security threats demands collective action….,”[[28]](#endnote-28) with Article 1.2 of the Global Agenda specifically calling for ensuring comprehensive global cooperation to achieve coverage for early warning of emerging disease strains. As Stohr notes, global cooperation must include international coordinated responses, cooperation on domestic pandemic plan development, institutionalized cross-border information sharing and collaboration on novel and re-emerging viral infections.[[29]](#endnote-29)

The human and economic costs of a future pandemic are clear, as is the need for global cooperation. The following section evaluates how the international community is responding to this challenge. It focuses primarily on the PRC, a country noted for very likely being the source of a future emerging or reemerging pandemic disease. Recognizing the threat it faces, the PRC has made efforts to strengthen its domestic institutions while simultaneously reaching out to regional and international institutions. It is to these initiatives that I now turn.

**Key State, Regional and Global Actors in Pandemic Preparedness and Response**

***State – the PRC***

Successful pandemic responses require developing capabilities in a number of spheres. First, the public health infrastructure and government commitment must exist within a country.[[30]](#endnote-30) How have the PRC’s capabilities developed over time?

In the lead-up to the 2002-03 SARS pandemic, the PRC had allowed its public health infrastructure to deteriorate. The deterioration was in large part a result of the priorities established by the central government with the start of the 1979 economic reforms. In essence, the PRC shifted from a heavily state-subsidized, preventive care model incorporating the wide use of free services that included rural clinics, widespread vaccination and basic preventive care, to a western-style, privately financed, curative care model. As a result, numerous services disappeared or were simply no longer available without payment. Not surprisingly, the shift to the curative care model contributed to a reversal of previously positively trending health indicators.[[31]](#endnote-31) Thus, by the time the PRC documented its first case of SARS in Foshan, Guangdong province on 16 November 2002, the public health infrastructure necessary to tackle the outbreak had suffered significant deterioration.

Not surprisingly, the PRC’s initial response to SARS was therefore slow and ineffective. While by mid-December, local health officials had contacted their provincial government counterparts with requests to help diagnose the strange new disease, this information was neither widely nor quickly disseminated as local officials preferred to keep news of the disease quiet to avoid deleterious effects on the region’s economy, even as SARS quickly spread to ten additional provincial level entities. By 31 March, 2003, there were 1,190 cases of SARS reported in the PRC.[[32]](#endnote-32)

As at the local level, the initial PRC central government reaction to the outbreak was to keep news of the disease a secret. The central government shared the local government’s goal of avoiding a negative economic impact that would arise should information about an unidentified yet deadly disease become known abroad. Since the promise of ongoing economic growth is a key source of Communist Party legitimacy for continued rule, news that might potentially threaten economic growth had to be suppressed. Furthermore, the PRC’s leadership sought to avoid being criticized by the international community as the source of SARS, or being pressured into allowing international interventions which might challenge PRC sovereignty. Thus, the PRC’s goal was to develop a domestic response and, only after the disease had been controlled, inform the world of the PRC’s great success.[[33]](#endnote-33)

In order to mount a successful response, the Party-controlled central government recentralized power to itself after years of reform era decentralization. The central government mobilized sub-national actors, including provincial and local governments, hospitals, and public health units. It also activated the media, the ministry of education and public security bureaus and other relevant bureaucracies. In addition, the government enabled and obtained assistance from government organized non-governmental organizations (GONGOs) such as the All-China Women’s Federation, as well as from more traditional non-governmental organizations (NGOs) such as the Chinese Red Cross and religious organizations including Buddhist, Daoist and Catholic groups. The state also mobilized Neighborhood and Village Committees which, while not completely independent of the state, are defined by the state as self-governing grassroots organizations.[[34]](#endnote-34) Finally, the state utilized mass mobilization campaigns reminiscent of the Mao era.[[35]](#endnote-35) Thus, despite a structural lack of preparedness arising from the past de-emphasis of preventive care and preparedness, in mid-April 2003 when the Party/State decided to actively combat SARS, it was able to mobilize actors in the Party and State bureaucracies as well as a range of additional actors and the general public.

The decision to re-centralize power and direct resources to addressing the SARS outbreak reflects the political nature of the SARS threat. As PRC public health officials repeatedly noted, SARS was not as much a public health challenge as it was a political one.[[36]](#endnote-36) Would the central government invest the resources, political and economic, necessary to take on this unanticipated crisis? Would it be willing to look outside its own institutions for assistance in pandemic response and control? In fact, the central government proved willing to expend political capital in order to “ramp up” response capabilities by concentrating resources and expanding capabilities and cooperation in the face of the SARS crisis.[[37]](#endnote-37)

In addition, the central government leadership came to realize both that the PRC required international assistance to effectively combat the disease, and that the disease could not be kept secret. PRC officials struggling to identify the nature of the novel disease recognized that international and foreign public health institutions were an important source of information, advice and support. Furthermore, secrecy became impossible when SARS spread to Hong Kong, a Special Autonomous Region of the PRC, with the result that media attention grew tremendously. Indeed, the PRC’s efforts to hide the SARS outbreak eventually resulted in the WHO very publicly chastising Beijing for misleading the international community regarding the actual threat and extent of SARS.[[38]](#endnote-38)

As the need for international cooperation became increasingly obvious, the PRC did expand its contacts with the WHO and the WHO’s Global Outbreak Alert and Response Network (GOARN).[[39]](#endnote-39) However, the PRC was far less cooperative than WHO officials sought. Despite pressure from the WHO, and the obvious benefits of cooperation, Beijing only allowed GOARN representatives to travel to Beijing on 23 March, 2003, towards the end of the outbreak. And, despite repeated requests, WHO officials were only allowed to travel to the presumed source of SARS in the PRC’s south-east Guangdong province in early April 2003, almost six months after the first known case of SARS was identified.

By the conclusion of the SARS pandemic, globally reported cases had reached 8,437, and SARS-related deaths had reached 813.[[40]](#endnote-40) Among the lessons derived from the SARS experience, the PRC government learned the benefits of a commitment to strengthened domestic public health institutions, enhanced public awareness and greater openness and cooperation with domestic NGOs and the international community. Indeed, had the PRC government more rapidly reached out to domestic and international actors for assistance earlier on in the SARS outbreak, the result might have been far better both for the PRC and the rest of the world.[[41]](#endnote-41) These lessons and the initiatives that arose from them ensured that the H1N1 outbreak in spring 2009 was met with a greater level of preparedness than would otherwise have been possible.

As noted, domestic capabilities development is alone insufficient for effective response, as pandemics by definition spread across borders. Recognizing that domestic capabilities must be supplemented with strong international collaboration to rapidly identify potential threats and to design real-time responses, the PRC engaged with regional and global partners, three of which are explored here.

***Regional – ASEAN and ASEAN Plus Three***

A key regional player in the Asia Pacific is ASEAN. ASEAN relies heavily on World Health Organization protocols, recommendations and institutions to develop regional preparedness and response mechanisms. Following the SARS outbreak, ASEAN members worked to establish four key regional forums to address pandemics: 1) The ASEAN Expert Group on Communicable Diseases; 2) The ASEAN Highly Pathogenic Avian Influenza (HPAI) Taskforce; 3) The ASEAN Plus Three (APT) (S. Korea, Japan and the PRC) Emerging Infectious Disease (EID) Program; and 4) The Regional Forum for Control and Eradication of HPAI.[[42]](#endnote-42)

The main focus of these organizations is to improve domestic and regional capacity for surveillance and response to future pandemics. In 2002, the PRC and ASEAN members signed a joint declaration recognizing “extensive common interests” and the need for more extensive cooperation in coping with non-traditional security threats. And while initially, non-traditional security did not include pandemic diseases, the SARS outbreak forced pandemics onto the non-traditional security agenda.[[43]](#endnote-43) In 2003, APT ministers of health met to discuss health cooperation, with the PRC donating $1.2 million towards an anti-SARS fund. One outcome of this meeting is that the PRC became ASEAN’s first “strategic partner”; a strengthening of relations that eased earlier fears by ASEAN countries of the PRC’s growing geo-political clout.[[44]](#endnote-44)

At the 2004 annual ASEAN health ministers meeting, Article 7 of the ensuing Declaration commended ongoing work by the ASEAN experts group on communicable diseases in expanding and improving the APT Action Plan on Prevention and Control of SARS and other Infectious Diseases. Article 10 commends the PRC for organizing and hosting the PRC-ASEAN summit on control of HPAI.[[45]](#endnote-45)

ASEAN and the PRC also agreed to regular meetings to address regional health concerns, with participation by officials at various levels. This initiative was led by Premier Wen Jiabao, who attended the 2007 ASEAN summit where he called for regular information sharing on public health emergencies and infectious diseases. Such leadership summits are supplemented by ministerial meetings for health ministers and for foreign affairs ministers, meetings of senior bureaucrats, and joint regional think-tanks.[[46]](#endnote-46) In 2009, the PRC along with the other APT members adopted the ASEAN Strategic Framework on Health Development (2010-2015), which includes, among other goals, the development of a response framework for communicable diseases and pandemic preparedness and response.[[47]](#endnote-47) While many of these initiatives have yet to be fully implemented, the tremendous level of activity, in particular in the post-SARS era, suggest a serious commitment on the part of APT members to improving regional capacity for pandemic response and control while concurrently reflecting growing cooperation and trust that may have positive spill-over effects into other spheres of international relations.

***Global - The World Health Organization & the U.S. Centers for Disease Control***

At the international level, the most important actor in pandemic response is the World Health Organization (WHO). Its key tool is the International Health Regulations (IHR) revised in 2005 in part as a response to SARS.[[48]](#endnote-48) The IHR came into effect in summer 2007 and is a legally binding international agreement designed to build and strengthen national alert response systems. The IHR provides ground rules on how to respond to public health threats with the potential to become global emergencies. Member states are required to: 1) establish a National IHR Focal Point for communication with the WHO; 2) meet core capacity requirements for disease surveillance; 3) inform the WHO in a timely manner of any incident that might be considered a Public Health Emergency of International Concern (PHEIC); and 4) respond to additional requests for information by the WHO.[[49]](#endnote-49)

All members of the WHO are bound by the IHR and are therefore committed to establishing a Focal Point, that is, a point of contact established by states to interact with the WHO Contact Point. The Focal Point must be available at all times to receive information regarding outbreaks abroad and provide information to the WHO Contact Point regarding domestic PHEIC. In order to meet core capacity requirements, countries are required to develop a pandemic response plan. Many countries rely on the WHO pandemic plan which was first developed in 1999 and most recently updated in 2009 as the basis for their own plans.[[50]](#endnote-50) The WHO is also tasked with assisting member states with expertise and guidance as they seek to meet this IHR requirement.

As noted, all states adhering to the WHO must also alert the international community in a timely manner regarding any threat that might constitute a PHEIC. They must also seek to control the emergency within their own borders and beyond. Timely manner is defined as within 24 hours of identifying a public health emergency. The WHO is notified via the relevant country’s national Focal Point. A public health emergency of international concern is assessed based on four criteria: 1) Does the event have, or may later develop a serious public health impact?; 2) Is the event unusual or unexpected; 3) Does the event create a risk of international disease spread; 4) Does the event create a risk that travel or trade restrictions will be imposed? A positive response to any *two* of these criteria is sufficient to trigger notification to the WHO.[[51]](#endnote-51) The regulations require that all countries notify the WHO of potential threats to international health and that they give the WHO authority to issue temporary and standing recommendations regarding such international health concerns as travel advisories and requirements for vaccinating travelers.[[52]](#endnote-52)

Implementing these reforms to the original IHR required overcoming several obstacles. Obstacles included participating countries’ concerns over conflicts between the proposed regulations and existing international law, agencies, and treaties regarding health risks; application of IHR to terrorist attacks, and; interference by the WHO in issues relating to state sovereignty such as decisions on travel and trade. Despite these significant obstacles, 194 countries, including the PRC, nonetheless agreed to adopt the revised IHR without reservations.[[53]](#endnote-53)

The USCDC is another major international actor in pandemic prevention and control. The USCDC has traditionally been a first port of call for foreign governments seeking information and assistance in response to public health questions in general, and pandemics in particular. Its staffs are present in over fifty countries and forty international organizations. In terms of its international mandate, the USCDC’s over-arching goal is to improve the global public health system through collaboration, training and provision of expertise and funds. Among its international initiatives is the Global Health Initiative which focuses on assisting countries faced with outbreaks of HIV/AIDS, Malaria, Tuberculosis and other significant infectious diseases. The USCDC also maintains a Global Health Program that includes field epidemiology training for foreign government health officials in establishing and implementing improved public health systems. The International Emerging Infections Program is a key component of CDC’s global disease detection efforts, strengthening global capacity to identify and respond to global emerging infectious diseases. This program provides funding, but also involves direct CDC cooperation with Ministry’s of Health of foreign countries, the WHO and international health NGOs.[[54]](#endnote-54)

In a 2005 Memorandum of Understanding signed between the US Department of Health and the PRC MoH, the two sides committed to cooperation on emerging and reemerging infectious diseases, including ministry level information sharing as well as cooperation on programs such as a Field Training Epidemiology Program (FTEP). Also, cooperation in training extends to pandemic preparedness and response, and surveillance systems monitoring. The US CDC also provides training for spokespersons on pandemic response at the provincial level in the PRC, helping to develop and craft messages that achieve the goals of informing, preparing but not panicking the public.

The PRC’s national CDC conducts weekly meetings with the USCDC and the WHO where they share technical data, interpretations and recommendations.[[55]](#endnote-55) The USCDC and the China CDC also share offices and personnel, and in addition to meeting regularly, many officials from both sides are temporarily stationed in each others’ offices. The US decision to base one of only six US Global Disease Detection Regional Centers in the PRC reflects recognition of the PRC’s significant place in pandemic prevention and control.[[56]](#endnote-56)

Clearly, effective pandemic response requires cooperation at many levels. As illustrated by the example of China’s pandemic response efforts, cooperation is required among domestic, regional and international actors if pandemics are to be controlled. I turn now to an evaluation of such cooperation during the 2009 H1N1 pandemic with particular focus on the PRC’s engagement with international public health institutions.

**Global Opportunity for PRC’s International Cooperation: The Case of H1N1**

The PRC’s post-SARS willingness to cooperate with international institutions was first tested with the 2005 H5N1 (Avian Influenza) outbreak in Xinjiang Autonomous Region and Qinghai province. During the outbreak tens of thousands of birds were infected and approximately 6,000 died. The PRC reacted by taking domestic precautions including quarantine and cullings, while also quickly and extensively sharing information about the outbreak and cooperating with international actors including both the WHO and the USCDC. The PRC’s behaviour during this outbreak was described by a key US health official based in Beijing as representing a significant improvement over the PRC’s behavior during the SARS outbreak.[[57]](#endnote-57)

The PRC’s commitment to international cooperation has been further tested by its response to H1N1. The PRC’s response to H1N1 differed from its response to SARS. Most obviously, since Mexico rather than the PRC proved to be the source of the new pandemic, the PRC had some time to prepare for the inevitable arrival of the disease at its borders and did not suffer the embarrassment of being blamed for its outbreak (as was the case with SARS).

With initial reports that the case fatality rate was between 10 percent and 20 percent the PRC government responded quickly.[[58]](#endnote-58) According to Dr. C.K. Lee, the WHO Contact Point representative in the PRC, early on in the outbreak the PRC sought to delay the pandemic’s entry to the country and to develop a vaccine and treatment for H1N1. The PRC’s response included drastic quarantine and isolation policies such as canceling flights to and from Mexico, initiating temperature checks on incoming flights and establishing quarantine and isolation protocols for visitors who may have had even tangential contact with a person diagnosed with H1N1 or arriving from a “global hotspot”. In addition, the third ranking leader of the PRC’s state council (the Cabinet) made a special visit to the China National CDC, the first such visit since the SARS outbreak. During the visit, the official committed the government to providing “whatever is needed” to ensure an effective H1N1 response.[[59]](#endnote-59) The government also activated numerous hospitals, quarantine stations and laboratories and accompanied these actions with expanded training of public health officials and hospital workers. The government also committed to covering all costs associated with hospitalization and quarantine for those exhibiting H1N1 symptoms but lacking health insurance. In addition to these domestic initiatives, the PRC engaged in international, regional and bi-lateral cooperative initiatives.

The PRC and ASEAN have developed strong cooperative relations in terms of pandemic response. This cooperation has developed despite ongoing tensions in the sphere of high politics. The most obvious example of tensions is the ongoing dispute between the PRC and her South East Asian neighbours over the South China Sea. This dispute has involved occasional clashes and numerous confrontations between PRC and ASEAN country forces. And yet the PRC and ASEAN do cooperate as well, in particular within the framework of APT.

During a number of meetings in May 2009, APT ministers gathered to coordinate their responses to H1N1, focusing on vaccine distribution and regional disease spread, as well as actions to contain and control the virus. The emphasis was on applying IHR (2005) requirements for cooperation in pandemic response while obtaining information from the WHO and the USCDC regarding the nature of the virus. The ministers also committed to sharing information, technology, resources, laboratory facilities, stockpiles of essential medicines and supplies in the region. Ministers also agreed to establish hotlines among the national health authorities, as well as joint outbreak investigation and response teams across countries as appropriate and as requested. The PRC, the first country to develop an H1N1 vaccine, also committed to assisting ASEAN members with vaccine development and antiviral medicines.[[60]](#endnote-60)

At the global level, early on during the H1N1 outbreak, the PRC MoH turned to the WHO for information on potentially ill travelers, and for assistance in contact tracing – following the history of contacts by individuals with influenza-like illnesses (ILI) – to their country of origin. The PRC also received virus samples from the WHO and USCDC.[[61]](#endnote-61) Communication occurred through official channels via letters, phone calls, emails and text messages as well as through regular meetings between the WHO and MoH representatives. The MoH also requested that WHO experts join an H1N1 prevention and control team. According to WHO Focal Point, Dr. Lee, the PRC exceeded its responsibilities under the IHR, providing abundant information regarding H1N1, even to the point of providing weekly updates on H1N1 cases in the PRC well after the outbreak peaked.[[62]](#endnote-62)

Of particular importance has been growing cooperation between the U.S. and the PRC. As noted, the USCDC is a major contributor to international efforts at data gathering, analysis, and expert advice and support to regions facing potential pandemics. Also, the US and the PRC have developed close cooperative relations on pandemic preparedness and response. Many of these programs are run by the USCDC in the PRC for China CDC and health officials from across the country.[[63]](#endnote-63) And yet, while cooperation is clearly desirable, as with ASEAN, obstacles to US-PRC cooperation exist.

These obstacles include disagreements on issues well outside the sphere of public health policy. The U.S. and the PRC disagree over the PRC’s currency controls, sovereignty over various territories in East and Southeast Asia, the PRC’s rising military power, and the correct way of handling international actors of concern to the U.S., such as Iran. These issues and many more contribute to ongoing tensions between the United States and the PRC, and lessen the likelihood that the two countries will view each other as partners. Each new inter-state “crisis” increases the likelihood that the two sides will enter into disputes that may destabilize the Asia-Pacific.

The cooperative US-PRC relationship on pandemic preparedness was tested during the H1N1 pandemic. The PRC collaborated effectively with the USCDC, exchanging information, seeking advice on best practices, and obtaining virus strains for vaccine development. Exemplifying the openness and cooperative nature of the US-PRC relationship, during the H1N1 outbreak, a high ranking China CDC official happened to be undergoing training at the USCDC in Atlanta at the time of the outbreak. He attended USCDC meetings as it developed the US pandemic response. He was then able to transmit technical data and protocols developed in the US to the Chinese National CDC. These increasingly extensive exchanges, occurring in both formal and informal settings, result in growing trust and openness to collaboration and information sharing.[[64]](#endnote-64) When asked if the PRC sought to hide data on H1N1 cases, USCDC official based in the PRC asserted unequivocally “no, absolutely not”.[[65]](#endnote-65)

As a result of the extensive and increasingly institutionalized nature of cooperation among the PRC, ASEAN, the WHO and the USCDC, not only is the arrival of an inevitable and highly disruptive pandemic more likely to be effectively addressed, but trust is being strengthened among key international actors. Trust built through successful cooperation and improved understanding is a tremendous benefit that extends well beyond the global public health sphere and should be a source of optimism for future improved relations. However, while pandemic response may be viewed as a sphere ripe for continued successful cooperation, there are nonetheless circumstances where, should pandemics be considered a non-traditional security issue, response may be detrimentally affected. Should this be the case, there will be an immediate threat: the worsening of the impact of a potentially deadly pandemic. However, there may also be a more general threat: destabilized international relations. The place of Taiwan in pandemic response exemplifies the potential threat embedded in the encroachment of securitizing pandemics on cooperative efforts to develop an effective global pandemic response.

**Challenges to Cooperation in Pandemic Response: The Taiwan Case**

Since it is widely accepted that effective pandemic response cannot be achieved without global cooperation, a failure to incorporate all relevant actors into the global pandemic response network will necessarily result in a gap in global disease identification and control capabilities. Rational international actors would therefore seek to incorporate as many actors into such a network as possible. Taiwan exemplifies a challenge to this goal.

Discussions of Taiwan are fraught with pitfalls. In addition to ongoing tensions between Taiwan and the PRC, one must be sensitive to political disagreements within Taiwan itself. Taiwan’s actual vulnerability in the face of a pandemic outbreak, the level of PRC support, and the disadvantages Taiwan faces due to lack of full membership in international public health institutions, is open to interpretation; so too is the health security threat to the international community arising from Taiwan’s non-participation. Members of the Democratic Progressive Party (in power during SARS) tend to focus on Taiwan’s vulnerability and the global threat stemming from its lack of participation in global public health institutions. By contrast, members of the Kuomintang (in power during H1N1) tend to focus on how effectively Taiwan has responded to outbreaks and how its relationships with both the PRC and international public health institutions have greatly improved.

In 1972, the Republic of China (on Taiwan) was replaced by the People’s Republic of China at the WHO. From that point forward, WHO officials ceased visits and direct interaction with Taiwanese officials. Taiwan’s health officials and medical professionals were now excluded from WHO forums and workshops on issues ranging from how to conduct disease diagnoses to effective monitoring and controlling of newly emerging infectious diseases. Taiwan also lost access to information such as pandemic surveillance, risk assessment and early warning information that is provided by the Pandemic Influenza Program Intergovernmental Meeting, a WHO service available only to member states. Furthermore, having lost its WHO membership, Taiwan was no longer provided access to WHO virus samples and equipment stockpiles. With the WHO categorizing Taiwan a province of the PRC, Taiwan was now expected to obtain pandemic-related information and aid from the WHO indirectly, via the PRC.

Referring to the threat to health security that Taiwan faced as a result of its lost membership status, former Taiwan President Chen Shui-bian argued that “…Taiwan has had to fight pandemics without help from the World Health Organization…” greatly increasing Taiwan’s vulnerability to new and re-emerging diseases.[[66]](#endnote-66) Furthermore, government officials in Taiwan asserted that “China…refused to provide Taiwan with epidemiological information regarding SARS, Avian Flu, or any other disease in a timely manner even though it claims to take responsibility for the health and wellbeing of the Taiwanese people.”[[67]](#endnote-67) As a result, contending that the PRC was intentionally blocking efforts to protect the health of its population, Taiwan has continually sought some form of WHO status. Until recently, such efforts have been regularly stymied by Beijing.[[68]](#endnote-68)

As noted, at the time of the SARS outbreak, the WHO considered Taiwan a province of the PRC and therefore ineligible to interact directly with the WHO. Taiwan health professionals seeking information from the WHO were told by the WHO to request it from Beijing, a politically difficult option.[[69]](#endnote-69) Another option was to obtain data from the WHO website. However, according to Chen Yuan-Tsong, 2003 director of the institute of Bio-Medical Sciences at Academia Sinica, “by the time the information is in the public domain, it is probably out of date”.[[70]](#endnote-70) In essence, any real time information about the nature and spread of SARS that Taiwan required had to be obtained from the PRC government. The WHO was only allowed to work with Taiwan directly on an ad hoc basis, with prior PRC approval. Since Beijing hindered direct communication during SARS, Taiwan health officials were forced to work through intermediaries when seeking information from the WHO.[[71]](#endnote-71) And yet the intermediaries could not replace the benefits of attending SARS meetings in the WHO collaborating centers, or compensate for the challenges Taiwan health officials faced obtaining diagnostic reagents and test kits that had been distributed by the WHO to its member states.[[72]](#endnote-72)

According to C.J. Chen, Taiwan’s Minister of Health during the SARS pandemic, the PRC’s promise to ensure Taiwan access to essential epidemiologically related information went repeatedly unfulfilled. Thus, after the SARS outbreak in the PRC, but well before SARS arrived in Taiwan, Taiwan CDC officials requested samples of the disease from their HK counterparts. The request was based on a longstanding informal relationship between the two CDCs, and HK CDC officials promised to provide the information following PRC government approval. However, even after weeks of waiting, no information had been provided, forcing Taiwan to turn instead to the USCDC. This delay reflects the heightened threat to Taiwan’s response capacity arising from its international status. The result, according to Chen, was that Taiwan’s response to SARS was less effective.[[73]](#endnote-73)

While during the SARS outbreak, the PRC eventually permitted five WHO investigators to visit Taiwan, the PRC’s vice premier and health minister Wu Yi met with then WHO Director General Gro Harlem to emphasize that Taiwan is a province of China and its needs were being met through close interaction with the PRC.[[74]](#endnote-74) As a result of the PRC’s position, while WHO investigators were eventually permitted by the PRC to visit Taiwan, they were banned from having any direct contact with Taiwan government officials.[[75]](#endnote-75)

Taiwanese researchers assert that the PRC’s political stance during the SARS outbreak created unnecessary difficulties and denied them access to crucial information consolidated by the WHO. While it would be incorrect to attribute the costs of the SARS outbreak in Taiwan solely to PRC actions, analysts have described Taiwan’s SARS response as lacking, and according to DeLisle and Cozen, the PRC’s actions contributed to Taiwan suffering many casualties and high health costs, while reflecting the PRC’s prioritization of politics over international public health. These decisions “endangered people in Taiwan…. and around the world,” while also serving to damage the WHO’s “international legitimacy and efficiency”.[[76]](#endnote-76)

According to Taiwan CDC officials, a separate case further illustrates this point. In 2007 a flight from Taiwan to Nanjing via Hong Kong contained a person suffering from multidrug resistant tuberculosis. The Taiwan CDC notified both the WHO and the PRC but received no response. While eventually the Taiwan government made arrangements to return the passenger, this was of no benefit to the remaining 285 passengers on the flight who were not tracked or notified. This outcome was attributed to Taiwan’s unclear status in the WHO.[[77]](#endnote-77)

Having blocked applications by Taiwan for participation in the World Health Assembly (WHA) since 1995, in 2009 the PRC signed a Memorandum of Understanding with the WHO enabling Taiwan to obtain WHO Observer Status. Though the MOU is not publicly available, it did enable Taiwan’s participation as Chinese Taipei.[[78]](#endnote-78) Taiwan now seemingly has the status of an NGO at the WHA. While not appearing in the WHO constitution, observer status under the WHA Rules of Procedure allows observers to participate in the WHA and its plenary meetings, and access non-confidential documents. However, should the WHA President invite, and the WHA or one of its Committees consent, the observer may be given the opportunity to make a statement regarding the subject under discussion.[[79]](#endnote-79) Otherwise, while Taiwan’s status enables it to attend meetings, its representatives may only speak following presentations by all states party to the WHA, during the period allotted to observers. In addition, Taiwan continues to require permission from the PRC to attend WHO meetings. According to Chen, the result is that Taiwan representatives attend only three to four percent of such meetings.[[80]](#endnote-80)

With its new status, Taiwan has been authorized to establish a Focal Point for interaction with the WHO. However, Chen notes that the WHO will only work with the Taiwan Focal Point through the PRC’s Focal Point unless there is an emergency, in which case it may work directly with the Taiwan Focal Point.[[81]](#endnote-81)

Although even within Taiwan circles the specifics of the Taiwan situation remain open to debate and disagreement, the examples provided illustrate the type of threat that may develop if pandemics are framed as a non-traditional security issue with the result that developing effective, institutionalized cooperative global pandemic responses becomes more difficult. Clearly Taiwan’s ambiguous status has resulted in a potentially dangerous gap in global pandemic preparedness and response.

**Conclusion**

The potential human and economic costs inherent in pandemic outbreaks clearly provide incentives and opportunities for improving global cooperation. Prior to the 2002-03 SARS outbreak, pandemic preparedness enjoyed low, if any, consideration by governments. And yet, with SARS, H5N1 and H1N1, and the accompanying deaths and economic losses, came a new galvanizing of the international community. Having experienced pandemics and become aware of their own vulnerability to future pandemics, countries became motivated to cooperate in creating effective, and necessarily cross-border, pandemic response mechanisms and institutions.

As a result, even where countries have been unable to find common ground on numerous unresolved disputes relating to sovereignty and security, pandemic response offers a sphere that not only encourages international cooperation, but requires it for there to be any hope of successfully protecting the health security of populations. Pandemic preparedness and response provides an avenue for bringing together often distrustful governments for a shared goal: building and institutionalizing formal and informal relationships in the public health sphere. Over time, these relationships can encourage the confidence and trust that are necessary to tackling global challenges that extend well beyond pandemic control. Thus can pandemics be viewed as providing an opportunity.

However, while cooperation on global public health and pandemic control provides room for optimism, there is a danger in framing pandemics as a non-traditional, human security issue. As noted, the greater the importance attributed to pandemic response, and the more pandemics are conflated with security, the more difficult compromise and cooperation may become. This finds reflection in Taiwan’s status and relationship with the WHO and the PRC in the early stages of SARS. The result of PRC sovereignty concerns was gaps in global preparedness in response to SARS. Such gaps represent a threat not only to China and Taiwan, but to the capacity of the entire international community to protect itself from the next global pandemic. One might argue that had SARS not been conflated with security, the PRC would have had more room to show flexibility on the nature of Taiwan’s relationship with global public health institutions. Thus can the framing of pandemics as non-traditional security be viewed as a risk.

Still, while the danger exists that improved global pandemic preparedness will be compromised by framing pandemics as a non-traditional security issue, ultimately there remains room for optimism. Global cooperation has grown tremendously since the SARS outbreak. While the PRC was initially secretive and non-cooperative about its own outbreak and took actions to constrain assistance to Taiwan, this changed in the late stages of SARS and in its aftermath. In part the change resulted from PRC realization that international cooperation is essential for effective pandemic response, and in part the change resulted from international efforts that stemmed from the realization that SARS and future pandemics were global security threats. Thus, by framing pandemics as security concerns the international community raised their status, resulting in expanded efforts to achieve difficult compromises as was the case with Taiwan.

Ultimately, this study finds that framing pandemics as a form of non-traditional security reflects an important step towards improving international preparedness. Incorporating China in this process as an active partner is essential given its centrality to effective pandemic response. Ensuring China’s cooperation in this process requires achieving a balance between recognizing pandemics as a form of non-traditional security, and doing so in a way that limits constraints on achieving flexibility and compromise. Failing to achieve this balance will complicate essential efforts to encourage global cooperation on pandemic response, a result that may prove a serious threat to future international preparedness and security.

1. Jennifer Brower and Peter Chalk, *The Global Threat of New and Reemerging Infectious Diseases: Reconciling U.S. National Security and Public Health Policies* (Santa Monica: Rand, 2003): 14. [↑](#endnote-ref-1)
2. Rachel Schwartz and Jonathan Schwartz, “Confronting Global Pandemics: Lessons from China and the U.S.,” *Global Health Governance* vo. 3(2) (Spring 2010). Also, World Bank, “Spread of Avian Flu Could Affect Next Year’s Economic Outlook,” *East Asia Update – Countering Global Shocks* (Washington D.C.: World Bank press (2005). [↑](#endnote-ref-2)
3. Mely Caballero-Anthony, “Non-traditional Security and Infectious Diseases in Asia: The Need for a Global Approach for Health and Human Security,” (2007). <http://ideas.berkeley.edu/events/pdf/2007.03.08-mely-caballero-anthony.pdf>. (accessed December 15, 2008). . [↑](#endnote-ref-3)
4. Orvik, Nils, “Nordic Cooperation and High Politics.” *International Organization* 28, no. 1 (Winter 1974): 74. [↑](#endnote-ref-4)
5. Walter Clemens, *Can Russia Change?: The USSR Confronts Global Interdependence.*  (Boston: Unwin Hyman, 1990): 6. [↑](#endnote-ref-5)
6. The obvious exception is intentional release of biological agents by one state against the other. [↑](#endnote-ref-6)
7. WHO, *Asia Pacific Strategy for Emerging Diseases*, WPR/RC/7 (28 July 2005). [↑](#endnote-ref-7)
8. Conference Report, “Non-traditional security issues in Asia: What role for Multi-lateralism?” Consortium of Non-traditional security studies in Asia and the International Peace Academy (5 March, 2007): 3-4. <http://www.rsis.edu.sg/publications/conference_reports/NTS-IPA%20report_050307.pdf> (accessed 7 December 2010). Also, Mely Caballero-Anthony, pp. 5-6. [↑](#endnote-ref-8)
9. Similar arguments are made by Deudney with regards to environmental degradation. Daniel Deudney, “The case against linking environmental degradation and national security,” *Millennium: Journal of International Studies* vol. 19 (3) (1990). [↑](#endnote-ref-9)
10. David M. Morens, et al., “The Challenge of Emerging and Re-emerging Infectious Diseases,” *Nature* 430 (8 July 2004): 242. [↑](#endnote-ref-10)
11. Case Fatality Rate is usually expressed as the percentage of persons diagnosed as having a specified disease who die as a result of that illness within a given period. Jeffery K. Taubenberger and David M. Morens, “1918 Influenza: Mother of All Pandemics,” *Emerging Infectious Diseases* 12, no. 1(2006). Laurie Garrett “The Next Pandemic,” *Foreign Affairs* 84, no 4 (July/August 2005). [↑](#endnote-ref-11)
12. Erik Bloom et.al., “Potential Economic Impact of an Avian Flu Pandemic on Asia,” *ERD Policy Brief Series* 42 (Asia Development Bank, Economic and Research Department, 2005). [↑](#endnote-ref-12)
13. Vidal Seegobin, “Examining the Economic Costs of H1N1,” Stimson Center. <http://www.stimson.org/globalhealth/?SN=GH200905112048> (accessed 14 September 2010). [↑](#endnote-ref-13)
14. # Margaret Chan, Director-General, WHO, “H1N1 in post-pandemic period.” <http://www.who.int/mediacentre/news/statements/2010/h1n1_vpc_20100810/en/index.html> (accessed 14 September 2010).

    [↑](#endnote-ref-14)
15. Promed, H1N1 update 112 (6 August 2010) <http://www.promedmail.org/pls/apex/f?p=2400:1001:4176923836234668::::F2400_P1001_BACK_PAGE,F2400_P1001_ARCHIVE_NUMBER,F2400_P1001_USE_ARCHIVE:1001,20100807.2680,Y> (accessed 14 September, 2010). Also, N. Wilson and M.G. Baker, “The Emerging Influenza Pandemic: Estimating The Case Fatality Ratio,” *Eurosurveillance* 14, no. 26 (2 July 2009). <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19255> (accessed 14 September 2010). [↑](#endnote-ref-15)
16. Laurie Garrett (2005). [↑](#endnote-ref-16)
17. World Health Organization (WHO), GAR, Disease Outbreak News [edited]. “Avian Influenza, Human (57): Indonesia, WHO update 4.” <http://www.who.int/csr/don/2010_10_18/en/index.html> (accessed, 18 October, 2010). [↑](#endnote-ref-17)
18. Promed, H5N1 update 44 (02 September, 2010). <http://www.fao.org/docrep/012/ak779e/ak779e00.pdf> (accessed, 20 September, 2010) [↑](#endnote-ref-18)
19. National Intelligence Council, “National Intelligence Estimate: The Global Infectious Disease Threat and its Implications for the United States,” *Environmental Change and Security Project Report* 6 (Summer 2000): 48. [↑](#endnote-ref-19)
20. Kate E. Jones, et. al., “Global Trends in Emerging Infectious Diseases,” *Nature* 451, no. 21 (February 2008): 990. [↑](#endnote-ref-20)
21. WHO, *China to Study Links Between Sustainable Development and Investment in Health* (18 December 2002). <http://www.who.int/mediacentre/news/releases/pr96/en/> (accessed 25 October 2010). [↑](#endnote-ref-21)
22. David M. Morens, et.al. (2004). [↑](#endnote-ref-22)
23. Laurie Garrett (2005). [↑](#endnote-ref-23)
24. Asian Development Bank, “Avian Flu Pandemic Could Halt Asian Growth, ADB Report Says,” (3 November 2005). http://www.adb.org/Media/Articles/2005/8716\_Asia\_avian\_flu/ (accessed 21 September 2010). [↑](#endnote-ref-24)
25. Milan Brahmbhatt, *Avian Influenza: Economic and Social Impacts*. (Washington, DC: World Bank, 23 September 2005). [↑](#endnote-ref-25)
26. Laurie Garrett (2005). [↑](#endnote-ref-26)
27. Global Health Partnerships, *US Centers for Disease Control*. <http://www.cdc.gov/globalhealth/partnerships.htm> (accessed 20 October 2010). [↑](#endnote-ref-27)
28. *The WHO Agenda*. <http://www.who.int/about/agenda/en/index.html> (accessed 5 October 2010). [↑](#endnote-ref-28)
29. Klaus Stohr, “The global Agenda on Influenza Surveillance and Control,” *Vaccine* 21 (2003): 1745, 1747. [↑](#endnote-ref-29)
30. See for example, Jonathan Schwartz and R. Gregory Evans, “Causes of Effective Policy Implementation: China’s Public Health Response to SARS,” *Journal of Contemporary China* 16, no. 51 (May 2007); Schwartz and Schwartz “Confronting Global Pandemics: Lessons from China and the U.S.” [↑](#endnote-ref-30)
31. Jonathan Schwartz, et. al., “Evolution of Health Provision in Pre-SARS China: The Changing Nature of Disease Prevention,” *The China Review* 7, no. 1 (Spring 2007). [↑](#endnote-ref-31)
32. The genesis of the SARS outbreak can be found in Joan Kaufman, “SARS and China’s Healthcare

    Response,” in Arthur Kleinman and James L. Watson, eds, *SARS in China: Prelude to Pandemic?* (Stanford: Stanford University Press, 2006), pp. 55–57. [↑](#endnote-ref-32)
33. Interview, Henk Bekedam, WHO Country Representative, China (31 May, 2005); Interview, Anonymous US CDC official based in Beijing (13 July, 2010). [↑](#endnote-ref-33)
34. S. Wang and B. Sun, “Zhong guo min jian zu zhi fazhan gai kuang,” [Introduction to the development of civil organizations], in K. Yu et al. (eds) *Zhong guo gongmin shi hui de ying qi yu zhi li de bianqian* [The emergence of civil society and its significance to governance in reform China] (Beijing: Social Science Documents Press, 2002). [↑](#endnote-ref-34)
35. Schwartz and Evans (2007). For a more detailed discussion of the roles played by the various non-state actors in the SARS response refer to Jonathan Schwartz, “The impact of crises on social service provision in China: The State and Society Respond to SARS,” in J. Schwartz and S. Shieh (eds.) State and Society Responses to Social Welfare Needs in China (Abingdon: Routledge, 2009) chp. 7. [↑](#endnote-ref-35)
36. Interview, Dr. Cheng Jun, Beijing Ditan Infectious Disease Hospital (30 May 2005); Henk Bekedam (31 May 2005); Interview, Jiang Qingwu and Zhao Genming, Fudan School of Public Health (6 June 2005). [↑](#endnote-ref-36)
37. Schwartz and Evans (2007); Interview, Bekedam (31 May 2005). [↑](#endnote-ref-37)
38. John Pomfret, “Underreporting , Secrecy, Fuel SARS in Beijing WHO Says,” *The Washington Post* (17 April 2003). [↑](#endnote-ref-38)
39. <http://www.who.int/csr/outbreaknetwork/en/> (accessed 13 October 2010). [↑](#endnote-ref-39)
40. # WHO, Cumulative Number of Reported Probable Cases of SARS. <http://www.who.int/csr/sars/country/2003_07_11/en/index.html> (accessed 27 September 2010). Other sources estimate total probable cases worldwide at 8,098 of whom 774 resulted in death. See Leslie Jacobs, “China’s Capacity to Respond to the H1N1 Pandemic Alert and Future Global Public Health Crises: A Policy Window for Canada,” *China Paper No. 12* (Canadian International Council, June 2010): 5. <http://www.onlinecic.org> (accessed 15 October 2010).

    [↑](#endnote-ref-40)
41. This view was widely held, and was exemplified by then WHO Director General Gro Harlem Brundtland, “China: Its cooperating Now, Says WHO,” *Straits Times* (3 April 2003): 4. [↑](#endnote-ref-41)
42. Mely Caballero-Anthony (2007). [↑](#endnote-ref-42)
43. *Joint Declaration of ASEAN and China on Cooperation in the Field of Non-Traditional Security Issues*6th ASEAN-China Summit. <http://www.aseansec.org/13186.htm> (accessed 24 October 2010); David G. Brown, *China-Taiwan Relations: The Shadow of SARS* (2003) http://www.csis.org/files/media/csis/pubs/0302qchina\_taiwan.pdf [↑](#endnote-ref-43)
44. Susan Lawrence, “Testing Wen’s Mettle,” *Far Eastern Economic Review* (11 December 2003). [↑](#endnote-ref-44)
45. Declaration of the 7th Health Ministers Meeting, “Health Without Frontiers” (22 April 2004). <http://www.aseansec.org/16089.htm> (accessed 24 October 2010). [↑](#endnote-ref-45)
46. Yanzhong Huang, “Pursuing Health as Foreign Policy: The Case of China,” *Indiana Journal of Global Legal Studies* 17, no. 1 (2010): 130-1. [↑](#endnote-ref-46)
47. Press Release: *Health Ministers of ASEAN+3 Countries Pave Way for Better Healthcare* (23 July 2009). <http://www.moh.gov.sg/mohcorp/pressreleases.aspx?id=24720> (accessed 25 October, 2010). [↑](#endnote-ref-47)
48. The first proposal of this version was presented in January 1998. David Fidler and Lawrence Gostin “The New International Health Regulations: An Historic Development for International Law and Public Health,” *Journal of Law Medicine & Ethics* 34, no. 1 (2006). The original IHR date from 1969. [↑](#endnote-ref-48)
49. World Health Organization. *International Health Regulations*, 2nd ed. (Geneva: WHO press, 2005). <http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf> (accessed 22 September 2010). [↑](#endnote-ref-49)
50. World Health Organization. *Pandemic Influenza Preparedness and Response* (April 2009). <http://www.who.int/csr/disease/influenza/PIPGuidance09.pdf> (accessed 22 September 2010). [↑](#endnote-ref-50)
51. G. Rodier, et. al., “Implementing the International Health Regulations (2005) in Europe,” *Eurosurveillance* 11, no. 12 (1 December 2006). <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=664>(accessed 22 September 2010) **.** [↑](#endnote-ref-51)
52. WHO (2005). [↑](#endnote-ref-52)
53. Interestingly, the US agreed to sign on with the stipulation that it would implement the IHR “in a manner consistent with American federalism,” expressing concern that the revised IHR might interfere with states’ rights and other elements of the federal system. See, WHO (2005). [↑](#endnote-ref-53)
54. Centers for Disease Control website. <http://www.cdc.gov/globalhealth/> (accessed 20 October 2010). [↑](#endnote-ref-54)
55. Anonymous Interview, official – China National CDC disease control and emergency response office (Feb. 8 2010). [↑](#endnote-ref-55)
56. USCDC, *Global Disease Detection – CDC in China.*  <http://www.cdc.gov/globalhealth/GDD/china.htm> (accessed 28 September 2010). [↑](#endnote-ref-56)
57. Interview, Henk Bekedam; anonymous interview, US Department of Health official based in Beijing (26 May 2005). [↑](#endnote-ref-57)
58. Eventually it became clear that the Case Fatality Rate for H1N1 was far lower – below 1%. See for example Hiroshi Nishiura, “Case Fatality Ratio of Pandemic Influenza,” *The Lancet – Infectious Disease* 10, no. 7 (July 2010): 443-444. [↑](#endnote-ref-58)
59. Anonymous interview, USCDC official based in Beijing (13 July 2010). [↑](#endnote-ref-59)
60. Leslie Jacobs (June 2010). Also, *ASEAN Plus Three Special Health Ministers Meeting on Influenza A(H1N1).* <http://www.aseansec.org/22543.htm> (accessed 7 October 2010); *China assures support of antiviral drug to ASEAN members*, <http://asean3.ddc.moph.go.th/> (accessed 15 October 2010). [↑](#endnote-ref-60)
61. Xinhua, “China asks WHO experts to join Influenza-Prevention Team,” *People’s Daily* (3 May 2009). <http://english.pepole.com.cn/90001/90776/90883/6649683.html> (accessed 5 June 2009). [↑](#endnote-ref-61)
62. Dr. C.K. Lee, Epidemiologist and Team Leader of Communicable Disease Surveillance and Response for the WHO office in Beijing and Dr. Dong Jie, WHO Program Assistant, WHO – seconded from the China CDC Interview by Shawn Shieh. "The Global Infectious Disease Response System Project," Chris Ansell, Ann Keller, and Art Reingold (Principal Investigators). NSF Project #0826995 (19 January 2010). [↑](#endnote-ref-62)
63. Anonymous USCDC officer, Joint US-China CDC Field Training Epidemiology project. Interview by Shawn Shieh. "The Global Infectious Disease Response System Project," Chris Ansell, Ann Keller, and Art Reingold (Principal Investigators). NSF Project #0826995 (29 January 2010). [↑](#endnote-ref-63)
64. Anonymous USCDC official in Beijing, Interview by Shawn Shieh. "The Global Infectious Disease Response System Project," Chris Ansell, Ann Keller, and Art Reingold (Principal Investigators). NSF Project #0826995 (21 January 2010).

    Note: the discussion here is of the civilian public health system. Distinct from it is the military system. Should an outbreak occur in a military base with high hospitalization rates in military hospitals, this information would not be provided directly to the MoH. Rather, it would travel up the stove-pipe to the State Council which would then, likely, inform the MoH. This might delay any information sharing between China and its international partners. [↑](#endnote-ref-64)
65. Fidler and Gostin (2006). [↑](#endnote-ref-65)
66. Chen Shui-bian, “The Shunning of a State,” *Washington Post* (11 May 2007): A19. [↑](#endnote-ref-66)
67. ROK government report. <http://english/www.gov.tw/content.asp?mp=3&CuItem=18289>. (accessed 22 May 2007). [↑](#endnote-ref-67)
68. Interview, Chin-shui Shih, Deputy Director, 1st division, Taiwan CDC (1 June 2009); Interview, Shi-Chia Lin, Executive director, the Foundation of Medical Professionals Alliance in Taiwan (27 May 2009); Interview, Szu-chien Hsu, Academia Sinica (1 June 2009). [↑](#endnote-ref-68)
69. David G. Brown (2003). [↑](#endnote-ref-69)
70. David Cyranoski, “Taiwan Left Isolated in Fight Against SARS,” *Nature* 422, no. 652 (17 April 2003). <http://www.nature.com/nature/journal/v422/n6933/full/422652a.html> (accessed 14 October 2010). [↑](#endnote-ref-70)
71. Attaran, Amir et. al., “Taiwan, China and the WHO: Of Pandas and Pandemics,” *Canadian Medical Association Journal* 180, no. 10 (12 May 2009): 993. [↑](#endnote-ref-71)
72. Perry Tan, “SARS Brings Out Taiwan’s Sovereignty Issue,” *Asia Pacific Biotech News* 7, no. 10 (12 May 2007): 444-447. [↑](#endnote-ref-72)
73. Interview, C.J. Chen (29 May 2009). [↑](#endnote-ref-73)
74. “China vice premier Wu Yi meets WHO Chief,” *Renmin Ribao* (19 May 2003). <http://english.peopledaily.com.cn/200305/19/eng20030519_116894.shtml> (accessed 25 October 2010). [↑](#endnote-ref-74)
75. In an effort to offset lack of access to WHO assistance, in a separate effort, the WHO organized a visit by USCDC officials. [↑](#endnote-ref-75)
76. Schwartz and Evans (2007). DeLisle, Jacques and Stephen A. Cozen. “Taiwan in the World Health Assembly: A Victory, With Limits,” *Brookings Northeast Asia Commentary*, no. 29 (May 2009). <http://www.brookings.edu/opinions/2009/05_taiwan_delisle.aspx>. (accessed 2 October 2010). [↑](#endnote-ref-76)
77. “Taiwan Says Exclusion from the WHO Sparks Health Risks,” *The China Post* (15 September 2007). [↑](#endnote-ref-77)
78. Interview, Deputy Minister, Mainland Affairs Council, Executive Yuan: Chien-min Chao (May 2009). An unconfirmed version of the MOU can be found at <http://www.fapa.org/who/index.html> (accessed 19 October 2010). [↑](#endnote-ref-78)
79. Jaw-ling Chang (2010). [↑](#endnote-ref-79)
80. Also, according to Chang (2010), between 2005 and 2009 the WHO organized thousands of technical meetings on infectious diseases, and yet Taiwanese representatives attended 21 meetings – reflecting an inability to participate “meaningfully” in the WHO (pp. 141-142). [↑](#endnote-ref-80)
81. Interview, C.J. Chen (29 May 2009). [↑](#endnote-ref-81)