

NORTH-EAST ASIA DEVELOPMENT COOPERATION FORUM *POLICY BRIEF*

This was prepared as one of four policy briefs from the North-East Asia Development Cooperation Forum in 2020 organized under the theme “Experience and challenges of North-East Asian countries on development cooperation in the face of the COVID19 pandemic”.

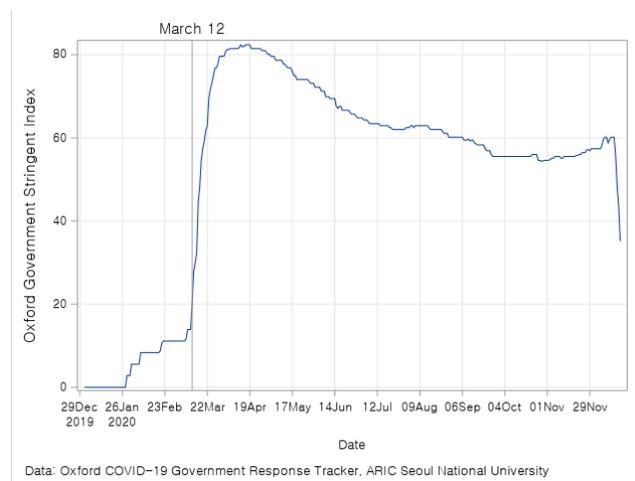
COVID-19 AND INTERNATIONAL COOPERATION: LOOKING FOR LESSONS FROM ASIAN COUNTRIES

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I. Introduction

When the COVID-19 dubbed the Wuhan virus in December 2019 and brought severe damage to China in early 2020, few predicted it would become novel pandemics in human history. At that time, there was unrealistic hope that COVID-19 would fade away along with hot weather. Some developed countries considered the outbreak of COVID-19 as evidence for developing countries with the deficient public health system and disaster management system. Accordingly, many developed countries underestimated the infectivity of COVID-19. They regarded COVID-19 as a disease limited to developing countries, especially China. Due to the low level of risk awareness, most developed countries had not been well prepared until the World Health Organization (WHO) declared the pandemic on 12th March 2020. Figure 1 shows the median Oxford COVID-19 government stringent index trend, which measures the stringent level of policies such as school closures, workplace closures, cancellation of public events, travel bans, etc. As the figure suggests, WHO's declaration of pandemic

Figure 1: The Trend of Government Stringent Index



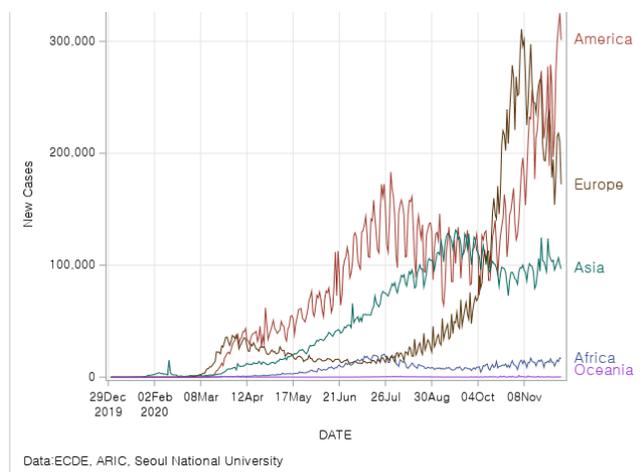
invokes the rapid increase of the stringency of the COVID-19 response.

Given the full scope and depth of the impacts of COVID-19, global cooperation becomes more prominent to disentangle the miserable situation of COVID-19. Besides, many countries still suffer from the increase in extreme poverty, the fall in global GDP growth, heavy fiscal burdens to the governments, and

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the collapse of global value chain. All these negative impacts would not remain a local problem but highly likely to affect the international community. Even if one country successfully controls the spread of disease by the lockdown and bans of international travels or herd immunity through successful vaccination of COVID-19, it does not exclude the possibility of a resurgence due to the highly connected global community. As shown in Figure 2, America, Europe, and Asia have been heavily affected by COVID-19, and we can observe the aggravation of infections in the second wave or even the third wave. Given this trend of spreads, the pandemic will never end with a single country's effort.

Figure 2: Trend of New COVID-19 Cases by Continents



Suppose we admit that COVID-19 should be understood as a global disaster. In that case, the comparative analysis of the response to COVID-19 and drawing lessons from other countries is essential to prevent future failure in disaster management. In particular, while the developed countries have well-designed the disaster management system, empirical evidence suggests that the most severely infected countries with high death rates are the developed countries in Europe and the United States. On the contrary, some developing countries such as Viet Nam and Thailand performed well while others did not. Hence, the comparative perspective is essential to understand the complexity of such heterogeneity of COVID-19 situations and responses.

¹ Reuters, October 1, 2020, "Turkey has only been publishing symptomatic coronavirus cases – minister"

2. Accessibility and Quality of Global COVID-19 Data

Reliable and timely data are essential for the diagnosis of situations and policy design. Chinese Center for Disease Control and Prevention (Chinese CDC), European CDC, WHO, and Johns Hopkins University's Coronavirus Resource Center publish the data every day, consumed by mass media, researchers, and citizens worldwide. Some research groups such as Our World in Data (OWID) at the University of Oxford and Asia Regional Information Center at Seoul National University combine and process these primary data with other socio-economic data and provide analysis results to other users. Infographics and dashboards help people easily understand the status of other countries. Due to the accessibility and utilization of COVID-19 data, we can likely detect fake news and mistakes originated from ignorance.

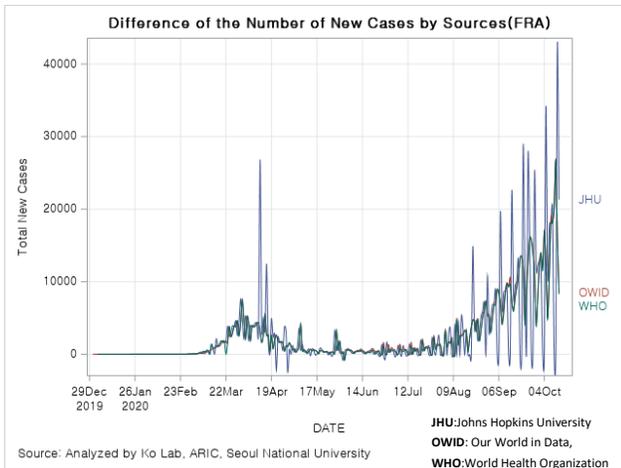
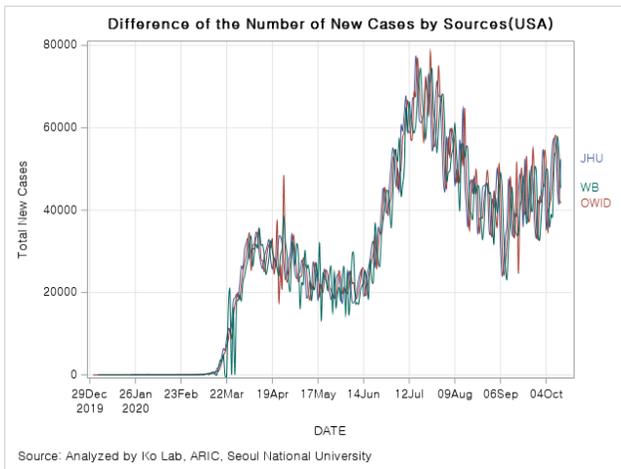
Despite the benefit from the high accessibility of data, criticism of COVID-19 data quality has been raised. The case definition of suspected, probable, and confirmed cases has changed over time, even within the same country or international organization. According to the WHO guideline (WHO, August 2020), the confirmed case is defined as "a person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms." However, high-quality comparative research data are not available if there is a lack of tests, a flawed statistical reporting system, inconsistent case definitions. For instance, in China, the National Health Commission issued the seven versions of the case definition for COVID-19 from 15th January to 3rd March, 2020. The change of the case definition causes significant differences in the confirmed cases. According to Tsang et al. (2000), China's confirmed case by 20th February, 2020, would have been five times larger than that of officially reported cases if the fifth version of definition were used. In the case of Turkey, the Health Minister admitted that his country only reported the symptomatic patients.¹

The poor quality of data is also a problem in developed countries. As shown in Figure 3, developed countries such as the United States and France show different

<https://uk.reuters.com/article/health-coronavirus-turkey/turkey-has-only-been-publishing-symptomatic-coronavirus-cases-minister-idUKL8N2GR7BJ>

new case trend among WHO, OWID, and Johns Hopkins data. For instance, France's confirmed cases are 2.52 million cases in Johns Hopkins University database, but 2.46 in Google. When there is a massive outbreak, the timely report of test results fails, and test errors increase. Even if an individual country corrects the error later, the global databases frequently were unable to update their data reflecting the correction.

Figure 3: Different Trends of New Cases among Different Data Sources



Some crucial information, such as the number of tests, the positive rate, severe condition cases, and patients at quarantine are not reported nor collected in many countries. Developing countries do not have a systematic public health information system collecting and sharing public health data among hospitals, local and central governments, and citizens. Moreover, their statistical capacity dealing with the massive data is not satisfactory at all. The WHO should exert the leadership for providing statistical training, guideline,

and a reporting system. The international organizations needed to support developing countries to establish the infective disease monitoring system connecting local, national, and global organizations, in order for the global community to respond to future pandemics effectively.

3. High Infection Rate vs. High Death Rate

Because of the unpreparedness to COVID-19 and inadequate responses, even the developed countries are facing the continuous rise of mass infection, as shown in Figure 4. Interestingly, the high-income countries showed a high death/case rate at the early stage, but quickly controlled it to below 3% since mid-June. Such a response suggests that developed countries begin to find a way to treat patients using their medical resources. On the contrary, the upper-middle-income countries also had many infectives similar to the developed countries but lowered the death/case rate below 3% in October. This suggests that high-income countries can provide better health care services to vulnerable groups of people than developing countries. Also, the high-income countries can afford to purchase billions of doses of vaccine through a pre-purchasing contract, leaving developing countries without enough supply for years.

Interestingly, we find the best exemplars for the effective response to COVID-19 not among the developed countries but the developing countries. Although the developed countries control deaths, many developing countries in Asia showed better performance in saving lives than European countries. Compared to European countries, many Asian countries are below the 5% line of the case fatality rate, suggesting that developing countries can even do better despite their low economic and public health facility level. (Figure 5)

Figure 4: The Change of New Cases and Death Rates by Economy Level

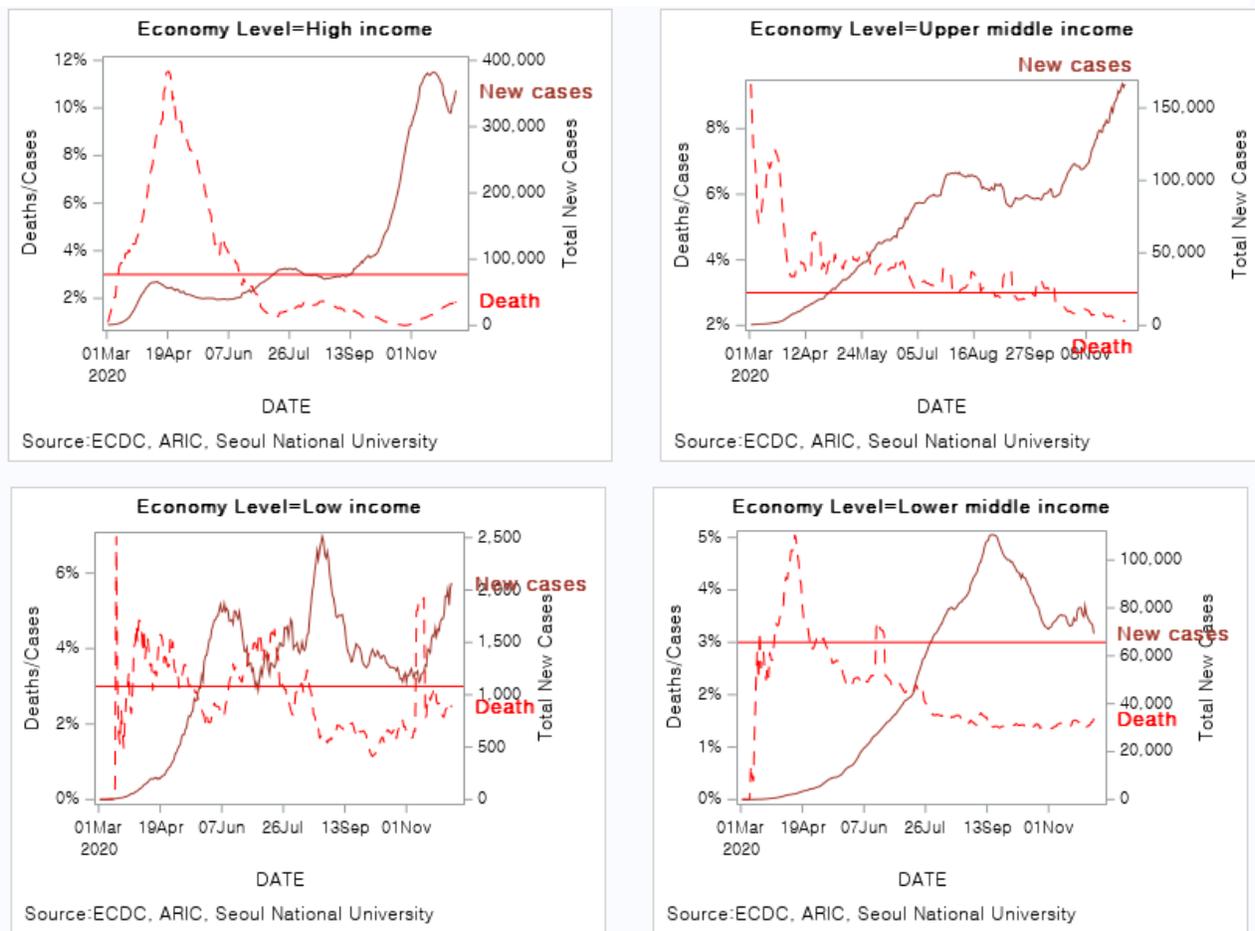
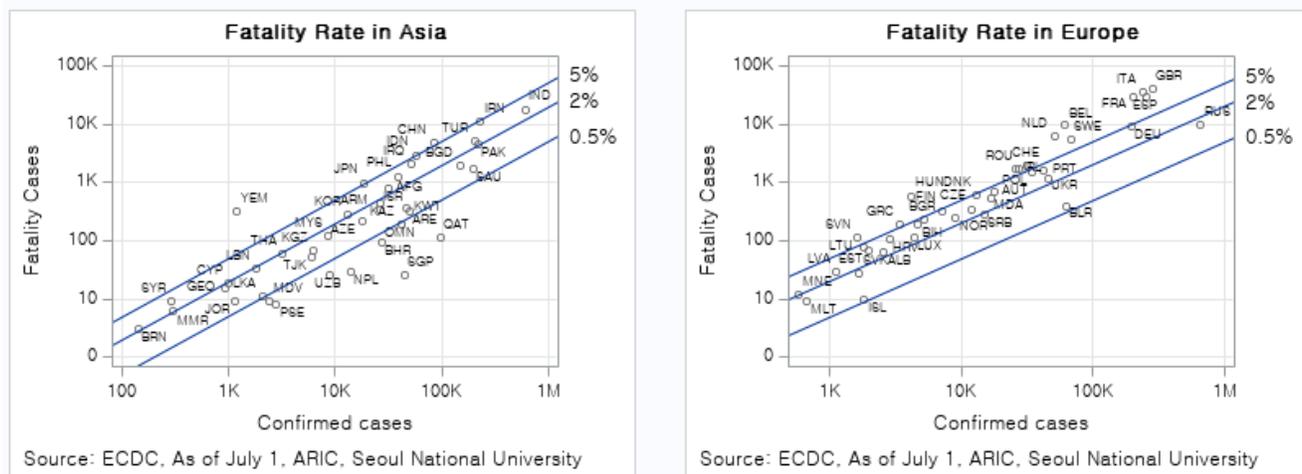


Figure 5: Case Fatality Rate of Asian and European countries



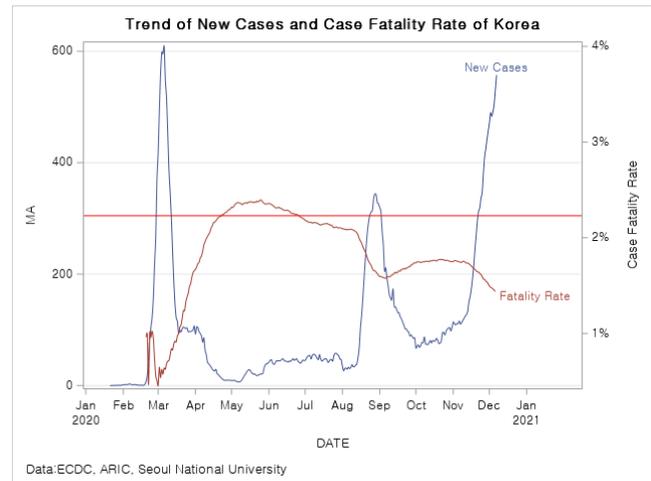
4. Some Exemplars of Effective Responses

There are some exemplars in Asia that responded to COVID-19 effectively. Republic of Korea has minimal infection cases and case fatality rate, as shown in Figure 6. As of 1st December, the infection cases per million were around 970, and the fatality rate was about 1.44%, which is far lower than the global fatality rate, 2.23%. Proposed success factors are 3Ts (tracing, test, and transparency), intercrisis learning from MERS in 2015, advanced information communication technologies enabling information collection and sharing, the high level of risk cognition of citizens and local governments, and the universal healthcare system (Comfort et al. 2020, Moon 2020). When the major outbreak was reported in the city of Daegu on 20th February 2020, there were huge debates on whether to lockdown the city and close the border to Chinese travellers. Interestingly, the central and local government recommended the voluntary movement restriction on citizens and imposed the travel restriction to China's heavily infected region. Also, Republic of Korea did not lower its alert level, although the number of new cases dropped to below 50 cases in April. Many serious restrictions were imposed in May and August, along with the sudden increase in the number of new cases. According to the Korean government's guideline, the highest social distancing policy will be issued in the country if there are 800~1,000 cases per week. Considering that the Republic of Korea has a 50 million population slightly larger than that of Spain, and more than half of the population resides in the Seoul Metropolitan area, we can interpret that the country adopted a very conservative guideline.

Viet Nam also shows an awe-inspiring response. The country had around 1,400 patients, with 35 deaths as of 1st December 2020. Some argued that such a small number of infection cases was because of incomprehensive tests. Unlike the allegation, Viet Nam performed 19,000 tests per million population and initiated the quick tests once an infection case was reported. The universal healthcare system also allowed free tests and high accessibility of medical services, although the quality of medical service is not entirely satisfactory.

As the risk cognition of the Viet Nam government was very high at the early stage of COVID-19, the series of immediate preventive measures such as the border

Figure 6: The Trend of New Cases and Case Fatality Rate of Republic of Korea



closure to China (1st February), school closing (2nd February), suspension of all entry VISA service (18th March), and the nationwide isolation (1st April). We can call these measures preemptive and decisive given that there were only 204 patients and zero death by 31st March in Viet Nam.

Viet Nam had a painful experience associated with a previous infectious disease like SARS, same as Korea. Accordingly, both governments realized that they needed to prepare a high level of medical facilities to handle massive infections, acknowledging the shortage of medical facilities. With the support from World Health Organization (WHO), Viet Nam tried to develop a plan to cope with public health emergencies reflecting SARS's experience. Also, it strengthened hospital procedures to prevent infection in health care settings and issued the community level quarantine to prevent further infections of other areas. As a result, national health emergency operation centers and a national public health surveillance system played an essential role in COVID-19 response.

Voluntary personal hygiene was encouraged by sharing information through the Internet and a hand-washing song, "Ghencovy" was made. The business entrepreneurs initiated philanthropic activities such as the 'Rice ATMs' and 'Zero VNDong supermarkets' that gave away the necessities for free to people.

Cambodia is another exemplar. It had around 300 patients with zero death before 1st December 2020. Such a low infection rate is remarkable, given that it

has many international tourists and migrant workers in foreign countries, especially in Thailand. Like Republic of Korea and Viet Nam, the Cambodian government showed high-level risk cognition. Rather than closing the border, the Cambodian government adopted an open but rigid travel control policy. International organizations such as Medical Sans Frontiers helped tracking contactors of COVID-19 patients and participated in preparing the guideline for the treatment and control of COVID-19 in March. The WHO worked with the Cambodian government to develop the National Action Plan: "Preparing for and Responding to Novel Coronavirus (COVID-19) in the Kingdom of Cambodia" in February and deployed the 'Rapid Response Teams' with more than 3,000 members, multi-sources of surveillances deep into the community level. The World Bank also helped the Cambodian government activate the contingent emergency response component(CERC) (27th March). Using the CERC, the Cambodian government procured ambulances and medical equipment (including ventilators, mobile X-rays, and PCR machines).²

5. Restoring the Spirit of International Cooperation and Solidarity

Although the global community has praised the interconnected world through information communication technology, transportation network, trade, and shared norms such as human rights and sustainable developments, COVID-19 makes us realize the vulnerability of our international cooperation and solidarity. Many countries took it for granted the border closures, the ban of medical equipment export (e.g. mask), and discrimination against foreigners. The privacy rights and the freedom of movement were suspended in the name of public health. However, the lessons we have to draw from the experience are not the authoritarian approaches. First, the global community has to build up a better disease information system. International organizations should help developing countries enhance their statistical capacity for monitoring and analyzing COVID-19. We experienced many problems such as different case definitions, flawed reporting system, absence of leadership collecting international

statistics, and civil servants' statistical illiteracy. Hence, the global society needs to work together to develop a better system, guidelines, and human resource training program for evidence-driven pandemic management. Second, we should frame COVID-19 as a global problem. One country's successful containment of the disease does not solve economic and political issues due to the global value-chain change, trading system, and international relations. Even if some developed countries control COVID-19, they would still be vulnerable to the risk of virus and economic depression from other countries. Therefore, we should restore the platform for global collaboration rather than emphasizing "my country first." Finally, the experiences of some good exemplars such as Republic of Korea, Cambodia, and Viet Nam suggest that the effective responses to COVID-19 are attributed to the high-risk cognition, the leadership of the government, cooperation among governments, citizens, and international organizations. Moreover, developing countries should necessarily garner insight from other countries, including the universal healthcare system in Republic of Korea and Viet Nam, active collaboration with international organizations observed in Viet Nam and Cambodia, and the advanced information communication technology in Republic of Korea.

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