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State Effectiveness and Crises in East and Southeast Asia: The Case of COVID-19

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Abstract: East and Southeast Asian countries have recorded significant success in dealing with the COVID-19 pandemic. They have employed more effective crisis management strategies than countries in many other parts of the world. This article examines in detail the experiences of two of Asia's pandemic success stories—South Korea and Vietnam—to identify the ways in which they responded to COVID-19 and how they related to state effectiveness. The lessons learned from the analysis of South Korean and Vietnamese crisis management include: the importance of preparedness and decisive action; the need for flexibility to cope with changing circumstances; that there are alternative crisis management strategies to reach the same desired outcomes; and that crisis management is best served by securing unity of purpose among government, citizens, civil society and the private sector. State effectiveness is a foundation for such features of successful crisis management.

Keywords: COVID-19; crisis management; state effectiveness; South Korea; Vietnam



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1. Introduction

Crises are situations of extreme danger or difficulty that occur when an event or series of events lead to instability and negative consequences. They can be abrupt or develop gradually in the form of creeping crises [1] (p. 27). They bring generally undesirable and possibly calamitous changes to society, economy and environment. Such crises are no strangers to the countries of East and Southeast Asia. Crises of different types, sizes and durations have regularly brought adverse consequences to these nations. Natural disasters have occurred frequently and have resulted in death and destruction on a large scale. For example, in 2004 a tsunami wrought havoc on 14 states bordering the Indian Ocean. The Indonesian province of Aceh was the worst affected place with 130,000 dead and another 37,000 missing [2]. Half a million people were displaced and 250,000 houses destroyed. However, the Indonesian government's National Board for Disaster Management (BNBP) led a "highly successful reconstruction effort" that involved the coordination of over 900 domestic and international organizations and the transparent management of hundreds of millions of dollars of contributions [3,4]. In the Philippines, typhoons are a longstanding problem but are increasing in number, intensity and coverage. The most severe occurred in 2013 when Typhoon Yolanda (Haiyan) carved a path of destruction through the country's central islands leaving a trail of devastation and death [5,6]. Homes and infrastructure were destroyed, crops obliterated, livelihoods lost and at least 6300 dead with many more thousands displaced.

Crises occur not only in the developing countries of East and Southeast Asia. In 2011, a severe earthquake near Japan produced series of waves that crashed ashore in the Tohoku region killing 20,000 people and causing another 160,000 to flee their homes [7,8]. The waves penetrated the defensive walls of the Fukushima nuclear power plant and triggered a nuclear meltdown. Rebuilding affected communities cost at least USD 280 billion while making the nuclear power plant site safe is costing further billions of dollars over decades.

It also led to the reconsideration of nuclear power in Japan and the closure of other reactors deemed not safe. The Asian Financial Crisis of 1997–1998 hit South Korea particularly hard. Economic weaknesses that had developed during the remarkable rise of Korea's developmental state led to the abrupt collapse of the exchange rate of the country's currency, the value of assets in the stock exchange and elsewhere in the economy plunged, and the GDP per capita fell precipitously with many people losing their jobs [9]. More than a decade later, a crisis of a completely different kind hit Mongolia. Severe climatic conditions in 2009–2010 created conditions for a *dzud*. Too little rain in summer followed by an unusually severe winter resulted in the deaths of 8 million livestock, 17 per cent of the total, in a country where one-third of the population were pastoralists [10,11]. Rural livelihoods were adversely affected and hastened the migration of rural nomads to urban centres where they lacked the skills to secure employment.

It is not only natural events and economic conditions that have caused crises in East and Southeast Asia. They can result from diverse developments in political economy. For example, in the Philippines in 2017 a group of terrorist gunmen claiming allegiance to the Islamic State (IS) organization attacked the city of Marawi on the southern island of Mindanao. After 5 months, the Philippine military managed to defeat the terrorists and enable the reconstruction of a city in ruins. However, progress was slow and after 2 years the UN Office for the Coordination of Humanitarian Affairs (OCHA) estimated 66,000 remained homeless [12]. After 8 years, commentators still remarked on “exceedingly slow rehabilitation work” and how the affected communities had been left out of the planning process while the national government claimed success [13,14]. Remaining in the Philippines, between 1991 and 1993 there was a “kidnapping crisis”. The incidence of kidnap for ransom climbed dramatically, especially among the Philippine–Chinese community. This epidemic of kidnapping was seen as a crisis because it threatened investment in the economy, pointed to a decline in public confidence in law enforcement and questioned the legitimacy of a president who had been elected with only 25 per cent of the total vote [15].

The crisis which is the subject of this article is the current COVID-19 pandemic, which has swept across the world, including the countries of East and Southeast Asia. Like the other crises described above, COVID-19 has brought instability and negative consequences and has precipitated changes in economy and society. However, COVID-19 is not the first virus to wreak havoc across the world. There are many historical examples such as the devastations brought by the Black Death (1346–1353), the Spanish Flu (1918–1920) and HIV-AIDS (1981 onwards). The specific features of such outbreaks of deadly disease have included: considerable loss of life; enormous disruption to the normal workings of economy and society; the virus being unconstrained by national borders; negative consequences affecting extensive areas of the world and their populations; being generally unforeseen in terms of their nature and timing; and being series of linked events rather than a single one.

While the events described above demonstrate the diversity of crises that have occurred in East and Southeast Asia, they nevertheless have one thing in common. There is always a need to respond to limit the damage that these crises cause to society, economy and environment and to rehabilitate and rebuild. The major responsibility for such action inevitably falls upon the state. People see the state as having the obligation and resources to lead the way to recovery. However, the nature and success of such recovery initiatives depend on the state's effectiveness. An effective state is broadly defined in terms of being able “to deliver the collective goods that expand the capabilities of their citizens” [16] (p. 380). It is about the state's “capacity” and “capability” to shape and deliver the policies needed to enhance citizen welfare [17]. Crises present particularly difficult challenges far beyond the normal course of the policy cycle and day-to-day government management. Time is more pressing and complex novel management structures are often called for. Government must obtain access to the necessary resources and deploy them efficiently and effectively in a timely manner. The resources may be physical, financial or human and may derive from the public, private or non-government sectors. Government needs to coordinate the resources and actors involved, showing flexibility in organizational structures and processes. There

should also be transparency and accountability to help build trust in the operations of crisis management and prevent the misuse of resources. The East and Southeast Asian examples of crises set out earlier in this article all required such special responses and were, as we have indicated, successful to varying degrees. However, this article is concerned with a more recent crisis, one still with us at the time of writing—COVID-19. How was that managed in East and Southeast Asia and what were the results? What has the experience told us about state effectiveness and crisis management?.

2. Background and Method

The disease we know as COVID-19 spread rapidly across the globe from December 2019, leading to its classification by the World Health Organization (WHO) as a “public health emergency of international concern” in January 2020 and then a “pandemic” in March 2020. The health services of many countries have been severely tested by COVID-19, as have the citizens who have had to endure lockdowns, stress, job losses, falling incomes and other hardships as the pandemic has dragged on for more than 2 years. However, there are great differences in the incidence of COVID-19 and deaths caused by it between countries. There are also stark regional contrasts between success stories and policy failures. Thus, after over a year of COVID-19 it was apparent that East and Southeast Asia had performed considerably better than South Asia, North America, Europe and Latin America in containing the spread of COVID-19 (see Tables 1 and 2). This raised the question of whether the East and Southeast Asian countries had adopted the same measures to manage the virus, whether they demonstrated an Asian one-best-way for COVID-19 control [18,19]. In short, were these states more effective in crisis management? However, events in 2021 challenged this idea as former Asian leaders in COVID-19 prevention succumbed to huge increases in the numbers of cases. Furthermore, some of the region’s countries that had earlier performed less well now recorded declines in COVID-19 infections and seemed to be leading the way to a “new normal”.

Table 1. COVID-19 cases and deaths in East and Southeast Asia (25 March 2021).

Country	Number of Confirmed Cases	Number of Deaths	Case Fatality Rate (%)	Deaths (per 100,000 pop)
Southeast Asia				
Indonesia	1,471,225	39,865	2.7	14.89
Philippines	677,653	12,992	1.9	12.18
Myanmar	142,264	3204	2.3	5.97
Malaysia	335,540	1244	0.4	3.95
Singapore	50,221	39	0.0	0.53
Thailand	28,346	92	0.3	0.13
Vietnam	2575	35	1.4	0.04
Cambodia	1817	5	0.3	0.03
Laos	49	0		
East Asia				
China	101,582	4840	4.8	0.35
Japan	458,621	8908	1.9	7.04
Mongolia	5610	5	0.1	0.16
South Korea	9846	1707	1.7	3.31
Taiwan	1007	10		0.04
Thailand	28,346	92	0.3	0.13

Source: Johns Hopkins Coronavirus Resource Center, COVID-19 data by region.

Table 2. COVID-19 cases and deaths in selected North American and European countries (25 March 2021).

Country	Number of Confirmed Cases	Number of Deaths	Case Fatality Rate (%)	Deaths (per 100,000 pop)
North America				
Canada	947,489	22,715	2.4%	61.29
USA	26,321,120	443,355	1.7%	135.51
Western Europe				
UK	4,321,019	126,523	2.9%	190.29
Spain	3,234,319	73,744	2.3%	157.83
France	4,373,607	93,064	2.1%	138.93
Sweden	758,335	13,315	1.8%	130.79
Germany	2,699,231	75,255	2.8%	90.75
Finland	45,482	677	1.5%	12.27
Norway	89,120	649	0.7%	12.21
Iceland	6122	29	0.5%	8.2

Source: Johns Hopkins Coronavirus Resource Center, COVID-19 data by region.

This general experience of East and Southeast Asia raises several interesting research questions such as whether there was ever a one-best-way in the region and how far were governments able to manage the COVID-19 crisis to cause the least damage to economy and society. This article uses qualitative comparative analysis (QCA) to elucidate individual country responses to the COVID-19 pandemic and evaluate their effectiveness in managing the disease and safeguarding residents against the negative consequences associated with it. QCA is a case-based approach for investigating phenomena in particular contexts [20–22]. It requires in-depth knowledge of the cases as they are complex situations which require the identification of combinations of factors to provide explanations. QCA is used to explore why changes occur in some contexts but not others. However, the method also allows for equifinality to be achieved in different ways.

In utilizing QCA for this article, we have selected two contrasting countries from East and Southeast Asia—South Korea and Vietnam. As Table 3 shows, the most obvious contrasts are in their very different levels of economic development and their political regimes. For each country we examine government responses to COVID-19, the trajectory of the disease and the outcomes of the policies adopted. However, it is recognized that all three of these aspects of COVID-19 are highly interrelated and have causal effects on each other. For example, the choice of response affects the trajectory of COVID-19 infections as well as the economic repercussions. However, in turn, the trajectory influences the choice of responses while the emergent outcomes may guide the evolving responses. Identifying and untangled these is a major objective of this research and will assist in identifying effective policy responses to major crises in the future. The two case-study countries are of particular interest because they enjoyed early success in COVID-19 management but later experienced huge surges in the numbers of cases.

Table 3. Comparison of the case-study countries.

Country	Population (2020)	GDP per Capita (PPP) US\$	Country Income Classification	Political Regime	UNDP Human Development Index Ranking (2020)
South Korea	51,780,579	45,274	High Income	Liberal Democracy	23 (Very High)
Vietnam	97,338,583	8650	Low Middle Income	Authoritarian	117 (High)

Source: World Bank Data Center: Country 2020 figures for population, GDP per capita, income classification; UNDP Human Development Index Ranking 2020.

3. Case-Study Country Experiences

3.1. South Korea

South Korea recorded its first COVID-19 case on 20 January 2020, with the first cluster of locally transmitted cases occurring on 19 February. This outbreak was contained through swift action and the number of daily new cases dropped to single digits by mid-April [23,24]. A new outbreak occurred in central Seoul in May 2020, followed by the appearance of clusters in the greater Seoul area. In August 2020, another outbreak occurred, leading the government to introduce restrictions on indoor and outdoor gatherings across the Seoul metropolitan area. New cases of infection increased to more than 1000 by 1 September but declined to less than 100 cases by 20 September 2020. A third wave of the COVID-19 virus occurred from mid-November, rising to approximately 1000 per day and resulting in further restrictions being introduced across the country before the numbers of daily infections declined over January 2021. In late March 2021, the number of daily infections increased again, reaching over 600 cases per day by April 2021. New and more infectious COVID-19 variants from Brazil, the United Kingdom and South Africa made up a large proportion of these new cases.

Despite these waves of COVID-19 infections and the relative openness of the country, by 25 March 2021 there were still only 9846 recorded cases and 1707 deaths from the virus in South Korea, considerably less than in North American and Western European countries. So how was South Korea able to limit the spread of COVID-19 while employing a less restrictive management regime than found in most European countries? Five key factors can be identified as contributing to virus containment—preparedness, a comprehensive management strategy, a high-tech detection system, public–private cooperation and effective communication.

First, South Korea was prepared to deal with COVID-19. The government had learned from its “flawed response” to the Middle East Respiratory Syndrome (MERS) outbreak in 2015 [24,25]. It introduced reforms to boost readiness to deal with public health emergencies such as building infrastructure, recruiting and training health personnel, upgrading standard operating procedures and creating stocks of PPE and other equipment [25]. These matters are prescribed in a national infectious disease plan which is updated every 5 years [26]. Government preparedness was complemented by the public’s memories of MERS that made them more ready to accept mask-wearing and contact tracing. Government and citizens regarded the threat of infectious diseases very seriously and were ready and willing to act immediately when COVID-19 struck.

Due to its preparedness for managing COVID-19, the government was able to rapidly introduce a “comprehensive” approach [27]. A three-pronged strategy was identified and included (a) rapid response, (b) the “3-T” measures (widespread Testing, contact Tracing and rigorous Treating) and (c) public-private cooperation and civic trust. There was also a declared orientation to openness, transparency and democracy aimed at securing the trust and cooperation of citizens and avoiding severe actions such as lockdowns and bans on international travellers that were being employed in other countries. To institute a system embodying these characteristics the government rapidly activated the Central Disaster and Countermeasures Headquarters with the Prime Minister attending at least three times per week [28]. This was to ensure a whole-of-government approach. For the medical response, the Korean Centers for Disease Control and Prevention (KCDC), under the Ministry of Health and Welfare, was the prominent actor. It was given greater independence of action and increased staffing in September 2020 under its new name—the Korea Disease Control and Prevention Agency (KDCPA). A useful contextual factor aiding the medical response to COVID-19 was South Korea’s centralized medical system. Tried and tested arrangements were already in place for directions from the centre to be enacted at local government levels and for the efficient operation of nationwide supply chains.

For COVID-19 treatment, directions came from the National Medical Center. Cases were classified as mild, moderate, severe and critical [28,29]. For mild and moderate cases, patients were placed in community-level treatment centres and monitored by health work-

ers. Severe and critical patients went into government-designated specialized infectious disease hospitals. Persons who were identified as coming into contact with positive COVID-19 cases and arriving international travellers were placed into self-quarantine. They were required to use the Self-Quarantine Safety Protection app for 14 days and were medically monitored by case officers who could also track anyone breaking their quarantine [28].

Working in conjunction with the treatment of COVID-19 in South Korea was the third vital factor accounting for the country's early success in containing the virus—a high-tech contact tracing system. The government hired private sector epidemiologists and trained extra health centre staff to undertake contact tracing. Epidemiology officers used credit card transaction data, global positioning system (GPS) data from mobile phones and closed-circuit CCTV television footage to assist their contact tracing efforts [30–32]. The use of technological surveillance, in conjunction with interviews with COVID-19 patients, enabled faster contact tracing of cases and minimized the spread of the disease, particularly among more vulnerable populations [29].

The fourth factor facilitating the containment of COVID-19 in South Korea was public–private cooperation [26,33]. The government was able to undertake a very high level of testing among the population to identify positive cases and take appropriate action [24]. This was achieved through partnerships with the private sector. The KCDC in association with the Korean Society for Laboratory Medicine (KSLM) and the Korean Association of External Quality Service (KAEQUAS) developed testing methods which they then shared with the Korean biotech industry to produce the desired number of test kits. Processing of the tests was undertaken by 150 largely private sector laboratories and testing capacity increased from 20,000 tests per day in April 2020 to 110,000 by the end of November 2020 [34]. Public–private sector partnership was also evident in the development of COVID-19 treatments and vaccines. Government collaboration with the private sector enabled the increased production of face masks by 130 local manufacturers [33]. Measures were also instituted to prevent hoarding including regulating the number of masks that the private sector could sell to each citizen per week. The availability of PPE was increased by partnerships with private pharmacies and four large private convenience store chains. Some corporations also donated products to help provide food security, hygiene and health, especially to those in quarantine. Cooperation with local governments enabled medical and hygiene products to be assembled into standardized kits.

The final factor explaining South Korea's success in containing COVID-19 was effective communication in which the president was clearly seen to be leading the nation. Following the MERS experience, the government adopted standard operating procedures for risk communication in public health emergencies [26]. Borrowing from WHO and US Center for Disease Control (CDC) recommendations, South Korea based its communications approach on five principles—be right, be first, build trust, express empathy and promote action. These guiding principles were immediately brought into practice on the confirmation of the first four cases on 30 January 2020. The KCDC provided two daily briefings for citizens and the media, and reporters were free to ask questions. This service provided up-to-date accurate information to citizens and promoted the idea of transparency thus helping to build confidence and trust in the government's plans and actions [24,35,36]. A 24-h hotline and portal site were established to provide COVID-19 information and respond to queries from citizens. Fake news transmitted through the internet was dealt with swiftly through a consortium of police, health and communication agencies, while major internet platforms like Google, Facebook and Twitter agreed to prioritize official COVID-19 data and government messages.

While the above analysis demonstrates the success of South Korea in keeping COVID-19 numbers very low in 2020 and manageable in 2021 until the beginning of September, the situation then changed as the Omicron variant began to spread rapidly. In January 2022, it was hoped that the worst was over, but February saw skyrocketing numbers and by mid-March the 7-day average for cases had reached 388,085 [37]. After that peak case numbers began to decline so that by mid-April the 7-day average was 104,570 and at the

end of the month 43,355. Approximately 33 percent of the population had been infected (see Table 4). It should be noted that even after the Omicron spike, South Korea's deaths per 100,000 population were well below those of many Western countries—South Korea with 44.62 per 100,000 as compared to the USA with 301.61 and the UK with 258.6.

Table 4. COVID-19 cases, deaths and fatality rates for South Korea and Vietnam (2 May 2022).

Country	Number of Confirmed Cases	Number of Deaths	Case Fatality Rate (%)	Deaths (per 100,000 pop)
South Korea	17,275,649	22,875	0.1	44.62
Vietnam	10,649,809	43,041	0.4	44.2

Source: Johns Hopkins Coronavirus Resource Center, Regional data for South Korea and Vietnam.

So did this mean that outstanding policy success had rapidly transformed into policy failure? Three factors are significant. The first was that the government got off to a very slow start with its vaccination program [38,39]. Some degree of complacency seems to have set in, possibly born of early success in COVID-19 management. There was a lack of urgency in procuring vaccines in a highly competitive market and hope that Korean vaccines would have been developed by early 2021. Such hope was misplaced, and foreign vaccines were hard to come by. Thus, by 8 June 2021 only 16.4 per cent of the population had received at least one dose [40]. This situation drew considerable criticism and forced the government into an accelerated vaccine drive. This proved to be successful and by mid-November 2021, 80 per cent of the population were fully immunized, making Korea one of the top ten countries in the world for immunization coverage [41].

Second, while infection rates increased dramatically in 2022, death rates did not mirror this trajectory. Indeed, the case fatality rate declined to 0.1 per cent, about one-tenth of those experienced in the USA and UK. This was because government ensured that the health system could cope. Testing capacity was increased to 1 million per day. This enabled the identification of at-risk patients and the arrangement of treatment either at home or in medical facilities. Thus, in mid-March when there were hundreds of thousands cases daily, intensive care was only working at 65 per cent capacity [42].

Third, Korea switched from a policy that focused on stopping the spread of COVID-19 and reducing the number of cases to one which allowed the spread of infections while minimizing the damage [43]. The hitherto successful contact tracing system was overwhelmed by the burgeoning numbers of cases and was abandoned. The authorities had also realized that while Omicron was 15 times more infectious than earlier strains, it was much less deadly. Furthermore, most of the population had been fully vaccinated. Thus, South Korea was able to move to a policy of living with COVID-19 through the incremental loosening of restrictions.

3.2. Vietnam

Vietnam's first case of COVID-19 occurred on 23 January 2020 and marked the start of the country's first wave [44]. After this wave had been contained, another outbreak occurred in the central city of Da Nang in July 2020. This was successfully tackled with a program of quarantine, lockdowns, contact tracing, hospital treatment and communication. A third wave of the virus broke out in late January 2021 in the northern provinces of Hai Duong and Quang Ninh. However, in each case actions taken by the government ensured that the number of cases was extraordinarily low, with only 2575 cases and 35 deaths recorded by 25 March 2021. Furthermore, the economic cost was much less than in other Southeast Asian countries and Vietnam still managed to produce a positive figure for economic growth in 2020 [45].

So how did this developing country with limited resources manage to produce such an effective response to COVID-19? Five items stand out as central to Vietnam's COVID-19 success—preparedness, decisive action, clear operating systems, leadership and effective communication.

First, Vietnam was ready for COVID-19 [46,47]. The government and medical system had learned from previous outbreaks of infectious diseases, notably Severe Acute Respiratory Syndrome (SARS) in 2003. Following SARS, the government invested heavily in public health infrastructure that included a national public health operations centre and a national public health surveillance system. The national centre and four regional centres ran simulation exercises and incrementally built in the lessons learned from other pandemics. Thus, investments in organizational systems, facilities, equipment, supplies and training were made with these lessons in mind as were changes to operational processes.

Preparedness meant that the Vietnamese government was ready to take decisive action, the second item explaining their COVID-19 success [48–50]. As soon as the first case had been recorded for Wuhan, Vietnam introduced screening and other restrictions on flights from Wuhan, while no visas were issued to Chinese citizens one week after Vietnam's first case [37]. Flights to China were suspended on 1 February 2020. All persons entering Vietnam by air were placed in compulsory quarantine from 6 March 2020 [34]. A day after Vietnam's first COVID-19 case the Emergency Epidemic Vaccination Centre was activated [51]. On 31 January, after the Lunar New Year Holiday, schools were closed and other gatherings of large numbers of people banned. The military were mobilized to guard the country's lengthy land border. Lockdowns in communities where COVID-19 was detected were swiftly enforced and the army was deployed to undertake sanitization "as if this were biological warfare" [46]. In addition, extensive quarantine facilities were quickly established, and by mid-March, face masks became mandatory for all persons outdoors [38]. The government acted fast and decisively on all fronts in its war on COVID-19.

To undertake the necessary tasks for prevention and treatment required efficient and effective operating systems, the third element accounting for Vietnam's early success in fighting COVID-19. Actions needed to be coordinated to produce the optimum performance from the available resources. The country's political leaders declared a "whole of government" approach involving multiple organizations of the state and supplemented by cooperation with the private sector and other non-state actors [47,52]. At the apex of control and coordination was a national steering committee for the prevention and control of the virus, established on 30 January, one week after the first case was recorded in Vietnam [50]. Lower-level steering committees were established in each ministry and province. Ministries attended to clearly designated activities that fell within their area of specialization.

The organizational coordination evident in Vietnam's efforts to constrain the COVID-19 virus benefitted from a system of government with strong central control and in which decentralization is of the administrative variety rather than the political. Well-established linkages bind the different local tiers of government with the centre and facilitate the transmission and implementation of directives emanating from the capital. This is related to Vietnam being a one-party state in which the idea and practice of command are well established [53]. There is unlikely to be local disputation with the centre during normal times and even less so when there is universal acknowledgment in government and society that the nation was experiencing an existential crisis. Opinion polls reflected a high degree of trust in government actions relating to COVID-19 in Vietnam [48].

In terms of operating systems, particular mention should be made of Vietnam's "rigorous" quarantine system and "aggressive" and "comprehensive" contact tracing [47–49]. These were major initiatives that made considerable contributions to restricting the transmission of COVID-19. Testing was used to identify clusters of infections and to prevent further transmission. When infections were recorded, officials moved quickly to undertake widespread testing and to implement commune-level lockdowns. Not only were close contacts with the infected persons traced but also contacts of the contacts, that is, at least three levels of contact and sometimes more. This official system was supplemented in March with the introduction of an app, NCOVI, which has been described as being like "a neighbourhood watch system" [47,52]. Quarantine was applied to the locations of outbreaks of the virus and involved either government quarantine facilities or home

quarantine. All returning residents and incoming key workers were required to quarantine from early February 2020.

The fourth element contributing to Vietnam's success has been leadership. There was decisive leadership from the top levels of government and party from the outset. It was consistently emphasized that defeating COVID-19 was a national priority of the utmost urgency. Furthermore, it was presented as a health problem and depoliticized [46]. This meant that transparency could be practiced in communicating about COVID-19 and there was no need for officials to engage in cover-ups or obfuscation. Three important leadership behaviours were evident. First was being led by expertise with science and evidence forming the basis of the virus-constraining approach. Second was the need to mobilize collective effort. Vietnam achieved this through informing and educating citizens about COVID-19 and what each citizen could do to help the government. It was stressed that the battle against the virus required everybody's participation. Third was clear communication about what government was doing and why, including how citizens could contribute to winning the war on COVID-19. Learning was a big part of facilitating people's capacity to cope with the stressful and threatening situations they faced. Leadership helped people to make sense of what was happening and how to come to terms with it thus boosting trust in government.

The final important element in Vietnam's effective management of COVID-19 was communication [47,49,54,55]. Overall there was a "clear, consistent and creative public health messaging" that greatly assisted the collective effort to combat COVID-19. From the start, government leaders drew on nationalist-imbued memories of past and more recent conflicts and used the metaphor of war to depict the anti-virus struggle. There was also creativity. For example, a Vietnamese pop song was given new words about hand-washing by the National Institute of Occupational Safety and Health and it went viral. Social media such as Facebook and a local app, Zalo, were used to spread the messages that were also being broadcast by state media. Government communicated frequently in clear and strong terms and "stayed on message" [47]. Citizens were encouraged to adopt the "5-K" (*Nam Khong*)—wear face masks, practice hygiene, keep a safe distance, avoid gatherings and make health declarations. A short message about virus prevention was attached to all phone calls while celebrities shared "stay strong" posts. This multi-faceted, multi-media communications campaign had the desired effect of raising people's awareness of the dangers of COVID-19, the latest situations, what to do to avoid infection and how to assist the country's collective efforts to combat the virus.

Vietnam's successful COVID-19 policies received enthusiastic international praise and domestic satisfaction. At the beginning of February 2021, there had been only 1850 COVID-19 cases and 35 deaths [37]. However, at the end of April 2021, the situation changed rapidly as the fourth wave of COVID-19 began [56]. By the end of May, it had spread across the country to 30 cities and provinces with the largest urban centre, Ho Chi Minh City, and its environs being particularly badly affected leading to lockdowns of increasing strictness. By late July, over one-third of the country's population was under lockdown [57]. By the end of August, the 7-day average number of cases had risen to around 12,000 per day. In December, it reached 16,000 and then in February–March the spread of the highly infectious Omicron variant saw infections rise precipitously to 270,000 per day and then decline equally fast. Deaths had also risen dramatically with the fourth wave but declined greatly during the 2022 Omicron spike. Nonetheless, by the beginning of May 2022, Vietnam had recorded over 10 million cases and 43,000 deaths (see Table 4).

Three essential aspects of the dramatic changes in Vietnam's COVID-19 experience require identification and elaboration. First, the government moved slowly to vaccinate the population. Thus, when COVID-19 cases were surging in July 2021, only 3.9 per cent of the population had been vaccinated, the lowest percentage among ASEAN countries [57]. Initial success in managing COVID-19 had bred complacency manifested in the government's lack of urgency in procuring vaccines. Additionally, the costs were judged as high and

the vaccine queue long while there was the prospect of an effective domestic vaccine emerging from the four under development [58]. Government miscalculated on the easier transmissibility of the Delta variant, but rapid rises in case numbers and deaths forced it to approve and urgently seek vaccines from Western pharmaceutical companies, other countries and foreign aid channels. The scramble for and delivery of vaccines was belatedly successful so that by the end of March 2022, 90 per cent of the adult population had received two doses [59]. This played a major role in the much lower death rates when the Omicron spike occurred in 2022.

The second feature of note was that the government was reluctant to change its approach to COVID-19 management that had worked so well in 2020 and up to April 2021. Thus, it continued with the use of lockdowns to eliminate the virus when outbreaks occurred. However, in the earlier times, outbreaks were much smaller and lockdowns affected relatively few people over short periods. Once the Delta variant began to spread the numbers of infected persons ballooned and lockdowns were scaled up to include ever growing numbers of people [60]. In late July 2021, one-third of the country's population was in lockdown [61]. The official thinking was still that the virus could be eliminated through lockdowns when it had become obvious that they were not working.

The third essential aspect of the fourth wave derives from the second. The lockdown policy was causing great damage to the economy, people's livelihoods and their socio-economic and psychological wellbeing. There was a sharp contraction of the economy in the third quarter of 2021 [62]. People engaged in the informal economy could not work during lockdowns. In Vietnam, it has been estimated that 11 million out of 46 million jobs are created by the informal sector, which includes 8.4 million household businesses [63]. Already living on low incomes and often experiencing precarious employment conditions, this significant group and their families were particularly vulnerable when lockdowns were imposed. At the other end of the economic scale, manufacturing enterprises, many owned by foreign interests, had to shut down or work with reduced staff numbers. Some orders were reportedly directed to other countries and the reliability of Vietnam as a business partner was raised. The economy registered a sharp contraction in the third quarter of 2021. These conditions pushed the government into reconsidering its approach to managing COVID-19. Thus, the need to loosen COVID-19 rules was indicated in a government resolution in October 2021 on "safe and flexible adaptation and effective control of the pandemic" [64,65]. The incremental relaxation of COVID-19 rules followed, especially in early 2022, boosted by the government's USD 15.3 billion economic aid package aimed at virus-hit businesses, workers and increased infrastructure spending [66]. Schools, factories and tourism were back in business and the economic growth for 2022 was predicted to return to 6 per cent as the government and society learned to live with COVID-19 [67,68].

4. Discussion

South Korea and Vietnam provide two cases of remarkable initial success in managing the COVID-19 crisis but later experienced more difficult times with rapidly rising infections and increased deaths. The Korean economy made a strong recovery into 2022 from the main period of disruption caused by the COVID-19 pandemic in 2020–2021. By May 2022, some 86% of the Korean population were vaccinated and the rate of unemployment was approximately 3.7%. There were emerging risks though from rising inflation, in particular rising energy prices, and increased geopolitical instability following the war in Ukraine, that were expected to curtail economic growth and exports. Korea's economy was still anticipated to deliver GDP growth of 2.7% in 2022 and 2.5% in 2023 [69,70]. Vietnam's economy also proved resilient to the COVID-19 pandemic, and economic growth at the end of 2021 was approximately 2.6%. Vietnam's manufacturing sector was also recovering from COVID-19 disruptions by 2022, though disruptions to global supply chains and inflationary risks in many of Vietnam's major export markets in North America and Europe were expected to create headwinds for Vietnam's ability to sustain its strong economic

growth [71,72]. For the purposes of this article, what we need to learn from these case study experiences are the lessons they provide for crisis management.

The first lesson is the importance of preparedness. This has been demonstrated many times in different crisis situations, but with COVID-19 many countries were not fully prepared and suffered great human and economic tolls as a result. By contrast, South Korea and Vietnam had learned from previous viruses such as SARs and MERS and had instituted changes to their health systems to enhance their responsiveness and capacity to deal with such viruses. Thus, the problems and shortcomings identified in managing these earlier infections had been rectified by the time COVID-19 arrived. Both countries had the capability to deal with a pandemic.

The second lesson is the need for decisive action. This is closely linked to preparedness as it enables informed and timely responses. South Korea and Vietnam were both ready to institute the policies and systems that had been put in place as a result of the analysis of earlier virus episodes. Systems could be operationalized immediately and participating institutions knew their roles in the complex business of crisis management. This experience contrasts with the dithering and changing, sometimes conflicting, decisions made in other countries that resulted in far more severe repercussions for their economies and societies than in South Korea and Vietnam.

However, what happens if the situation changes as it did in both South Korea and Vietnam? What if there are surprises? This consideration leads to the third lesson—the need for flexibility in crisis management. COVID-19 was not a single-event crisis. It was a crisis that lasted for over 2 years and is still with us at the time of writing. During that time, new variants of the virus emerged, resulting in successive waves of infections. In such circumstances, it is essential to be able to move quickly and with agility to modify what has worked in the past but is no longer so effective for present circumstances. To borrow Mintzberg's terminology, there is a need for an emergent strategy to replace some items of the intended strategy to produce a realized strategy that works for current circumstances [73]. This does not mean redesigning the entire crisis management system. Rather, it is about modification. Thus, when case numbers rose rapidly in South Korea due to the Omicron variant, it was apparent that the hitherto successful high-tech contact tracing was no longer feasible or useful. It was no longer fit for purpose. However, the government calculated that the health system had the capacity to cope with the large number of new cases through a combination of hospital and home care. Omicron was a more infectious variant but it produced milder symptoms. By this stage, most of the population had also been fully vaccinated. By contrast, in Vietnam the government persisted with its successful strategy from 2020, especially lockdowns. It was also slow to vaccinate. It was only when a third of the country's population were under lockdown and there was widespread economic and social distress that the government moved to change its approach. Its emergent strategy was delayed.

A fourth lesson is that there can be alternative crisis management strategies for achieving similar outcomes. Thus, while both South Korea and Vietnam registered great success in managing COVID-19 in 2020 and the first part of 2021, they obtained these results using strategies that had some significant contrasts. For example, Vietnam used lockdowns to contain outbreaks of the virus, while South Korea never employed this method. South Korea relied heavily on a high-tech contact tracing system for which Vietnam did not have the resources. South Korea had a more liberal approach to travel than Vietnam. These observations give support to a contingency theory view "organizational effectiveness derives from fitting the characteristics of the organization, such as its structure to contingencies that reflect the situation of the organization" [74] (p. 1) [75]. It is important to note that there was no blank slate for leaders, planners and managers to design and implement best-practice systems of identification, testing, treatment and prevention. The approaches of both governments were shaped by the organizational environments in which they operated. Institutional structures, organizational arrangements and capability, resource availability, level of technology, culture and the nature of leadership are some of the many

environmental factors that account for the differences between the two countries. They offer possibilities and direction and exert constraints on decisions and measures taken. This does not mean that the strategies adopted by South Korea and Vietnam did not take note of and borrow from other countries and international organizations. Indeed, both embraced policy transfer but pragmatically filtered the transferred items to ascertain what was appropriate, what was useful—in contingency terms “what fits”. The transferred items were adapted to suit the new circumstances and complement domestic policy learning and practice [76].

A final significant factor in both countries’ management of COVID-19 was securing the support of the population at large and other sectors for a united approach characterized by commitment and coordination. Neither country had to deal with the protests and civil disobedience that flared up in some other countries. The private sectors cooperated with government in the production and supply of equipment and services required items for managing the pandemic. At least for the first year and a half of the pandemic, the populations of both countries gave full support to their governments’ approaches to COVID. While the East Asian value of collectivism, as opposed to Western individualism, seems to have contributed to such acceptance of state directives, it is by no means a full explanation. Consistent, clear, transparent and regular communication led by government was apparent in both Vietnam and South Korea, leading to trust in leadership and willingness to follow government instructions for the perceived collective good. Leadership was also significant as it always is in crisis management. In both countries, effective leadership was evident. The leaders were seen to be in control of the situation, to be led by science, decisive and empathetic to people’s needs. They also provided citizens with hope for the future in times of severe stress. In the case of Vietnam, such leadership characteristics were complemented by the regime’s ability to command obedience to its decisions. The leadership gloss was somewhat tarnished in both countries with the surges of infection and deaths in 2021 and 2022.

5. Conclusions

South Korea and Vietnam have been very successful in managing the COVID-19 crisis. While there were surges of infections which brought rising numbers of deaths in the second half of 2021 and in 2022, the overall record is still far superior to many European, North American and South American countries. As Table 4 shows, even after the Omicron spike in South Korea and the rapid spread of Delta in Vietnam, both countries’ deaths per 100,000 population were well below those of many Western countries—South Korea with 44.62 per 100,000 and Vietnam with 44.2 as compared to the USA with 301.61 and the UK with 258.6. The figures for South Korea and Vietnam are indicative of more effective crisis management than in many other parts of the world. While their populations undoubtedly suffered and their economies contracted, the damage was not nearly as severe as elsewhere. Such results do not come through luck but through the effectiveness of the state to prepare for and manage a crisis. Both South Korea and Vietnam demonstrated state effectiveness in their planning for and management of the pandemic.

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