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Clare Wenham

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Regionalizing Health Security: Thailand's Leadership Ambitions in Mainland Southeast Asian Disease Control

CLARE WENHAM

CLARE WENHAM is Assistant Professor of Global Health Policy in the Department of Health Policy, The London School of Economics and Political Science, United Kingdom. Postal address: Department of Health Policy, London School of Economics and Political Science, Houghton Street, London, WC2A 2AE, United Kingdom; email: C.Wenham@lse.ac.uk

Since the emergence of HIV/AIDS and SARS, Thailand has understood the security threat posed by disease and has responded by investing in the country's disease control infrastructure, such as through the development of the Field Epidemiology Training Programme (FETP), improving pandemic preparedness, and collaborating with other states, international organizations, non-governmental organizations and private initiatives to ensure health security. This has led to the creation of a multi-stakeholder subregional governance network for disease control. However, underpinning this network is the individual transformation of Thailand, which, beyond acting as a norm entrepreneur, has scaled up its activities in disease control to become a would-be leader in disease control in mainland Southeast Asia. By using Lake's conceptions of hierarchy and Nolte's understanding of regional power, this article shows how Thailand has taken on this leadership role and has been able to dominate the normative processes of subregional disease control and in doing so has strengthened its own economic and national security. Moreover, this article draws conclusions for regional governance more broadly, through examining power dynamics between states within the arrangement.

Keywords: Thailand, governance, regional governance, hierarchy, disease control

Southeast Asia, and Thailand in particular, has often been referred to as a potential "hot zone" or hub of emerging infectious diseases.[1] This has been attributed to a multiplicity of factors including: a greater concentration and connectivity of livestock, persons and products with unsafe animal husbandry practices;[2] a lack of development coupled with population growth and urbanization;[3] problems with effective governance of infectious disease;[4] and increasing interconnectivity in the region due to improved transportation links.

Pandemic potential in Southeast Asia has been framed as a security threat,[5] and Thailand has also recognized the implications of disease for transnational security. Most evident has been the impact of "crisis" events which have changed Thai policy in this area to reflect shifting understandings of disease and security. The first of these was the impact of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS). Thailand recognized the implications of the virus for the country's national security through its impact on travel and trade.[6] This framing promoted a proactive policy pathway to limit the disease's spread through a series of campaigns such as the 100 per cent condom campaign,[7] scaling up access to antiretroviral drugs[8] and normalizing discussions of family planning through initiatives like the Cabbages and Condoms restaurant.[9] Accordingly, Thailand has been touted as one of the "success stories" of state responses to HIV/AIDS.[10] However, taking into account the pivotal role of tourism in Thailand's economy, a critical view could consider such efforts in HIV/AIDS control as having been undertaken to protect the country's economic security.[11]

In 2002-03, the spread of severe acute respiratory syndrome (SARS) represented a further key moment for understanding Thailand's infectious disease policy, similar to the "tipping point" it proved to be for regional activity in disease control.[12] Although Thailand only reported a few cases (resulting in two deaths),[13] the government made every effort to promote Thailand as a zero-transmission SARS country.[14] Despite the low impact SARS had on Thailand, it was Bangkok's leadership that was instrumental in summoning the involvement of its regional counterparts in a series of special Association of South East Asian Nations (ASEAN)+3 meetings culminating in the region being declared SARS free by June 2003. This activity was undertaken in an attempt to limit the damage to the tourism industry and the wider economy, which occurred elsewhere in Asia such as Hong Kong and mainland China.

This focus on economic and national security was further evident in the outbreak of the H5N1 influenza virus in 2004-05. Despite having laboratory confirmation of the circulating virus, the Thai government tried to cover this outbreak up for over three months in order to protect its poultry and tourism industries.[15] This approach was exemplified by Deputy Agriculture Minister Newin Chidchob when he stated: "the chicken industry would have collapsed immediately and the economy would have lost more than 100 billion baht".[16] However, simultaneous to rejecting emerging global health norms of prompt reporting and outbreak transparency, Thailand took to regional activity, seizing a leadership position for disease control, notably by hosting a meeting of ASEAN+3 on how best to control the outbreak, culminating in the production of a Joint Ministerial Statement on Prevention and Control of Avian Influenza.[17]

By regionalizing the risk of disease, Thailand demonstrated that only a collective response would combat its spread. In taking the agency to establish such regional activity, Thailand placed itself at the centre of discussions on how to respond to the threat posed by the disease. Such action is indicative of Thailand's efforts for regional and subregional preponderance in disease control, which have visibly increased in the last 15 years through a range of formal and informal mechanisms, to the extent that Thailand can now be considered a subregional disease governor, arguably extending its own sovereign power in this arena beyond its borders.

Thailand's activity in disease control raises important questions for understanding regional governance of disease more broadly. While recent academic literature has used Martha Finnemore and Kathryn Sikkink's conceptions of norm entrepreneurs and norm cascade in global health governance to explain how ideas and expectations of health security spread among actors in disease control,[18] this article seeks to push this approach one step further by considering the role of individual state agency in the propagation of disease control expectations. Traditionally more powerful regional states have been expected to take care of their own backyard in a necessarily benevolent manner, to provide stability and peace within their geographical spheres of influence.[19] Thailand, as one of the most materially and economically powerful states in mainland Southeast Asia, has arguably become the *de facto* leader in discussions regarding collaborative subregional disease surveillance and response efforts. This article considers Thailand, Cambodia, Laos, Myanmar and Vietnam as a subregion of Southeast Asia (also known as mainland Southeast Asia).[20]

To some extent, this realizes the requirements of the World Health Organization (WHO)'s International Health Regulations 2005 (IHR (2005)) which strongly encourages states to provide each other with technical cooperation and logistical support for capacity building in disease control.[21] While formal regional organizations for disease control have been a regular feature in contemporary global health, such as regional offices of the WHO, Thailand's quasi-creation of a subregional grouping in this informal manner represents a new departure for understanding global health. However, this article argues that Thailand's assertions in disease control are not only undertaken to improve the subregion's health, but also to allow Thailand to protect its own national and economic security from the threat of disease, as initiated through their approach to HIV/AIDS, SARS and H5N1 control.

Using the work of David Lake on hierarchy,[22] and Detlef Nolte on regional power,[23] as a theoretical framework to understand regional governance, this article demonstrates how Thailand has scaled up its disease control activity beyond its borders to assume a position of subregional disease governor. This governance arrangement has been welcomed by Thailand's neighbours in mainland Southeast Asia as it has increased their capacity to respond to an outbreak, and meet their normative obligations to global health security.

Methodology

The findings of this article are drawn from elite semi-structured interviews with a range of policymakers involved in disease control in Thailand, Cambodia, Laos and Vietnam. Interview participants were identified through document and Internet searches, followed by snowball sampling, after making initial contact with an individual in each ministry of health. Policymakers were contacted by email and asked to participate in the research, having been sent detailed information about the research project and a list of sample questions. Interviews were recorded, where consent was given, or notes taken. Content analysis was conducted on the interview transcripts, to identify key themes and policy aims from each country. This interview content was then triangulated with policy documents from Thailand's Ministry of Public Health (MOPH) and its subregional counterparts, as well as other global and disease control actors, such as (but not limited to) the WHO, America's Centers for Disease Control (CDC) and the Asian Development Bank.

Moving Beyond the Norm Entrepreneurs

Current literature on global heath governance and global disease control focuses on the role of norms in explaining state activity with global health security. Governments are expected to comply with new standards of behaviour for minimizing infectious disease, as codified in the WHO's IHR (2005) and have instigated the necessary structural changes to their national public health provision to reflect this.[24] Based on the work on Finnemore and Sikkink,[25] the assumption is that states act in accordance with global social expectations, and this includes how they should report outbreaks of disease, implement the IHR (2005) and concern themselves with global health security. Working within this norm life cycle, Sara Davies, Adam Kamradt-Scott and Simon Rushton[26] suggest that within the global health space there exist norm entrepreneurs that propose how states should act in global disease control and convince others to commit to a collective security framework. Once several states have accepted a norm proposed by such entrepreneurs, such as improving surveillance and response mechanisms, this norm is considered to have cascaded amid states and becomes embedded within the architecture of global health governance which then becomes the expected behaviour by which all states are judged.

Using such a framework, Thailand could be considered as a subregional norm entrepreneur, as it offers mainland Southeast Asian states an example for how to understand disease—in terms of national and economic security—and a model of technical /financial support for how to implement public health provisions in surveillance, prevention, reporting and response to limit the spread of diseases. Southeast Asian countries have already accepted the need for outbreak transparency and the importance of global health security.[27] Global norms for disease control have cascaded and been internalized from global actors such as the WHO.[28] As such, this framework may not be suitable for understanding the dynamic role of Thailand as a subregional disease governor, as this normative agenda is not generated at this level of analysis.

Moreover, the norm life cycle framework for understanding state activity in disease control misses the important nuance of an individual state's agency and influence in a regional grouping. Thailand does not only encourage its neighbours to behave in accordance with its normative perception of disease control as a norm

entrepreneur, but simultaneously actively participates and directly involves itself in the disease control of other states beyond that which might be expected or justified in an anarchical structure of regional disease control. A theoretical basis for understanding this governing, beyond norm entrepreneurship, is through consideration of regional hierarchy, based on the work of Lake on regional power and developed by Nolte.

Regional Hierarchy

Firstly, for a country to become a regional or subregional disease governor, it is important to challenge the concept of anarchy~~ at the regional level~~. As Lake suggests,[29] it is a fallacy to assume that all the relationships within regional systems are anarchic. Secondly, the creation of a subregional governance framework whereby Thailand is at the centre is not an objective fact, but is produced and reproduced by the interactions of states themselves and through the self-identification as such by the regional power.[30] This approach is centred on the concept of relational authority, which rests on a bargain between the "governor" and the "governed" premised on the former's provision of a social order of value sufficient to offset the latter's loss of freedom to reach an equilibrium in a regional network.[31] This mimics Nolte's conjuncture that a regional leader must provide collective goods for the region,[32] and that it must be accepted by its neighbours as performing this leadership position. In this instance, Thailand, the governor state, offers disease control resources to its neighbours who in turn relinquish some of their sovereign power in the control of information about their pathogenic status.

A hierarchical relationship then becomes contingent on the performance of the prevailing state providing social order to its subsidiaries, and having the internal structure and material resources to do so.[33] Thailand must demonstrate that it is able to support subregional counterparts in disease control activities, and this in turn legitimates the hierarchal relationship; governed states in turn accept the authority of the leader to exert restraints on their behaviours necessary to provide that social order. In this instance the social order is the maintenance of global health security. Thailand can demand to know about outbreaks occurring in the subregion to enhance economic and national security, and its subregional counterparts will be transparent with their

disease surveillance—despite there being no legal obligation to do so—to contribute to ensuring global health security.

This leadership also has a normative dimension. A regional leader benefits from setting the rules of engagement in ways that reflect its interests, defining the world view and regional security agenda and the common project to combat the security threat subject to being accepted by a sufficient number of governed states.[34] Thailand benefits from the framing of subregional disease control activities in terms of the threat they pose to (Thai) national and economic security, and as such define the subregional response to disease outbreaks. This is helped by the fact that the mainland Southeast Asian states have already internalized a worldview of disease control as promoted by the norms of global health security. As the subregional disease governor, Thailand is able to ensure that epidemiological practice subregionally adheres to its standards and its conceptions of disease, and that Thailand will be rapidly informed about any potential disease threat in the subregion.

Similarly, regional states recognize the leading position of another, but typically only for something in return, most often protection from internal or external threats, such as, in this instance, infectious disease.[35] There are three reasons why a state would willingly enter into such a regional governance arrangement.

Firstly, governed states depend on governor states for a measure of social order (the maintenance of health security), and having received protection from the governor state, they themselves do not need to divert scarce resources to this area. It follows, therefore, that countries in hierarchical security relationships, all else held constant, spend fewer of their own resources on security and rely more on the efforts of their protector.[36] In mainland Southeast Asia, states which are quasi-governed by Thailand for disease control have not channelled vast resources to meet global health security standards.[37] Whether this is due to funding shortfalls, capacity, or a desire to concede this area of responsibility to Thailand the net result is the same, allowing the subregional power relationship to manifest itself.

Secondly, governor states are significantly more likely to come to the aid of their regional counterparts.[38] For example, Thailand has sent its Surveillance and Rapid Response Teams (SRRTs) to Myanmar, Cambodia and Laos to undertake epidemiological study and outbreak response when rumours of disease have emerged.[39]

Thirdly, the governor state helps the governed to meet the general standards of international behaviour.[40] While subregional states have internalized the norms of global health security, they lack the ability to implement these fully. For example, a review of compliance with these core competencies of the IHR (2005) showed that governed states in Southeast Asia had not yet met these requirements.[41] However, subsequently, these states have been able to evidence subregional arrangements with Thailand, demonstrating that the epidemiological resources are available for them to use, as part of this hierarchical network, and they are taking strides towards implementing their normative expectations at the global level.[42] In spite of these reasons why governed states may comply, demonstrating this compliance can be challenging.[43]

Thus, it is difficult to distinguish whether this governance relationship is based on domination by Thailand or cooperation with its subregional counterparts. Yet, when understanding a hierarchal relationship based on relational authority, then this relationship can be said to be both of these.[44] Relational authority represents a social contract between a ruler—who provides a social order of value to the ruled—and the ruled who comply with the ruler's commands necessary to the production of that order.[45] Thailand makes efforts to dominate subregional disease governance in the maintenance of global health security, and these efforts are accepted and reproduced by the governed states as they understand the benefits they derive from ensuring global health security through this subregional governance framework. By using a social approach to authority, any obligation in this hierarchy does not "follow from the ruler to the ruled", but as a bargain between these two actors.[46] Moreover, this relational authority is not total, but a continuous dynamic variable, dependent on context. Thailand may possess authority over its governed states in some areas of disease control, as will be illustrated below, and not in other areas which remain beyond expectations of compliance. These areas of authority may not be restricted to disease control; Thailand has created a similar governance arrangement for economic cooperation,[47] environmental concerns,[48] and dominance over water resource management in the subregion.[49]

Regional Governance

Based on the framework suggested by Lake and Nolte, understanding Thailand as a subregional disease governor relies on the supposition of a subregion as a unit in the emerging regional architecture of world politics.[50] Such a collection of states has been defined in several ways, including "a collective cognitive, socially constructed entity as well as a territorial one",[51] "a bridge for the gaps at national level by developing collective regional solutions to common challenges",[52] or a collective intersubjective formulation whereby "national interests come to be understood as best met and protected through collective action and compliance with norms that reflect and sustain the regional community".[53] Often, such regional groupings can also be considered in terms of regional security complex theory[54] or regional security communities[55] with states conceiving of sharing certain security externalities, such as the threat posed by infectious disease, that arise from a common geographic area and have consciously or unconsciously chosen to construct a regional mechanism to combat the threat.[56] As highlighted by Jürgen Haake[57] and Amitav Acharya,[58] Southeast Asia is more likely to localize such activity rather than adopt global norms wholesale, so it is unsurprising that (sub)regional states may favour (sub)regional coordinated activity.

Reflecting broader trends of regionalism, regional organizations have scaled up their activities in disease control, sharing strong converging reciprocal interests in addressing the risk of outbreaks, allowing a reconfiguration and expansion of the nature of regional security cooperation among Southeast Asian states.[59] It was initially through these organizations that Thailand was able to scale up its regional activities to play a critical role in regional disease control.[60]

For example, during the SARS and H5N1 outbreaks, Thailand actively pushed other ASEAN+3 states to appreciate that the region was increasingly interconnected by disease threats—an ASEAN disease security community.[61] Consequentially this regional grouping established a range of mechanisms for health cooperation ensuring multi-sectorial regional protocols for pandemic preparedness. These were formulated at a number of ASEAN+3 meetings, many of which have often been hosted by Thailand, and notably included a regional meeting on H5N1 that produced the ASEAN+3 Joint Ministerial Statement on Prevention and Control of Avian Influenza.[62] Moreover, this ASEAN+3 hub has developed the ASEAN+3 Field Epidemiology Training Network, which has its permanent office in Thailand, with the support of the Thai MOPH.[63] Thailand was also pivotal in the development of a regional strategic framework to collectively address the risks posed by infectious

disease control and simultaneously meet IHR (2005) obligations and strengthen health security: the Asia Pacific Strategy for Emerging Disease (APSED).[64]

Thailand has also played a key role in other formalized regional disease control activity, such as initiating the Asia Pacific Economic Cooperation (APEC) forum role in disease control, which has established a health working group aimed at enhancing and strengthening health security for member states; the APEC Emerging Infections Network (APEX EINet).[65] Likewise Thailand has dominated the development of the Ayeyawady Chao Phraya Mekong Economic Cooperation Strategy (ACMECS), promoting regional disease control as a regional public good to which all member states should contribute in order to promote development and economic stability.[66]

These regional governance activities have not just appeared amid multilateral institutional settings, but networks have also emerged informally. A pertinent example is the Mekong Basin Disease Surveillance (MBDS) network, a subregional network for communication between departments of disease control, improving cross border infectious disease outbreak surveillance and response, to limit the spread of infectious disease in mainland Southeast Asia.[67] Importantly for this analysis, it is Thailand that hosts this network in the MOPH, where it is formally registered, and, moreover, has been pivotal in its success, through its support in the technical development of the epidemiological systems and hosting a number of events to get health professionals together under the MBDS umbrella to foster greater trust and understanding.[68]

It could be deduced that Thailand's involvement in regional governance mechanisms have only been in areas where the state has been able to exercise a high degree of control in setting the agenda. While other states in the region showed strong convergence over maintaining the social order of global health security,[69] it can be argued that the ultimate motive for Thailand's involvement in such regional initiatives is to allow it to further its broader geostrategic ambitions[70] or ensure its own national and economic security through dominating the normative approach to disease control, being in a position to garner more information about diseases occurring regionally and in doing so, its transformation into a would-be regional disease governor.

The Transformation of Thailand into a Subr~~R~~egional Disease Governor

As noted, several mainland Southeast Asian countries consider Thailand as a subregional leader for disease control and a model for their surveillance and response systems.[71] Thailand has been able to foster this identity not only through its involvement in regional organizations, but further through transforming its state-based disease control activities into subregional efforts as the subregional disease governor. This can be evidenced through five key facets of Thailand's disease control activity.

Firstly, Thailand has invested heavily in the creation of an internationally acclaimed infectious disease surveillance and response training programme. In 1980 the MOPH, in collaboration with the WHO and the CDC, established the first Field Epidemiology Training Program (FETP) outside North America.[72] This visionary move aimed to enhance human capacity for disease surveillance, response, investigation and control in Thailand and neighbouring countries.[73] Through this, Thai nationals were trained in advanced epidemiological methods and how to combat any potential outbreak—thus limiting any national security or economic fallout of an emerging infectious disease—to maintain social order. Accordingly, the alumni from this programme "have provided the backbone of epidemiological surveillance and broader public health responses in Thailand".[74]

Interestingly, since 2001 this programme has included numbers of foreign nationals from the subregion in the training of this (Thai) public health curriculum, which was renamed the International Field Epidemiology Training Program (IFETP) in 1998. More recently, this is in spite of some subregional states having their own national epidemiology programmes, including Laos and Cambodia. Beyond the IFETP, Thailand also conducts short training courses in disease control for subregional health workers who do not have the capacity to take the whole training programme.[75] The result of this investment has been that public health professionals from neighbouring states have been taught in Thai epidemiological methods, and in doing so understand disease control as Thailand does, i.e. in terms of national security. While this frame reflects the global trend for conceptualizing infectious disease, this domination of the type of knowledge taught in these courses emulates Lake's theory of hierarchy and Nolte's consideration of normative leadership. Thailand offers epidemiological education as part of its provision of social order to subregional states, and, in return, these states legitimate Thailand's dominance by

implementing similar normative understandings of disease; the framing of disease as a security threat and maintaining similar epidemiological practice in their national health infrastructures. Most practically, this can be seen in the creation of Surveillance and Rapid Response Teams (SRRTs) in Laos and Cambodia, based on the example set by Thailand's public health infrastructure.

Moreover, foreign alumni of the IFETP remain in contact with the Thai officials and thus Thailand maintains direct (yet informal) communication with public health colleagues in subregional health ministries, who can share information of potential outbreaks occurring in their own states.[76] Moreover, IFETP students are closely involved in the MBDS mechanism, further consolidating this relationship.[77] Accordingly Thailand enjoys an increasingly more networked position compared to other states in the subregion. This puts Thailand in an unrivalled position for subregional outbreak awareness, and such information accumulation allows Thailand to remain at the apex of subregional disease governance and use any information collected to protect its domestic security interests.

Secondly, Thailand maintains one of the best reference laboratories in the region, alongside those in Singapore, Japan and Malaysia.[78] Through this reference laboratory (located in the MOPH), Thailand is able to rapidly identify any pathogens occurring within its borders. Under the IHR (2005), each state is supposed to have their own reference laboratory facilities, yet as Laos, Cambodia and Myanmar have not been able to achieve this, they have increasingly sent their disease samples to Thailand for diagnostic testing, and have used this facility as part of their reporting compliance under IHR (2005).[79] Cambodia, Laos and Myanmar are thus able to show the WHO that they have use of subregional reference laboratories to confirm diseases, and thus they comply with the global normative and regulatory requirements, if not within their own territory. This reflects Lake's understanding that a governor state helps its ancillaries meet international standards of behaviour.[80]

Interestingly, in the wake of the Indonesian virus sharing controversy,[81] states have chosen to send their virus samples to Thailand, rather than to a WHO reference laboratory, or a CDC laboratory (which are active in the region) or any other non-state scientific organization (such as Institut Pasteur or the Robert Koch Institute).[82] Through such faculty, Thailand has furthered its position as the subregional leader as each of the other states has sought to use Thai services in order to identify outbreaks occurring in the subregion rather than accepted global leaders. The recognition of

Thailand as a subregional disease governor becomes ever more apparent as subregional actors are able to benefit from the material scientific resources of Thailand to gather pathogenic intelligence. Thus Thailand extends its sovereign control in both the areas of training public health professionals, and offering services which should fall to states to perform, such as laboratory capabilities.

Yet, beyond the altruistic, this collective use of the reference laboratory creates an unusual power dynamic in the subregion. By undertaking the diagnostics, Thailand has unrivalled knowledge of its neighbour's pathogenic status prior to official inter-state or global reporting, placing it in a position to dominate the subregional response to any outbreak, as well as protect its own national and economic security interests. One key area of convergence in understanding hierarchical relationships is that governed states complicity cede some of their sovereign authority to the governor state. Equally important to this laboratory power relationship is the fact that if Thailand identified diseases occurring in the subregion, it could put pressure on the reporting relationship between that state and the WHO (under the IHR (2005)). While Thailand will type the pathogen, it will be up to the member state where the pathogen was found to report this outbreak to the WHO. There could be instances where transparent reporting from a subregional state was not forthcoming, and knowing that Thailand is aware of the disease outbreak (through this increasing subregional hierarchal dynamic) may encourage the infected state to fulfil their obligations under the IHR (2005).[83] This relationship could highlight the coercive aspect of a regional governance framework, that through this power dynamic a governor state maintains the authority to punish non-compliance with international standards of behaviour,[84] such as through the "naming and shaming" of a state's failure to meet normative expectations of global health security.[85] However, to date there is no example of this occurring, which is why the delineation of the subregional governance relationship as hegemonic is not suitable.[86]

Thirdly, Thailand's disease surveillance infrastructure functions beyond the borders of the state and is able to detect outbreaks in other states. As the materially and economic preponderant state in the subregion, Thailand enjoys a much more comprehensive disease surveillance programme than its neighbours, both in terms of effective training as well as resources. As a consequence, a neighbouring state may not have detected a circulating pathogen until it has reached the Thai border, where it is then identified by the Thai surveillance apparatus. This became apparent during the

outbreak of H5N1 in 2007 when a girl infected with the virus was not diagnosed in her home state, Laos, but only when her family took her across the border to Nong Khai in northern Thailand for medical attention.[87] While this illustrates the lack of surveillance in Laos, it also suggests, importantly, that Thailand is able to have an influence on assessing viral status beyond its borders.

Moreover, with the recent paradigm shift for collaborative working at the sub regional and regional (or global level) for infectious disease control,[88] there are numerous Thai public health teams working in Myanmar undertaking both disease surveillance and response activities.[89] Likewise, there are increasingly joint investigations between SRRTs from Thailand working across the border alongside their counterparts in Laos and Cambodia.[90] As Lake suggests, a hierarchal relationship can be evidenced through "boots on the ground" in a governed state, and this example of public health professionals working internationally further suggests this subregional governance network is based on hierarchy.[91] Through these activities, and influenced by the vast disparities in resources for disease surveillance, Thailand is able to ascertain the prevalence of a potential outbreak occurring externally, and before another subregional state has detected it. This represents the development of a hierarchal relationship where states, whether they are willing or not, share some of their sovereign duties in identifying pathogens to Thailand.[92] It could be considered that Thailand is acting as a responsible state, focused on the provision of subregional public goods for disease control,[93] and supporting other states to meet their global surveillance obligations under IHR (2005).[94] However, another interpretation may be that Thailand supports its neighbouring states through human resource development (such as IFETP), use of reference laboratories and functional surveillance capabilities in an effort to further its own national and economic security, ensuring that it is aware of any pathogenic presence occurring in the subregion. This would then allow Thailand the forewarning to take any steps it might deem necessary to protect the state, population or economy from the potential impact of trade and travel restrictions.[95]

Fourth, Thailand is able to dominate the subregional discourse of disease control as it is one of the only states in Southeast Asia engaged in South-South regional and sub-regional development cooperation.[96] Thailand has developed the International Partnership for Development Program which supports new initiatives to enhance South-South cooperation within the region (and beyond) in areas of health

and disease prevention.[97] This has included HIV/AIDS prevention, participation in international public health networks, providing expert referral services e.g. laboratory services, building influenza diagnostic capacity in Myanmar and sharing knowledge and experience of management of a host of infectious diseases including H1N1 with the Maldives, Nepal and Sri Lanka.[98] Through this South-South development cooperation, Thailand has further dominated the frame of reference, types of epidemiological practice and methods for the building of capacity in disease control in the states to whom it offers assistance, and even to those states beyond its immediate neighbourhood. This follows from Lake's argument of a governor state providing social order to their counterparts.[99] The social order favouring global health security is thus carried across into the aid recipient states.

As with the IFETP, Thai development officials are based in the health ministries of these states to implement these development programmes. Accordingly, Thailand will have insight into health concerns which might be occurring within these states ensuring their continued national and economic security protection from the threat of disease. In particular, the two overarching initiatives that Thailand promotes as part of its health development agenda are: first, addressing the least developed countries needs in health provision; and second, ensuring access to modern technology for these states.[100] Maintaining the social order of global health security is reliant upon improved surveillance protocols in the region and beyond. By improving access to digital technology, this will lead to improved disease reporting through MBDS or digital disease reporting. Thus, Thailand would be able to obtain disease-relevant information even more promptly and ensure continued health security, while appearing to altruistically be supporting other states in the region through development assistance.

Finally, Thailand has been able to take a governing role in subregional disease control due to the country's physical location and its economic and material development in comparison with other states in the subregion. Thailand is (relatively) central geographically to mainland Southeast Asia, as well as offering excellent transport connections and a subregional and regional travel hub.[101] Accordingly, a number of other organizations involved in Southeast Asian disease control have located their headquarters in Bangkok, including the Rockefeller Foundation, USAID's Regional Mission and the World Bank. More interesting still, the office of MBDS, and the regional offices of the CDC and WHO, are located physically within

Thailand's MOPH in Nonthaburi, and have essentially been "integrated into the political architecture of the Thai government ministry".[102] Not only does the presence of these organizations in Thailand represent Lake's understanding of symbolic obeisance, in that Thailand was not chosen by coincidence, but that the positioning of these external "neutral" actors in Thailand's MOPH form the central hub of a regional and subregional social order.[103] This means that Thailand is, to some extent, able to develop the agenda of these organizations as they have predominately Thai nationals working for them, who have been trained in the normative Thai public health approach and as such can influence external actors' regional activity in disease control. Thailand has dominated the theoretical underpinnings of these regional networks, including influencing which diseases to focus on, and which epidemiological practices and principles should be assumed. As Lake insinuates, the governing state is able to reflect its interest in activities of governed states and their relationship with third, external parties.[104] Moreover, Thailand is able to get first-hand (informal) information about any disease outbreaks which is sent to these organizations (especially CDC and WHO) as it has a network of cooperative staff within them ensuring continued health security. In doing so, it further ensures compliance from subregional states to ensure they notify Thailand through the various mechanisms available of any disease outbreak, knowing that otherwise they may become aware of these through the WHO/CDC connection at Nonthaburi.

These five examples illustrate that Thailand, beyond acting as a subregional norm entrepreneur, has exerted its activity in disease control beyond its own borders, and has transformed itself into the apex of collective subregional action for surveillance and response, as a subregional disease governor. Such a position in establishing a subregional disease governorship are mirrored in other areas of health, such as provision of universal health coverage,[105] medical tourism,[106] and its desire for regional dominance in tobacco production.[107] Yet, as shown, Thailand's involvement in subregional and regional efforts has been in areas where the state has had a high degree of discretion in setting the rules of engagement and can be seen to be doing so, mimicking its response to HIV/AIDS, SARS and H5N1, to protect its own national and economic security.[108]

Constraints

Nevertheless, it is important not to over-state the case of Thailand as a subregional disease governor, and terminologies of hierarchy and regional power risk doing so. For example, this case study of Thailand in subregional disease control does not meet the definition of regional power according to Iver Neumann[109] as it has not considered the subregional power's place on the global scale and its ability to stand up to other states in the broader region. As such, instead of stating Thailand's leadership position as an analytical given, a counter position could be to treat Thailand as having aspirations for regional disease governance.[110] This is important as there are other states in Southeast Asia which may challenge Thailand's role as a disease governor, including Indonesia and Singapore, and, in the Asia-Pacific, China.

Moreover, while transforming itself into a subregional disease governor, Thailand is constrained by global actors. As with other regional powers, they are often influential in their own sphere, but exert little influence on the global scale.[111] As Miriam Prys highlights,[112] regional powers have to operate within an overarching international system determined by the global distribution of power and by international institutions. This includes compliance with the normative understandings of global health security and the legislative requirements of the IHR (2005).[113] Yet, Thailand while complying with IHR (2005) for the most part, and making efforts as a global normative leader in health security through efforts such as the Prince Mahidol Award Conference—an annual global conference on global health security—it has simultaneously challenged parts of the globalized approach to health. As predicted by Philip Nel and Matthew Stephen,[114] regional powers play different roles in two plays that are playing in the same theatre; that of the prevailing regional power at home, and challenging the global order externally. Thailand has appeared to test the global rhetoric by contravening some global health norms and pushing for greater national policy space.[115] This has included Thailand's decision to issue compulsory licences for antiretroviral medications,[116] the inclusion of Thai traditional medicine techniques into epidemiological data,[117] challenging the perceived methodology of Langmuir,[118] as well as favouring informal reporting mechanisms and subregional activity between neighbouring states rather than full interaction and compliance with formal global disease governance. In championing subregional activity, and extending its role as subregional disease governor, Thailand could be seen to be challenging the overarching system of global disease governance and the status quo of the "the entrenched power structure of global health governance whereby economically and

politically powerful countries, principally in Europe and North America have had a disproportionate influence on the global health agenda".[119] This is where this subregional position of governor becomes important. If Thailand commands power over its subregional counterparts in disease control and continues to challenge the global status quo, we can expect such challenges to receive the support of their subregional counterparts, such as Lake's expectations that "subordinate states follow their hierarch into war",[120] potentially allowing such position to take hold in global fora with a greater number of states pushing for change.

This could have wide-reaching implications in the future if there comes a time when Thailand's approach to an outbreak or disease control norms diverges from that of the norms of global health governance. This is not conjecture, for as recently as 2005 Thailand tried to cover up the emergence of H5N1 which flew in the face of the normative assumption of outbreak transparency, putting the region (and the rest of the world) at risk of an avian influenza epidemic. Moreover, Indonesia, a competing regional counterpart, challenged the global normative expectations of disease control during the virus sharing controversy, highlighting the power that emerging regional powers can have at the global level. As highlighted by Frank Smith,[121] Indonesia's actions were inconsistent with the norm life cycle understanding of compliance in global disease control and showed the importance of state agency within global health governance. Indonesia's actions resulted in notable changes to the global virus sharing agreements, and as such it is important to remember that regional powers can provide the impetus for normative change at the global level, particularly if they have the backing of other states. Indonesia benefited from the support of a number of states; Brazil, Iran and the Non-Aligned Movement, creating greater power at the global discussion table. Accordingly, this article has hoped to show another manifestation of regional power and increased state agency within the global health literature, with a readymade group of supporters in mainland Southeast Asia, a subregion already identified as a hotspot for future outbreaks.

Conclusion

This article has considered Thailand's policy and activity in disease control which has transformed the state into a subregional disease governor. While regional arrangements for health are not new, such as ASEAN or WHO's regional grouping of

South-East Asia Regional Office (SEARO), the dominance of one state amid formal and informal regional and subregional mechanisms for improving disease control collectively has not been analyzed thus far. This article has shown that Thailand has purposively taken strides to lead regional initiatives and has scaled up its domestic activity beyond its borders to position itself at the apex of a subregional disease control, as a subregional disease governor, and in doing so furthers its own strategic goals of increased economic and national security. This governing relationship has not been undertaken solely by Thailand, but the governed states have been complicit in the creation of such a governance arrangement as they understand that considerable benefits can be derived from Thailand acting as a subregional governor for them to meet their global health security obligations. As such, this hierarchal relationship is one based on relational authority, where both sides agree to the arrangement.

Although contemporary global health discourse reflects on the role of norm entrepreneurs in leading changes for health security at the global level, analysis of this regional and subregional dimension is somewhat new. In the case of Thailand in mainland Southeast Asia, the norm life cycle framework does not sufficiently explain Thailand's disease control activity and dominance. Lake's theory of hierarchy and Nolte's framework of regional power[122] provide a clearer conceptual understanding of subregional disease governance, with Thailand in a leadership position, providing a social order of global health security to subregional states and these states have afforded Thailand this position. As such, for a (sub) regional governance mechanism to work, it is dependent on both the governor state and the governed states equally to sustain a hierarchical relationship based on relational authority.

NOTES

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