



World Health Organization Regime Effectiveness in Controlling COVID-19: Case Study of Malaysia, Thailand, and Indonesia

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Abstrak

The World Health Organization (WHO) is the only international organization to be given authority by the Charter of the United Nations to promote and protect the health of all people. Then it is not surprising that people look after the response and action of the WHO when COVID-19 cases explode worldwide. Observing the response of the WHO, some analysts criticized the organization for late, incomprehensive, and unsystematic policy. Some even blame the way the organization work, which is reactive rather than predictive, the shortage of the budget, and the decision-making process that needs to be more transparent.

This paper intends to analyze the effectiveness of the WHO's rule, norms and regulation in controlling the spread of the COVID-19. It tries to answer the question of how effective the WHO regime is in controlling COVID-19 spread. Using theory of regime effectiveness it studies the case of Malaysia, Thailand, and Indonesia. The three countries are chosen because WHO has appreciated Malaysia and Thailand for their compliance with International Health Regulations (2005) (IHR) core capacity requirements and have strong capacity and self-sufficiency in outbreak preparedness and response. Meanwhile, Indonesia faced considerable difficulties at the beginning of the pandemic but currently Indonesia achieves better performance in controlling the pandemic than that Malaysia and Thailand.

Keywords: World Health Organization, International Health Regulation, COVID-19, international regime, effectiveness

Abstrak

The World Health Organization (WHO) merupakan satu-satunya lembaga internasional yang yang diberikan kewenangan oleh Piagam PBB untuk menjaga dan meningkatkan kesehatan semua penduduk. Oleh karena itu tidak mengejutkan jika banyak orang mempertanyakan kinerja WHO ketika terjadi pandemi COVID-19 yang melanda semua negara.





Banyak pihak melontarkan kritik terhadap kinerja WHO terutama terkait keterlambatannya dalam mengumumkan kondisi darurat kesehatan masyarakat internasional serta dalam kebijakan penanganan pandemi yang tidak sistematis dan tidak komprehensif. Ada pula kritik tentang cara kerja WHO yang lebih bersifat reaktif dan tidak prediktif, minimnya anggaran, serta proses pengambilan keputusannya yang tidak transparan.

Tulisan ini menyajikan analisis tentang efektifitas ketentuan, aturan dan norma yang ditetapkan WHO dalam rangka mengendalikan penyebaran COVID-19. Pokok masalah yang hendak didiskusikan adalah bagaimana efektifitas rezim WHO dalam pengendalian penyebaran COVID-19. Menggunakan kerangka berfikir efektivitas rezim internasional, tulisan ini mengkaji kasus di tiga negara, yaitu Malaysia, Thailand, dan Indonesia. Malaysia dan Thailand dipilih karena kedua negara itu dinilai telah memenuhi standar International Health Regulation dan memiliki kesiap-siagaan yang baik dalam menghadapi kondisi darurat kesehatan. Dalam penanganan pandemi COVID-19 ternyata kedua negara itu kurang berhasil. Sebaliknya Indonesia belum bagus memenuhi standar IHR tetapi justru berhasil dalam mengendalikan penyebaran COVID-19.

Kata kunci: World Health Organization, International Health Regulation, COVID-19, rezim internasional, efektifitas

Introduction

The World Health Organization (WHO) is the only international institution with the authority to decide whether a disease outbreak is a pandemic. WHO is also the only institution with the authority to determine how to contain outbreaks, ranging from prevention, and treatment, to treatment methods. All WHO member states are obliged to comply with the decisions and detailed measures prescribed by the organization. It is regulated in the WHO constitution articles 21, 23, and articles 61 to 65.

The WHO constitution article 21 states that The Health Assembly shall have the authority to adopt regulations concerning: (a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease; (b) nomenclatures concerning diseases, causes of death and public health practices; (c) standards concerning diagnostic procedures for international use; (d) standards concerning the safety, purity, and potency of biological, pharmaceutical and similar products moving in international commerce; and (e) advertising and labeling of biological, pharmaceutical and similar products moving in international commerce. Next, article 23 says the





Health Assembly shall have the authority to make recommendations to members with respect to any matter within the competence of the organization.

Then article 61-65 orders all member countries to report annually to the organization on the action taken and progress achieved in improving the health of its people; report annually on the action taken with respect to recommendations made to it by the organization and concerning conventions, agreements and regulations; communicate promptly to the organization essential laws, regulations, official reports and statistics about health which have been published in the state concerned; provide statistical and epidemiological reports in a manner to be determined by the Health Assembly; and transmit upon the request of the board such additional information about health as may be practicable.

In 2019-2021, the COVID-19 pandemic hit almost all countries in the world and caused the deaths of to millions of people. That prompted many people to question the WHO's performance. Several criticisms were directed at the organization. Some questioned the agency's ability to handle the outbreak, some questioned the ability of WHO officials, and some questioned the agency's authority to govern various countries regarding procedures for dealing with the pandemic.

In academic studies, one criticism was presented by Oona Hathaway and Alasdair Phillips-Robins (2020). They stated that the WHO was late in declaring an international emergency, was unable to coordinate each country's policies in dealing with the pandemic, and did not provide input against improper policies issued by its member states. In addition, according to Hathaway and Robins (2020), many WHO member states still need to comply with the standards set by WHO on pandemic preparedness, but the organization can do nothing.

Another criticism was delivered by Abraham D. Sofaer (2021). He stated that in dealing with biological and chemical threats, which still needs concrete guidance and steps. According to him, how to deal with physical and chemical threats cannot be done with regular measures in health maintenance. Therefore, he suggested reforms and improved WHO performance. He questioned the suitability or usefulness of the International Health Regulation (IHR) with each WHO member country's readiness and ability to overcome the COVID-19 pandemic. According to Sofaer (2021), IHR, as the main rule to govern international cooperation on global health is of little use.





The International Health Regulation (IHR) was revised in 2005. The revision was carried out as a follow-up to the experience of handling the severe acute respiratory syndrome (SARS) pandemic that occurred in 2002-2004. An essential content of the revision is granting the right WHO to collect data from other parties if countries experiencing the pandemic are slow or unwilling to submit reports. It turns out that in the case of COVID-19, according to Sofaer (2021), WHO still needs to decide to declare an emergency for the international community.

Criticism is also delivered by Gian Luca Burci (2020). He questioned the criteria used in determining international health emergencies. In addition, he criticized the inconsistency of the WHO's work patterns. On the one hand, each member state is obliged to build preparedness through the fulfillment of the IHR, on the other hand, the WHO's recommendations in overcoming the pandemic are temporary, and not systemic. According to Burci (2020), building preparedness to face the pandemic certainly requires time and costs so that it is carried out in stages. It becomes strange when there is a pandemic, it turns out that the handling measures suggested by WHO are temporary.

This paper intends to discuss the compatibility between the fullness of the IHR and the country's ability to handle the COVID-19 pandemic; whether the declared country has met high standards in the International Health Regulation (IHR) is able to handle the COVID-19 pandemic better than countries that do not meet IHR standards. This article wants to compare the handling of the COVID-19 pandemic in three countries in the Southeast Asian region, namely Malaysia, Thailand, and Indonesia. The difference is between countries that have achieved high IHR standards (Malaysia and Thailand) and country that does not meet IHR standards (Indonesia). The author is interested in comparing them because, based on data until October 2021, Indonesia's performance in handling the COVID-19 pandemic is better compared to that of Malaysia and Thailand. Data on January 8, 2023 still shows that Indonesia's achievements are better than the two countries.

Framework of Analysis





The International Health Regulation (IHR) is a set of rules established by the World Health Council in 1969 that was originally the International Sanitary Regulations adopted by the Fourth World Health Assembly in 1951. The IHR had undergone amendments in 1973, 1981, and 1995. The last amendment was made in 2005 and entered into force in 2007. The IHR amended in 2005 is called IHR-2005. IHR includes thirteen indicators as: legislation and financing, IHR coordination and national IHR focal function, zoonotic events and human-animal interface, food safety, laboratory, surveillance, human resources, national health emergency framework, health service provision, risk communication, point of entry, chemical events, and radiation emergencies. Each WHO member state's achievement of the thirteen indicators is examined and assessed annually (WHO, 2008).

In international relations study IHR can be categorized as an international regime. Here an international regime is defined as a set of principles, norms, rules, and decision-making procedures that are all stated implicitly or explicitly, by which the expectations of the actors can reach a common ground in a particular area of international relations (Andreas Hasenclever, Peter Mayer, Volker Rittberger, 1997).

The discussion on the performance of handling the COVID-19 pandemic in Malaysia, Thailand, and Indonesia here uses the framework of the international regime, especially in terms of regime effectiveness. According to Hasenclever, Mayer and Rittberger (1997) there are two meanings of the effect of the regime, that is the ability of the regime to bind the behavior of its members and the ability of the regime to achieve the desired goals.

According to Kal Raustiala (2000), the study of regime effectiveness must be distinguished from two other closely related things, namely compliance and implementation. Implementation is the process of embedding international commitment into domestic rules and enforcing those rules. Compliance is not in itself followed or evidenced by implementation. Compliance with the regime does not in itself produce effectiveness. Low compliance does not automatically indicate a low level of effectiveness. Raustiala (2000) defines effectiveness as the degree to which a given rule induces changes in behavior that further the goals of the rule; the degree to which a rule improves the state of the underlying problem; or the degree to which a rule achieves its inherent policy objectives.





According to Helm and Spinz (2000), analysis of the effectiveness of the regime deals with the study of the evaluation of public policy. The analysis of the effectiveness of the regime deals with three things, namely what precisely constitutes the object to be evaluated; against which standard is the object to be evaluated; and how we operationally go about comparing the object to our standard.

By distinguishing compliance with the regime effectiveness, this article shows the existence of an inconsistency between compliance with the IHR on the one hand, and the effectiveness in controlling COVID-19 on the other. The high standard value of meeting the IHR indicator does not in itself indicate the high ability to handle the COVID-19 pandemic effectively.

Results and Discussion

International Health Regulation article 2 states that the purpose of the IHR is to prevent, protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade. Article 5 of the IHR requires each country to develop, strengthen and maintain, the capacity to detect, assess, notify, and report events in accordance with the Regulations. In annex 1 of the IHR, the capacity that must be built by each country is described, which includes surveillance, reporting, notification, verification, response, and collaboration activities; and activities concerning designated airports, ports, and ground crossings, both at the local, regional, and national levels (WHO, 2008).

In August 2020, WHO published the results of an assessment of Malaysia regarding the fulfillment of the IHR-2005 standard as well as the country's preparedness in dealing with the spread of disease outbreaks. In the report WHO (2020) states that "Malaysia is an upper-middle-income country with strong capacity and self-sufficiency in outbreak preparedness and response, as evidenced by its previous experiences to infectious disease outbreaks as the severe acute respiratory syndrome (SARS) 2002-2003 and the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in the last few years." WHO (2020) also stated that coupled with the implementation of the Malaysia Strategy for Emerging Diseases and Public Health Emergencies (MySED), Malaysia has shaped and strengthened the country's robust structure to prevent, prepare, ensure rapid response to public health





emergencies, and recover. WHO also states that Malaysia has complied with International Health Regulations 2005 core capacity requirements since it entered into force.

In the WHO publication (2020) it is also stated that Malaysia has prepared for one year to follow Joint External Evaluation (JEE), facilitated by WHO in October 2019. The JEE is a voluntary, collaborative, multisectoral process to assess country capacities to prevent, detect and rapidly respond to public health risks whether occurring naturally or due to deliberate or accidental events. The findings of the JEE ultimately reinforced Malaysia's strong existing health security system, prepared for multi-sectoral health emergencies with surveillance capacity to detect and respond for emergencies promptly.

In relation to Malaysia's efforts to deal with the COVID-19 pandemic, WHO (2020) stated, "the government and health authorities took great steps to bolster Malaysia's capacity for health emergency and disaster preparedness, all of which played a crucial role in responding to COVID-19." Among these steps was implementation of the MySED II and establishment of the Crisis Preparedness and Response Centre (CPRC). The national CPRC is the Public Health Emergency Operation Centre for the Ministry of Health, is located within the Disease Control Centre, and is the lead agency for disasters involving health.

According to WHO (2020), Malaysia's health system has been acknowledged for its strong infrastructure and well-trained workforce providing high-quality care. Publicly funded and run by the government, in conjunction with a strong private-sector, Malaysia is one of the nations that has achieved Universal Health Coverage (UHC) for its population of 32 million. This strong system provided a stable foundation for scale-up when COVID-19 was reported in country. Health capacity was swiftly enhanced to meet both anticipating and emerging demands, as the government operationalised the CPRC at the national and state-levels, mobilized for recruitment and re-distribution of healthcare personnel according to high workload areas and more.

For another country, WHO published the assessment results for Thailand in September 2020. According to WHO (2020), "Thailand's four decades of investment in its health system has positioned the country to effectively respond to the current public health crisis. For over forty years





Thailand has invested in health infrastructure and achieving universal health coverage that has led to a near-total elimination of those without health insurance and has increased access to healthcare.” Population surveys regularly indicate high levels of consumer satisfaction with the health system. During emergencies the Thai people trust their health system’s capacity to respond in their best interests. WHO (2020) also publishes an assessment by Dr. Tedros Adhanom Ghebreyesus, WHO Director-General. It says, “Thailand’s response to COVID-19 offers a powerful example of how investment in public health and all-of-society engagement can control outbreaks of deadly diseases, protect people’s health and allow economies to continue functioning.”

Representatives from WHO Headquarters, the WHO South-East Asia Regional Office and the WHO Thailand Country Office (2022) concluded that Thailand has many strengths that contributed to the success of the pandemic response. First, the Prime Minister has a high level of political commitment to lead the response. Second, Thailand has established a robust health system for decades that provided the best platform for an effective response. Third, the covid-response involved many sectors and people from all walks of life. Fourth, a bottom-up support of the presence of more than one million village health volunteers accompanied by a strong community network.

Innovative solutions and problems encountered were developed quickly, such as cardboard beds in field hospitals. Recognizing the need to avoid complacency, Thailand was the first country globally to critically assess their national COVID-19 response from 20-24 July 2020 using the recently developed WHO ‘Intra-action review (IAR) tool (WHO South-East Asia Regional Office and the WHO Thailand Country Office, 2022).

The WHO publication shows that the average score for all indicators in the IHR for Malaysia and Thailand is relatively high. In 2019 Malaysia's score was 92, then in 2020 it dropped to 86. For Thailand the score in 2019 was 85, and in 2020 the score remained 85. Meanwhile, Indonesia's score is lower than the two countries. Indonesia's score in 2019 was 73 and in 2020 it dropped to 69. With a lower score, it can be said that Indonesia's preparedness in dealing with the emergency conditions of the COVID-19 pandemic is lower than that of Malaysia and Thailand (WHO, 2020).





A health rating agency called the Global Health Security Index (GHS Index) in December 2021 published the progress of the steps taken by 195 countries in the world. The measure of progress is broken down into several factors, and each factor is assigned a score. These factors include: (a) prevention, (b) detection and reporting, (c) treatment, (d) health systems, (e) commitment to national capacity building and compliance on international norms, and (f) the social risks encountered. The score of each of these indicators is then averaged so that a score index is obtained. Next is the ranking of 195 countries (Jessica A. Bell and Jennifer B. Nuzzo, 2021).

In the GHS Index, prevention is defined as the policies and measures taken by the government to prevent the outbreak or virus in the territory of the country. Included in prevention is national planning, surveillance, or reporting on the development of infectious diseases.

Detection and reporting are the government's ability to manage laboratory systems, laboratory supply chains, real-time surveillance, and the ability to carry out epidemic reporting may be of international concern.

Handling is the ability of the government to provide rapid handling and prevent (mitigate) the spread of an epidemic. This includes the national public health emergency response plan in place that addresses planning for multiple communicable diseases with epidemic and pandemic potential.

The Health System in relation to the GHS Index is the government's ability to provide health clinics, Community Health Centers, and hospitals, supplemented by plans, programs, or guidelines in carrying out medical measures such as vaccination and administration of antiviral drugs at the national level during a health emergency, as well as the sufficiency of medical personnel, work facilities, and access to Health services.

Commitment to improve national capacity, funding, and compliance with global rules is defined operationally through indicators that include: compliance to submit assessment results for International Health Regulation (IHR) to WHO; budget allocations for the fulfillment of pandemic preparedness indicators, and willingness to coordinate and comply with international rules.





In the GHS Index, social risks include power change, social unrest, international tensions and trusting the government's advice and recommendations in the health sector. All these things can affect the government's response and response to threats in the health sector. When the change of government was turbulent, there was a lot of social unrest, there were international tensions, and there was a public distrust of the government's recommendations in the field of Health, then the country will have great difficulties to utilize its capabilities in the health sector to overcome the pandemic.

In assessing and compiling rankings, the GHS Index bases itself on three principles, namely: first, respect for transparency, that is the GHS Index can only make an assessment if there is transparency and available data. Second, it recognizes that there are many factors that determine a country's preparedness. In this case, the GHS Index measures all aspects, ranging from the main things in public health, the preparedness of health equipment, other factors related to the health problem, mitigation of biological threats, socio-economic resilience, and social vulnerabilities. Third, expand accountability and responsibility. Here the GHS Index is equipped with the understanding that by measuring the capacity and possible risks faced by a country, it will increase accountability and motivation. Countries, international organizations, donors, and the private sector ensure that all countries in the world are prepared to deal with health security threats (Jessica A. Bell and Jennifer B. Nuzzo, 2021).

Furthermore, the GHS Index compared the six factors for 195 countries. Especially for this paper, the author cites data for Thailand, Malaysia, and Indonesia. From the comparison, the highest ranking was Thailand (rank 5), followed by Malaysia (rank 27), and finally Indonesia in rank 45. Of the six factors assessed, Indonesia was at the bottom of the list among the three countries studied except for health system factors and risk factors. In the health system factor, Indonesia's score is 41.2 which is higher than Malaysia's score of 36.6. Meanwhile, Thailand achieved the highest score among the three countries, at 64.7. Meanwhile, in the risk factor, Indonesia's score is 55 which is higher than that of Thailand which is 57.9. The highest score in terms of risk among the three countries is at 73.9. The full data is presented in table 1.





Table 1

Global Health Security Index Indicators in Thailand, Malaysia, and Indonesia

Year 2021

Country	Prevent	Detect	Respond	Health	Norm	Risk	Index Score	Rank
Malaysia	37,7	72,5	61,4	36,6	56,4	73,9	56,4	27
Thailand	59,7	91,5	67,3	64,7	68,9	57,2	68,2	5
Indonesian	31,8	55,4	50,2	41,2	68,9	55	50,4	45

Source: Jessica A. Bell and Jennifer B. Nuzzo, *Global Health Security Index: Advancing Collective Action and Accountability Amid Global Crisis*, 2021. Available: www.GHSIndex.org

Indonesia's preparedness in facing of the COVID-19 pandemic, which is inferior to Thailand and Malaysia, can be partly explained by the conditions at home. In the early days of the pandemic, as the outbreak continued to spread and the government has set a few policies, some people still do not believe in the existence of the coronavirus. Some people are still unwilling to implement health protocols that include washing hands, wearing masks, and maintaining distance, including avoiding crowds.

The report of the Task Force on COVID-19 handlers on December 3, 2020 shows that the level of public compliance with the 3M health protocol is still low. 3M Health Protocols include: wearing masks, maintaining distance, and washing hands. In terms of compliance with wearing masks and social distancing, of the 512 regencies/cities throughout Indonesia, only less than 9% of districts/cities were compliant in wearing masks. When it came to social distancing, districts/cities that were obedient in maintaining distance were less than 4% in proportion (<https://covid19.go.id>).

On July 12 to 18, 2021, there was one province with a mask-wearing compliance rate below 60 percent, 3 provinces between 61-75 percent, 19 provinces between 76-90 percent and 11 provinces between 91-100 percent. Then 2 provinces whose compliance rates on social distancing and avoiding crowds are below 60 percent, 3 provinces between 61-75 percent, 19 provinces between 76-90 percent and 10 provinces whose compliance rates are between 91-100 percent (<https://nasional.kompas.com/>).





In addition to non-compliance, there is also a rejection of government policies in dealing with the COVID-19 pandemic. One of them occurred at Suramadu Bridge, East Java on June 6, 2021. Several motorcyclists tried to escape the sealing and mass antigen swab tests at Suramadu Bridge on the Surabaya side. They tried to avoid sealing by passing through the rat path next to the bridge by breaking the fence (<https://www.cnnindonesia.com/>). The same event happened again on June 22, 2021 (<https://www.viva.co.id/>).

The performance of the handling of the COVID-19 pandemic by the three countries shows an interesting fact. Indonesia, which has a lower standard fulfillment score than that of Malaysia and Thailand, turned out to be more successful in handling COVID-19. Nikkei's report COVID-19 Recovery Index in September 2021 showed that Indonesia ranked 54th out of 121 countries studied. In the index, Malaysia is ranked 102nd and Thailand is ranked 109th.

In the previous index in July 2021, Indonesia was ranked 92nd. While Malaysia is ranked 115th and Thailand is ranked 118th. Thus, in September the Indonesian index increased by 38 levels. Malaysia only experienced an increase of 13 levels and Thailand only experienced an increase of 9 levels. Data in July is important to note because in that month Indonesia was at a peak period of increasing coronavirus infection cases and a high mortality rate.

Other data were issued by Worldometers. The data also showed that the results of Indonesia's COVID-19 handling until October 30, 2021 were better than the results achieved by Malaysia and Thailand. Active cases in Indonesia on that date were 12,309, while Malaysia had 70,058 cases, and Thailand 100,132 cases. In this case, it should be noted that the population of Indonesia is nine times bigger than the population of Malaysia and three times bigger than the population of Thailand (<https://www.worldometers.info/coronavirus/>).

Worldometer data also shows that the number of cases per one million population in Indonesia was 15.301, while Malaysia and Thailand were 74,762 and 27,176 cases, respectively. Thus, the number of cases in Indonesia was the smallest compared to the other two countries. In this case, Malaysia recorded the highest figure among the three countries studied (<https://www.worldometers.info/coronavirus/>).





Regarding deaths per million population, the figure for Indonesia was 517, while the figures for Malaysia and Thailand were 876 and 274, respectively. In this case Malaysia also recorded the highest number among the three countries. More data on the number of inhabitants and the number of coronavirus cases are presented in the table below.

Table 2
Number of Coronavirus Cases in Malaysia, Thailand, and Indonesia
October 30, 2021

Country	Juml Population	Number of Cases	Death	Recover	Active Cases	Cases per 1M	Deaths per 1m
Malaysia	32.915.085	2.460.809	28.832	2.361.919	70.058	74.762	876
Thailand	70.032.158	1.903.165	19.158	1.783.875	100.132	27.176	274
Indonesian	277.354.458	4.243.835	143.388	4.088.138	12.309	15.301	517

Source: <https://www.worldometers.info/coronavirus/>

The latest data from Johns Hopkins University Center for Systems Science and Engineering published by CNN on January 8, 2023, showed that in terms of the number of cases active per thousand inhabitants, Indonesia's figure was best among the three countries studied, at 2,484. Meanwhile, Thailand at 6,784 and Malaysia at 15,741. For the death rate per hundred thousand population, the best figure was achieved by Thailand at 48. As for Malaysia at 115. This figure was worse than Indonesia's figure of 59 (Henrik P, Byron Manley and Sergio Hernandez, 2023). More data is presented in table 3.

Table 3
Number of Cases and Deaths in Thailand, Malaysia, and Indonesia
January 8, 2023

Country	Case Numbers	Cases per 100,000	Mortality	Deaths per 100,000
Thailand	4,723,618	6,784	33,650	48
Malaysia	5,029,337	15,741	36,870	115
Indonesian	6,722,746	2,484	160,673	59





Source: Henrik Pettersson, Byron Manley and Sergio Hernandez (2023), “Tracking Covid-19’s Global Spread” in <https://edition.cnn.com/interactive/2020/health/coronavirus-maps-and-cases/>

From the series of data presented above, Malaysia and Thailand, which had high scores in fulfilling the International Health Regulations, turned out to be less effective in handling COVID-19 than Indonesia, which had a lower score in IHR standard compliance. Malaysia, which had the highest IHR standard fulfillment score, got the lowest result in handling COVID-19 compared to Thailand and Indonesia.

This fact implies at least two things that need to be studied further. First, there is no strong correlation between the ability to meet International Health Regulation Standards and the ability to handle COVID-19. Meanwhile, the WHO claims that the ability to meet IHR standards is an indication of high preparedness for health emergencies. The cause of the absence of correlation between the IHR indicator and the ability to handle COVID-19 can be caused by other factors outside the IHR indicator. It can also be caused by the IHR indicator itself is not quite right.

Second, the absence of a correlation between the fullness of IHR standards and success in dealing with COVID-19 reinforces the idea that studies on the effectiveness of international regimes should be distinguished from studies on compliance and studies on implementation. In the case of Malaysia and Thailand, although the rules in the regime have been observed and implemented, the turn out that the effectiveness of achieving goals is not automatically obtained.

The correlation between adherence to the regime, the implementation of the regime, and regime effectiveness can be simplified using mathematical equation i.e., compliance plus implementation produces the effectiveness. But in more in-depth studies the turns out is not always true. It is possible that compliance alone can already result in effectiveness. For example, in the World Trade Organization (WTO) regime, members' compliance with no subsidy can result in effectiveness in maintaining market mechanisms.

There is also the possibility that implementation alone can produce effectiveness. For example, in the anti-money laundering regime, the implementation of provisions to recognize customers in detail will be able to produce effectiveness in suppressing illicit transactions. And there is also the possibility that compliance coupled with implementation will result in efficiency. For





example, in the shipping safety regime, the compliance of member states to make regulations plus the implementation of such regulations will result in shipping safety.

The interesting one is the fact that in the study of the International Health Regulation (IHR) in this paper, it turns out that compliance plus implementation does not produce effectiveness.

As mentioned above, Kal Raustiala (2000) defines effectiveness as the degree of the rule's ability to drive behavior change that leads to the achievement of the goals of the rule; the degree of improvement of the ability of the rule to underlie an issue; or the degree of ability of the rules to realize the goal. In terms of handling the COVID-19 pandemic, effectiveness can be defined as the degree of ability of rules to prevent the spread of coronavirus, reduce the number of sufferers, and minimize the number of deaths due to coronavirus.

It is thus worth asking the question: if the IHR is adhered to and implemented, whether the prevention of the spread of coronavirus, the reduction in the number of sufferers, and the decrease in the number of patients death can be realized? In the case of Thailand, Malaysia, and Indonesia, the answer is negative. Therefore, it is necessary to look for other things that can explain the deviation.

Researchers on the GHS Index state that a country's preparedness in the face of pandemic threats can be called a potential. When a pandemic occurs, whether the potential is used or not, it is largely determined by the decision of the country's leader. Meanwhile, the decision of the leader is influenced by the social and political conditions in the country. Here political conditions mean the support or rejection of politicians for the policies of the executive, and the electoral interests of the leader (Jessica A. Bell and Jennifer B. Nuzzo, 2021).

In Malaysia, particularly urban areas, there is a lot of non-compliance with government policies regarding *the Movement Control Order* (MCO). The non-compliance is particularly true for people who are not concerned about COVID-19. Just like in other countries, most Malaysians are experiencing fear and unrest over COVID-19. But there are some people who do not feel worried.

Malaysia had imposed a lockdown on 18-31 March 2020 and extended to 14 April 2020. With the lockdown, the government expected people to self-isolate in their homes. There was a certain amount of evidence of non-compliance, especially those committed by the community, which is illustrated in at least two cases. First, the Malaysian government prohibited people throughout





Malaysia from holding congregational Friday prayers in mosques. But on Friday, March 27, 2020, police arrested 116 people who committed violations. The 116 people were in five different mosques. They are detained for 2 days as a form of reprimand and would be subject to sanctions in the form of fines or imprisonment for 3 months if they did so again.

Second, the Malaysian Government prohibited its citizens from traveling and leaving their homes. The reality was that many citizens did not comply with these rules. 400 of people in various parts of Malaysia were arrested on Thursday, March 26, 2020 for leaving their homes without any urgent need. This policy also applied to people who did jogging or exercise and just walked outside the house even though it was close. Some of the 400 people were detained for 2 days as a form of reprimand and would be subject to sanctions in the form of fines or imprisonment for 3 months if they did so again. Meanwhile, Thailand had come under sharp criticism in terms of its handling of the crisis. Criticism is aimed at inconsistent government policies on international travel and quarantine requirements, doubts and slowness in action, and poor communication and many official announcements or information to the public that were rapidly recalled or contradicted by other government agencies and then changed. The sudden closure of businesses in Bangkok had forced tens of thousands of workers to return home, potentially transmitting the virus widely. It reflected the failure of government agencies to coordinate a good response (https://en.wikipedia.org/wiki/2020_coronavirus_pandemic_in_Thailand).

An advocacy group for Thai commercial sex workers, The Empower Foundation, said the entertainment world could generate US\$ 6.4 billion a year, much of which was peddling sex in various forms. The group said women were the most disadvantaged in the pandemic. Many mothers and the backbone of their families are forced to become commercial sex workers due to the absence of opportunities or low wages. The group had written an open letter to the government and urged them to find ways to help all sex workers who have lost their income. There were concerns that the Thai Government's emergency scheme to provide US\$ 150 or 5,000 baht to millions of baht to new unemployed over the next three months did not include commercial sex workers as recipients because they could not prove themselves as official employment (<https://www.cnnindonesia.com/internasional/>).





The description of what is as real as it is happening in Malaysian and Thai society supports the argument that compliance with the IHR regime cannot automatically address the problem of the COVID-19 pandemic. It happened because of several things. First, compliance with the IHR regime is a matter for the government. That cannot mean that society is also compliant with the regime. Second, compliance with the IHR is a matter of resource readiness, while the use of resources to overcome real conditions is not always in accordance with the standard operating procedures prepared before the occurrence of the COVID-19 pandemic. Third, the assumptions and logic that underlie the preparation of the IHR cannot be immediately applied in all countries with different patterns of life and culture.

Conclusion

From the description in the previous sections, it follows that compliance with the WHO regime, in this case compliance in complying with the provisions of the International Health Regulations, is not directly proportional to the effectiveness for handling the COVID-19 pandemic. Malaysia and Thailand, whose compliance rates were higher than Indonesia, have proven to be less effective in dealing with the COVID-19 pandemic than Indonesia, whose compliance rates were lower. It corroborates Kal Raustiala's opinion that the study of the effectiveness of international regimes should be accompanied by the awareness that along with the concept of effectiveness lies the concept of compliance and the concept of implementation. The three concepts are interrelated but remain different things. The relationship of the three concepts is also not in a single pattern that compliance plus implementation inevitably produces effectiveness.

The contribution of this article to Raustiala's views is sharpening in its categorization. Raustiala points out the importance of separating the three concepts that are often attached to the regime, namely compliance, implementation, and effectiveness. This article shows that sorting is not only macro but can be micro by paying attention to the difference in levels or weights of each. This paper shows that Malaysia and Thailand, whose capacity values according to IHR standards were higher than Indonesia, were inferior to Indonesia, which has a lower IHR standard value, in handling the COVID-19 pandemic.





Finally, the discussion of the international regime cannot be conducted as if in a vacuum. When a regime is implemented in a country, its application must pay attention to the social, economic, and cultural aspects prevailing in the country.

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