2007-E-6

Regional Cooperation over Infectious Diseases: With A Focus on HIV/AIDS

Tsuneo Akaha

Monterey Institute of International Studies

March 2008

Presented at the 1st International Symposium on "Asian Cooperation,Integration and Human Resources" for Waseda University Global COE Program: Global Institute for Asia Regional Institute (GIARI), Tokyo, January 17-18, 2008.

Introduction

"Human security" is generally defined as freedom from want and freedom from fear.[1] These two essential elements of human security correspond generally to the concepts of prosperity and peace. Prosperity and peace are affected by a myriad of factors, including political, economic, social, and environmental developments. Among the threats to the life and quality of life of people, war and other forms of violent conflict are the most extensively scrutinized within the framework of traditional security studies. In recent decades, however, non-traditional security studies have mounted inquiries into developments that adversely affect human security. Among human security threats, the deterioration of public health has the most immediate impact on human security.[2] This paper is an attempt at examining this aspect of human security within the context of East Asia. Rather than an exhaustive study of all dimensions of public health, the paper is meant to be an illustration of how a study of public health as a human security issue can shed new light on both the opportunities and challenges presented by the need to develop international cooperation in the public health field.

In this brief analysis, we will first review the HIV/AIDS situation in the world generally and East Asia specifically and examine the current state of international cooperation in this policy area in East Asia. We will then discuss the potential contribution of multilateral cooperation over the HIV/AIDS epidemic to the building of an East Asia Community, as well as obstacles that need to be overcome. We will pay particular attention to the role of the state and non-state actors in regional cooperation.

The main conclusion is that capacity building in developing countries, particularly in Southeast Asia, will be critical if HIV/AIDS epidemic is to be brought under control. Therefore, we will call for international cooperation aimed at capacity building as the most urgent task in East Asia.

HIV/AIDS in the World and East Asia

HIV/AIDS as a Global Phenomenon

HIV/AIDS and other infectious diseases represent human security issues of growing concern to the international community. The global HIV/AIDS pandemic has been recognized as one of the world's major human security threats.[3] According to UNAIDS (Joint United Nations Programme on HIV/AIDS) and WHO (World Health Organization), estimates of the number of persons living with HIV around the world in 2007 ranged from a minimum of 30.6 million to a maximum of 36.1 million, including 2.2-2.6 million children under the age of 15 (see Table 1). That is, five out of every 1,000 persons around the world were HIV-infected. In 2007 alone an estimated 2.5 million persons were newly infected with HIV, including 420,000 children under 15 (Table 2), and there were an estimated 2.1 million AIDS deaths, 330,000 of them children under 15 (Table 3).

Table 1. Number of People Living with HIV in the World

	Estimates	[Minimum - Maximum Estimates]
World Total	33.2 million	[30.6 - 36.1 million]
Adults	30.8 million	[28.2 - 33.6 million]
Women	15.4 million	[13.9 - 16.6 million]
Children under 15 years	2.5 million	[2.2 - 2.6 million]

Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 1.

Table 2. People Newly Infected with HIV in 2007

	Estimates	Minimum - Maximum Estimates
World Total	2.5 million	[1.8 - 4.1 million]
Adults	2.1 million	[1.4 - 3.6 million]
Children under 15 years	420,000	[350,000 - 540,000]

Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 1.

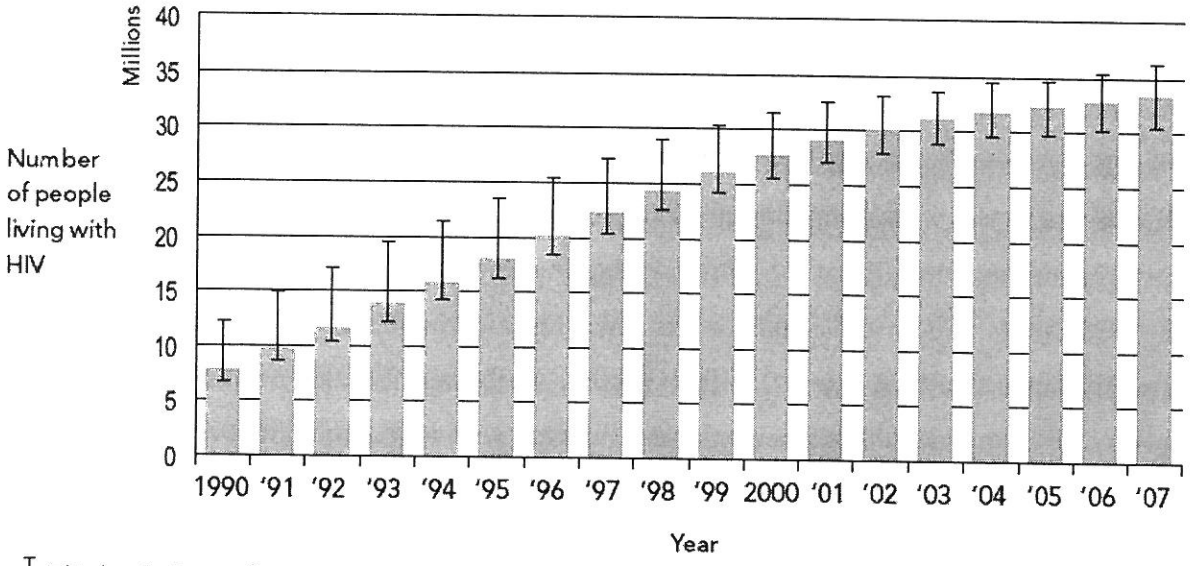
Table 3. AIDS Deaths in 2007

	Estimates	Minimum - Maximum Estimates
World Total	2.1 million	[1.9 - 2.4 million]
Adults	1.7 million	[1.6 - 2.1 million]
Children under 15 years	330,000	[310,000 - 380,000]

Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 1.

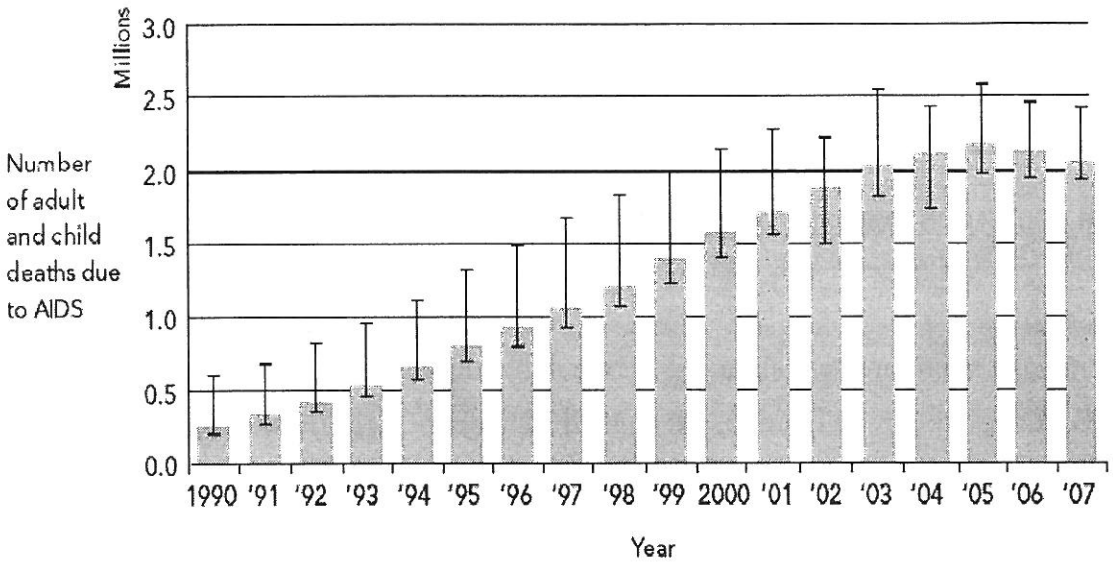
Global trends are very alarming. The number of people living with HIV around the world continues to grow (Figure 1), although the number of AIDS deaths appears to have peaked in 2005 (Figure 2).

Figure 1. Estimated Number of People Living with HIV Globally, 1990-2007



Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 4.

Figure 2. Estimated Number of Adult and Child Deaths Due to AIDS Globally, 1990-2007



I This bar indicates the range around the estimate.

Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 5.

How does East Asia compare with other regions of the world? UNAIDS and WHO report regional aggregate data for "East Asia" and "South and Southeast Asia" as shown in Table 4. Sub-Saharan Africa is the region with the most alarming numbers of people affected by HIV and AIDS in the world, with the total number of persons living with HIV in the region estimated at around 22.5 million, or 5.0% of the adult population infected with HIV, and an estimated 1.6 million AIDS deaths. South and Southeast Asia also has high incidence of HIV and AIDS deaths, with comparable figures at 4.0 million persons, 0.3%, and 270,000 deaths, respectively. In East Asia, an estimated 800,000 persons were infected with HIV, including 0.1% of the adult population, and there were an estimated 32,000 deaths due to AIDS. That is, about 14.5% of the world's total HIV-infected population live in South, Southeast, and East Asia, and AIDS-deaths in these regions represent around 14.3% of the world's total death toll due to AIDS.

Table 4. Regional HIV and AIDS Statistics, 2001 and 2007

	Adults and children living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
Sub-Saharan Africa				
2007	22.5 million [20.9 million–24.3 million]	1.7 million [1.4 million–2.4 million]	5.0% [4.6%–5.5%]	1.6 million [1.5 million–2.0 million]
2001	20.9 million [19.7 million–23.6 million]	2.2 million [1.7 million–2.7 million]	5.8% [5.5%–6.6%]	1.4 million [1.3 million–1.9 million]
Middle East and North Africa				
2007	380 000 [270 000–500 000]	35 000 [16 000–65 000]	0.3% [0.2%–0.4%]	25 000 [20 000–34 000]
2001	300 000 [220 000–400 000]	41 000 [17 000–58 000]	0.3% [0.2%–0.4%]	22 000 [11 000–39 000]
South and South-East Asia				
2007	4.0 million [3.3 million–5.1 million]	340 000 [180 000–740 000]	0.3% [0.2%–0.4%]	270 000 [230 000–380 000]
2001	3.5 million [2.9 million–4.5 million]	450 000 [150 000–800 000]	0.3% [0.2%–0.4%]	170 000 [120 000–220 000]
East Asia				
2007	800 000 [620 000–960 000]	92 000 [21 000–220 000]	0.1% [<0.2%]	32 000 [28 000–49 000]
2001	420 000 [350 000–510 000]	77 000 [4900–130 000]	<0.1% [<0.2%]	12 000 [8200–17 000]
Oceania				
2007	75 000 [53 000–120 000]	14 000 [11 000–26 000]	0.4% [0.3%–0.7%]	1200 [<500–2700]
2001	26 000 [19 000–39 000]	3800 [3000–5600]	0.2% [0.1%–0.3%]	<500 [1100]
Latin America				
2007	1.6 million [1.4 million–1.9 million]	100 000 [47 000–220 000]	0.5% [0.4%–0.6%]	58 000 [49 000–91 000]
2001	1.3 million [1.2 million–1.6 million]	130 000 [56 000–220 000]	0.4% [0.3%–0.5%]	51 000 [44 000–100 000]
Caribbean				
2007	230 000 [210 000–270 000]	17 000 [15 000–23 000]	1.0% [0.9%–1.2%]	11 000 [9800–18 000]
2001	190 000 [180 000–250 000]	20 000 [17 000–25 000]	1.0% [0.9%–1.2%]	14 000 [13 000–21 000]

Oceania				
2007	75 000 [53 000–120 000]	14 000 [11 000–26 000]	0.4% [0.3%–0.7%]	1200 [<500–2700]
2001	26 000 [19 000–39 000]	3800 [3000–5600]	0.2% [0.1%–0.3%]	<500 [1100]
Latin America				
2007	1.6 million [1.4 million–1.9 million]	100 000 [47 000–220 000]	0.5% [0.4%–0.6%]	58 000 [49 000–91 000]
2001	1.3 million [1.2 million–1.6 million]	130 000 [56 000–220 000]	0.4% [0.3%–0.5%]	51 000 [44 000–100 000]
Caribbean				
2007	230 000 [210 000–270 000]	17 000 [15 000–23 000]	1.0% [0.9%–1.2%]	11 000 [9800–18 000]
2001	190 000 [180 000–250 000]	20 000 [17 000–25 000]	1.0% [0.9%–1.2%]	14 000 [13 000–21 000]
Eastern Europe and Central Asia				
2007	1.6 million [1.2 million–2.1 million]	150 000 [70 000–290 000]	0.9% [0.7%–1.2%]	55 000 [42 000–88 000]
2001	630 000 [490 000–1.1 million]	230 000 [98 000–340 000]	0.4% [0.3%–0.6%]	8000 [5500–14 000]
Western and Central Europe				
2007	760 000 [600 000–1.1 million]	31 000 [19 000–86 000]	0.3% [0.2%–0.4%]	12 000 [<15 000]
2001	620 000 [500 000–870 000]	32 000 [19 000–76 000]	0.2% [0.1%–0.3%]	10 000 [<15 000]
North America				
2007	1.3 million [480 000–1.9 million]	46 000 [38 000–68 000]	0.6% [0.5%–0.9%]	21 000 [18 000–31 000]
2001	1.1 million [390 000–1.6 million]	44 000 [40 000–63 000]	0.6% [0.4%–0.8%]	21 000 [18 000–31 000]
TOTAL				
2007	33.2 million [30.6 million–36.1 million]	2.5 million [1.8 million–4.1 million]	0.8% [0.7%–0.9%]	2.1 million [1.9 million–2.4 million]
2001	29.0 million [26.9 million–32.4 million]	3.2 million [2.1 million–4.4 million]	0.8% [0.7%–0.9%]	1.7 million [1.6 million–2.3 million]

Source: 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 7.

HIV/AIDS in East Asia

Let us take a closer look at Northeast and Southeast Asia. Unfortunately, country-by-country statistics for these subregions are not yet available for 2007. In 2005, the number of persons living with HIV in Northeast Asia and Southeast Asia was about the same, estimated at 1,620,000 and 1,590,200, respectively. However, the number of AIDS deaths was dramatically different between the two subregions. Southeast Asia reported an estimated 560,000 deaths in 2005, in comparison with 32,400 deaths in Northeast Asia. (See Table 5.) The difference may be attributable to the vast difference between the two subregions in terms of AIDS awareness and availability of resources and infrastructure dedicated to medicine and health care.

Within each subregion, there is great variability in the state of HIV/AIDS epidemic. In Northeast Asia, Russia and China are by far the most seriously affected in terms of both the estimated number of HIV-infected persons and AIDS deaths. As shown in Table 6, in 2005, an estimated 940,000 Russians and 650,000 Chinese were living with HIV and the estimates for

AIDS deaths ranged between 22,000 and 55,000 in Russia and between 18,000 and 105,300 in China. Of particular note here is the great variance in the Chinese estimates for both HIV-infection cases and AIDS deaths. This shows both the poor state of data availability and the sheer size of the country's population, which makes sampling a daunting task.

Table 5. The Number of Persons Living with HIV and AIDS Deaths (Estimates) in Northeast and Southeast Asia, 2005

	Persons Living with HIV		Deaths	
	Estimates	[Minimum - Maximum Estimates]	Estimates	[Minimum - Maximum Estimates]
World Total	38 600 000	[33 400 000 - 46 000 000]	2 800 000	[2 400 000 - 3 300 000]
East Asia	3 210 200	[1867100 -3655200]	592400	[96530 - 222800]
Of which:				
Northeast Asia	1 620 000	[967900 - 2756000]	32 400	[40830 - 55700]
Southeast Asia	1 590 200	[899200 - 2686200]	560 000	[55700 - 167100]

Source: Calculated from statistics in Report on the Global AIDS Epidemic, UNAIDS/WHO, May 2006 http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp (accessed February 1, 2007)

Table 6. HIV-infected Persons, Deaths (Estimates) in Northeast Asia, 2005

	Persons Living with HIV		AIDS Deaths	
	Estimates	[Minimum - Maximum Estimates]	Estimates	[Minimum - Maximum Estimates]
Northeast Asia Total	1 620 000	[967900 - 2756000]	32 400	[40830 - 55700]
China	650 000	[390 000 – 1 100 000]	31 000	[18 000 – 105300]
North Korea	…	…	…	…
Japan	17 000	[10 000 – 29 000]	1400	[830 – 2100]
Mongolia	<500	[<2000]	<100	[<200]
South Korea	13 000	[7900 – 25 000]	<500	[<1000]
Russia	940 000	[560 000 – 1 600 000]	…	[22 000 – 56 000]

Source: Compiled from Report on the Global AIDS Epidemic, UNAIDS/WHO, May 2006 http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp (Accessed February 1, 2007)

As noted earlier, Southeast Asia is experiencing a far more serious epidemic of HIV/AIDS. A UNAIDS-WHO report in November 2007 notes, "HIV prevalence is highest in South-East Asia, with wide variation in epidemic trends between different countries – Myanmar, Thailand and Cambodia show declines in prevalence, but the epidemic is growing at a particularly high rate in Indonesia and in Viet Nam."[4] Estimates of HIV-infected persons are the highest in Thailand, followed by Burma and Vietnam, Indonesia, Cambodia, Malaysia, Singapore, and Laos (Table 7).

Table 7. HIV-Infected Persons and Deaths (Estimates) in Southeast Asia, 2005

	Persons Living with HIV		AIDS Deaths	
	Estimates	[Minimum - Maximum Estimates]	Estimates	[Minimum - Maximum Estimates]
Southeast Asia Total	1 590 200	[899200 - 2686200]	560 000	[55700 - 167100
Brunei	<100	[<200]	<100	[<200]
Cambodia	130 000	[74 000 – 210 000]	16 000	[8500 – 26 000]
Indonesia	170 000	[100 000 – 290 000]	5500	[3300 – 8300]
Laos	3700	[1800 – 12 000]	<100	[<200]
Malaysia	69 000	[33 000 – 220 000]	4000	[2100 – 7200]
Burma	360 000	[200 000 – 570 000]	37 000	[20 000 – 62 000]
Philippines	12 000	[7300 – 20 000]	<1000	[<1000]
Singapore	5500	[3100 – 14 000]	<100	[<200]
Thailand	580 000	[330 000 – 920 000]	21 000	[14 000 – 42 000]
Vietnam	260 000	[150 000 – 430 000]	13 000	[7800 – 20 000]

Source: Compiled from Report on the Global AIDS Epidemic, UNAIDS/WHO, May 2006 http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp (Accessed February 1, 2007).

Regional Cooperation on HIV/AIDS in East Asia

Cooperation in ASEAN

So far multilateral cooperation in East Asia regarding the issue of HIV/AIDS has been most actively pursued by and through ASEAN (the Association of Southeast Asian Nations). In 1992, the heads of SEAN member countries agreed on the need to promote regional cooperation. The following year ASEAN adopted its first ASEAN Regional Program on HIV/AIDS Prevention and Control (1995-2000), with the assistance of the World Health Organization (WHO). A Medium Term Work Programme, later developed with UNAIDS assistance to implement the ASEAN Regional Programme, established priorities for regional cooperation and identified a range of programs and activities aimed at strengthening collaboration among ASEAN member countries. These included "collaborating with non-health sectors, such as labour and education, identifying population movements, multi-sectoral collaboration on youth interventions, assessing family and community support systems, improving HIV surveillance, and involving Islamic religious leaders. An ASEAN AIDS Information and Research Reference Network was also established to share information and experiences."[5]

In November 2001, the ASEAN summit adopted a "Declaration on HIV/AIDS." This followed on the approval of a "Declaration of Commitment on HIV/AIDS" by the heads of state and representatives of governments at the United Nations General Assembly Special Session in June 2001.[6]

In the ASEAN declaration, the heads of state of the member countries pledged to undertake efforts at the national and regional levels. At the national level, the leaders were to "lead and guide the national responses to the HIV/AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans." The leaders also committed themselves to "promote the creation of a positive environment in confronting stigma, silence and denial; elimination of discrimination; addressing the prevention, treatment, care and support needs of those in vulnerable groups and people at risk, particularly young people and women; and strengthening the capacity of the health, education and legal systems." They further agreed to "intensify and strengthen multisectoral collaboration involving all development ministries and mobilizing for full and active participation a wide range of non governmental organizations, the business sector, media, community based organizations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and evaluation of national responses to HIV/AIDS including efforts to promote mutual self help."

The ASEAN declaration also called for joint regional actions to "strengthen regional mechanisms and increase and optimize the utilization of resources to support joint regional actions to increase access to affordable drugs and testing re-agents; reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socioeconomic vulnerability and impact, expand prevention strategies and provide care, treatment and support.," as well as to "monitor and evaluate the activities at all levels and systematically conduct periodic reviews and information sharing with the full and active participation of non-governmental organizations, community-based organizations, people living with HIV/AIDS, vulnerable groups and caregivers."

The ASEAN summit leaders further called on ASEAN Dialogue Partners, the UN system organizations, donor agencies, and other international organizations to "support greater action and coordination, including their full participation in the development and implementation of the actions contained in this Declaration, and also to support the establishment of the Global HIV/AIDS and health fund to ensure that countries in the region would have equal opportunity to access the fund."

The ASEAN leaders also endorsed a second "ASEAN Work Programme on HIV/AIDS" (2002-2005) to accomplish the regional activities in support of national programs and joint regional actions.[7] The program identified common country priorities as: HIV surveillance; prevention programs; access to drugs, reagents, and condoms; treatment, care, support, and counseling; creation of a positive environment, including laws and regulations; and gender and capacity building. The program's specific objectives included: reduction of the rate of HIV transmission in ASEAN member countries; creation of a positive and enabling environment for HIV/AIDS prevention activities, and provision of treatment, care and support for people living with HIV/AIDS; strengthening of national responses to HIV/AIDS prevention, treatment, care and support programs in ASEAN member countries through inter-country activities; and strengthening of multi-sectoral collaboration and coordination among governments and regional partners to facilitate national and regional programs, including international agencies and NGOs, regional networks of people living with HIV/AIDS, international donors and the private sector.[8]

The ASEAN Secretariat noted in 2001 that although there had been a significant decline in the number of new HIV/AIDS cases in Thailand and Cambodia, it was expected that the HIV/AIDS epidemic would continue to intensify throughout the region in the immediate future largely due to the continued presence of key high-risk behaviors and the length of time it takes for new infections to be detected.[9]

In June 2006, the UN members held a follow-up meeting on the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS. In January 2007, the ASEAN heads of state held a special session on AIDS. They adopted a joint declaration "ASEAN Commitments on HIS and AIDS." They recognized that the HIV epidemic was brought about by "factors such as poverty, gender inequality and inequity, illiteracy, stigma and discrimination, conflicts and disasters" and affected groups most at risk like sex workers, men having sex with men, transgenders, and drug users including injecting drug users; and

vulnerable groups such as migrants and mobile populations, women and girls, children and youth, people in correctional institutions, uniformed services, communities of populations in conflict and disaster-affected areas."[10] The leaders committed themselves to "prioritize and lead the mainstreaming and alignment of HIV policies and programmes with [their] national development and poverty reduction plans and strategies..., address the gender dimension of the epidemic, and ensure that all stakeholders at national and local levels are actively and effectively involved." They also pledged to "harmonize programmes, activities, target population on HIV and AIDS," and to "ensure that [their] policies and programmes give ample emphasis to containing the epidemic in vulnerable populations, sharing of lessons, best practices and evidence-informed prevention policies, and moving prevention and education efforts...beyond the health sector, and especially address aspirations of children and young people, women, couples and other vulnerable groups to protect themselves against the disease." They also agreed to "undertake to halt the spread of HIV, through not only the setting of ambitious national targets...but also through youth- and women-friendly sexual and reproductive health services, and specific HIV information, education, and communication." They further pledged to "put into place necessary legislation and regulations...to ensure that persons living with HIV and affected groups are protected and are not subjected to stigma and discrimination, have equal access to health, social welfare and education services, including continued food security and education for children." They also agreed to continue their cooperation with the ASEAN Dialogue Partners, UNAIDS Secretariat, other UN organizations, international partners, civil society organizations, and the private sector in an effort to scale up effective responses to HIV and AIDS.[11]

In addition, the ASEAN receives technical assistance and funding support from several key organizations outside of the region. They include the UNAIDS Secretariat, US Agency for International Aid (USAID), WHO, and the Rockefeller Foundation.

Besides government efforts at the national and regional level in the ASEAN region, a coalition of regional networks has also emerged and its importance has been recognized by the ASEAN Secretariat. A Coalition of Asia Pacific Regional Networks on HIV/AIDS, known as "Seven Sisters," was formed in February 2001. The coalition is composed of AIDS Society of Asia Pacific (ASAP), Asia Pacific Council of AIDS Service Organizations (APCASO), Asia Pacific Network of People Living with HIV/AIDS (APN+), Asia Pacific Network of Sex Workers (APNSW), Asia Pacific Rainbow (APR), Asian Harm Reduction Network (AHRN),

and Co-ordination of Action Research on AIDS and Mobility in Asia (CARAM Asia).[12] The coalition members cooperate with each other on programs dealing with affected communities and vulnerable populations such as drug users, sex workers, transgender communities, men who have sex with men (MSM), HIV+ people and mobile populations. They also cooperate closely with UNAIDS.[13] The latest coalition activity was the 8th International Congress on AIDS in Asia and the Pacific, held in Colombo in August 2007. The declaration adopted by the congress called on low prevalence countries to maintain their status by: recognizing that the low prevalence status could change quickly through complacency; by government leadership to address AIDS as a development issue; development partners continuing to give priority to low prevalence countries' needs and providing technical support; meaningfully employing civil society and people living with HIV/AIDS in formulation and implementation of programmes; and employing focused strategies for prevention.[14]

Cooperation in APEC

HIV/AIDS has also appeared on the agenda of Asia Pacific Economic Cooperation (APEC) in recent years.[15] The first time the APEC leadership demonstrated a collective concern about this issue was in October 2000, when the APEC leaders called for a strategy to fight infectious diseases, including HIV/AIDS. This was followed by the endorsement in October 2001 of a "Strategy on HIV/AIDS and Other Infectious Diseases," developed through the Industrial Science and Technology Working Group (ISTWG). The strategy called for cooperative activities in six areas: electronic networking, surveillance, outbreak response, capacity building, partnering across sectors, and political and economic leadership.[16]

A report prepared for the ministerial meeting in 2001 stated:

> *The nearly 22 million deaths that have occurred from HIV/AIDS surpass the number of war-related deaths globally during the twentieth century. The prospects for economies in East Asia and the Pacific are alarming with projections of the region's ability to surpass Africa in the number of HIV infections by 2010. Once HIV/AIDS infiltrates 8% of the adult population, per capita growth is 0.4% per year lower than it would have otherwise have been; above a 25% infection rate, the cost is at least 1% per capita loss per year. Mead Over and others estimate the average total cost of treatment and foregone*

productivity in Tanzania resulting from a single HIV infection to be about 8.5%-18.3% of per capita income. As reported by UNAIDS, AIDS threatens the urban professional class and, at least in Africa, has produced millions of orphans each year, directly reducing the size of the economically active population.[17]

Following the SARS outbreak in 2002-2003, the APEC leaders called for national efforts and regional cooperation to prevent the recurrence of the near-pandemic, but their concern was prompted as much by the economic impact of SARS and other infectious diseases as by public health and human security consequences.[18] In this connection, the APEC established a Health Task Force in 2003. Following the outbreak of avian influenza in 2004, the APEC Health Task Force designated as three priority areas the enhancement of avian and human pandemic influenza preparedness and response, fight against HIV/AIDS in the APEC region, and improvement of health outcomes through advances in health information technology.[19]

The outbreak of avian influenza in 2004 added to the urgency of regional cooperation to address public health issues. In November 2004, the APEC Ministers called for cooperation in "health security." The APEC leaders endorsed the initiative "Fighting Against AIDS in APEC." Particularly concerned about the economic and social impacts of HIV/AIDS, the leaders called for collective efforts by all stakeholders and committed themselves to working together regionally and globally to combat the spread of HIV/AIDS. In response, APEC has identified two priorities for cooperative efforts in the region: the management of HIV/AIDS in the workplace and the links between migration and HIV/AIDS.

APEC held two workshops in 2005, one in Thailand on the management of HIV/AIDS in the workplace and the other in the Philippines on HIV/AIDS and migrant/mobile workers. These workshops highlighted the need to combat HIV/AIDS-related stigma and discrimination in the workplace and to encourage more involvement of the business sector in addressing the challenges posed by HIV/AIDS.[20] The workshop on "HIV/AIDS and Migrant/Mobile Workers," held in Manila in December 2005, brought together health, labour, and foreign ministry officials, as well as national AIDS authorities, non-governmental organizations and international organizations representing 13 APEC economies. The participants explored the linkages between mobility and vulnerability to HIV/AIDS; regional and national strategies to address these challenges; gender and human rights issues; HIV/AIDS prevention in the workplace; safe

mobility, economic growth and development.[21] They issued recommendations to the APEC Health Task Force, including: the development of a "safe mobility framework" as a model for APEC economies in addressing the challenges of migrants and other mobile populations and vulnerability to HIV/AIDS; the development and implementation of clear and explicit rights-based policies and programs on HIV/AIDS and migration that incorporate gender needs and sexuality; a study on legal frameworks and bilateral agreements and practices of APEC members regarding HIV testing related to migration, with a view to harmonizing these policies and practices in accordance with international law and best practice; information sharing regarding best practices on HIV/AIDS prevention, care, and support initiatives in the workplace; and the broadening of the linkages between HIV/AIDS and its economic impacts and encouragement of more engagement of the business sector in combating the HIV/AIDS epidemic.[22]

HIV/AIDS, in addition to avian and pandemic influenza, received much attention at the 17th APEC Ministerial Meeting, held in Seoul, Korea in November 2005. The ministers welcomed the outcome of the above two workshops, recognizing it as APEC's contribution to the international community's efforts to combat HIV/AIDS, in cooperation with UNAIDS and WHO. They noted that the private sector was the largest employer in the region with the greatest potential to contribute to the well-being of the people living with HIV/AIDS and recognized the importance of the activities of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, established in 2001.[23] The APEC Ministers also stressed the need to enhance the capacity in prevention, treatment, and care in the developing economies in the ASEAN region.

As noted earlier, HIV/AIDS has continued to spread in spite of the national, regional, and global efforts to fight the infectious disease. At the 18th APEC Ministerial Meeting in November 2006, APEC Ministers expressed concern about the "rising HIV prevalence rates in the Asia-Pacific region" and renewed "their commitment to work individually and collectively to combat the spread of HIV/AIDS in the APEC region." They also recognized that "failure to properly address HIV/AIDS and its related illnesses could have potentially grievous impacts on human health and also on the social and economic well-being of APEC economies." They welcomed the release of an APEC HIV/AIDS Statement at the XVI International AIDS Conference held in Toronto, Canada, which reaffirmed APEC's commitment to fighting the disease and appealed to APEC Leaders to continue to scale up their engagement in the fight against HIV/AIDS.[24] They further noted progress achieved in the development of guidelines for creating an enabling

environment for employers to implement effective workplace practices for people living with HIV/AIDS, in particular migrant workers, women and girls and reiterated the importance of access to affordable life-saving medicines.

Most recently, APEC Health Ministers met in Sydney, Australia in June 2007 and endorsed "Guidelines for Creating an Enabling Environment for Employers to Implement Effective Workplace Practices for People Living with HIV/AIDS."[25] The guidelines built on the work in the preceding years of ASEAN and the International Labor Office (ILO).[26] The APEC guidelines are aimed at assisting "APEC member economies to create an enabling environment for employers to implement effective workplace practices on HIV." The document states, "Effective workplace practices should aim to ensure the rights of workers living with HIV, prevent HIV transmission in workplace settings, eliminate stigma and discrimination on the basis of real or perceived HIV status, and mitigate the impact of HIV and AIDS on the world of work." Drawing on the ILO "Code of Practice on HIV/AIDS and the World of Work," the APEC guidelines set the key principles as: (1) recognition of HIV/AIDS as a workplace issue; (2) non-discrimination based on real or perceived HIV status; (3) gender equality; (4) healthy work environment; (5) social dialogue; (6) no HIV testing for purposes of exclusion of employment or work processes; (7) confidentiality of HIV-related data; (8) continuation of employment relationship and adaptation of work; (9) prevention; and (10) care and support.[27]

Characteristics of Regional Cooperation

The above brief review regional cooperation to combat HIV/AIDS within the framework of ASEAN and APEC points to several general observations. First, from the outset, the region's leaders recognized the importance of regional cooperation. Second, the nature of regional cooperation has evolved from largely declaratory calls for cooperation in the 1990s to the development of a comprehensive set of guidelines, principles, and programs that have received the endorsement of ASEAN and APEC leaders. Third, cooperative initiatives in the region against HIV/AIDS have become increasingly progressive and expansive. Fourth, even though the initial concern of APEC leaders with respect to this infectious disease was mostly economic, they soon came to realize the multi-faceted nature of the consequences of HIV/AIDS, including social and human security dimensions. The fifth and related point is that the leaders soon endorsed the multi-sectoral approach involving economic, health, and foreign policy officials in

regional dialogue and development of collaborative programs in the region. Also to be noted is the cooperation of extraregional organizations and initiatives, such as UNAIDS, WHO, and ILO. Seventh, HIV/AIDS initiatives in the region have also emphasized the importance of the human rights aspect of HIV/AIDS. Discrimination against persons living with HIV both socially and at work has become an important focus of regional efforts to develop principles and good practice in countering the impact of HIV/AIDS. Eighth, both regional and international efforts have emphasized capacity building in developing countries in combating HIV/AIDS, whether in prevention, care, treatment, or support.

The last statement leads our attention to the sad truth that despite the regional efforts we have reviewed, HIV/AIDS remains a serious threat to human security in East Asia. The "2007 AIDS Epidemic Update" by the UNAIDS and WHO notes:

> *In Asia, national HIV prevalence is highest in South-East Asia, with wide variation in epidemic trends between different countries. While the epidemics in Cambodia, Myanmar and Thailand all show declines in HIV prevalence, those in Indonesia (especially in the Papua province) and Viet Nam are growing...Overall in Asia, an estimated 4.9 million [3.7 million–6.7 million] people were living with HIV in 2007, including the 440 000 [210 000–1.0 million] people who became newly infected in the past year. Approximately 300 000 [250 000–470 000] died from AIDS-related illnesses in 2007.*[28]

Even Japan, which has among the lowest HIV infection rates in East Asia, is witnessing increases in HIV infections. In 2007 reported infections exceeded the 1,000 mark for the first time, hitting a record high of 1,048, and the total number of people who have developed AIDS reached 400, with newly reported cases also reaching a record high.[29]

Conclusions

It is obvious that the protection of the life and quality of life of individuals who are infected with HIV and those who have developed AIDS, as well as their family members and others who may come into contact with them, is beyond the capacity of the individuals concerned. The role of governments is critical in HIV/AIDS prevention, care, treatment, and support. Medical and other social infrastructure to be mobilized clearly requires the investment

of public resources. Public education aimed at reducing risky behavior among both homosexual and heterosexual populations, including unprotected sex and drug use, also calls for public resource commitment. Human security capacity building, therefore, is of utmost importance, particularly in the developing countries of the region. The private sector must also participate in local, national, and regional efforts. Where civil society is underdeveloped, the international community needs to offer assistance and encouragement for the participation of non-governmental organizations and groups.

Currently, there is no framework for multilateral cooperation in this issue area in Northeast Asia. In comparison, as we have seen above, the ASEAN member countries have developed institutional mechanisms for cooperation. The APEC has also provided a useful framework within which to develop and facilitate regional cooperation initiatives. The developed countries of Northeast Asia, particularly Japan and South Korea, should take a leadership role in the human security capacity building in the region, through bilateral aid programs and, more importantly, through multilateral initiatives in ASEAN and APEC.

Regional cooperation in the fight against HIV/AIDS requires developments on several fronts. First, in order to enhance the capacity of the region's governments to undertake effective measures in HIV/AIDS prevention, care, treatment, and support, the international community needs to encourage the regional governments to develop domestic legislation and policy instruments required. The existing regional frameworks can be used most effectively for this purpose,

Second, to ensure the protection of the human rights of affected persons, the regional governments should be encouraged to ratify international treaties for the protection of human rights generally and the rights of persons living with HIV particularly. Relevant international treaties include:

- UN International Convention on the Elimination of All Forms of Racial Discrimination (adopted in 1965; entered into force in 1969; ratified by 170 as of March 1, 2005);
- UN International Convention on Civil and Political Rights (adopted in 1966; entered into force in 1976; ratified by 154 states as of March 1, 2005);
- UN International Covenant on Economic, Social, and Cultural Rights (adopted in 1966; entered into force in 1976; ratified by 151 states as of March 1, 2005);

- UN Convention on the Elimination of All Forms of Discrimination against Women (adopted in 1981; not yet in force; ratified by 179 states as of March 1, 2005);
- UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (adopted in 1987; not yet in force; ratified by 139 states as of March 1, 2005);
- UN Convention on the Rights of the Child (adopted in 1989; went into force in 1990; ratified by 192 states as of March 1, 2005);
- UN International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted in 1990; entered into force in 2003; ratified by 27 states as of March 1, 2005);
- ILO Convention concerning Migration for Employment (Convention No. 97; adopted in 1949; entered into force in 1952; ratified by 42 states); and,
- ILO Convention concerning Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers (Convention No. 143; adopted in 1975; entered into force in 1978; ratified by 18 states as of March 1, 2005).

Thirdly, while state capacity is the most critical in the fight against HIV/AIDS, the participation of all other parties with interest and concern is also important. Governments should be open to the participation of international organizations as well as non-governmental organizations and groups, including persons living with HIV and those who have developed AIDS and their spokespersons. The participation of the latter is particularly important to develop and implement legislation, policy, and programs in a manner consistent with the goal of protecting individual citizens' human security, including their fundamental rights. Their participation can also enhance the transparency of government policymaking in this area. In short, what is required is no less than the democratization of political systems and policy processes in the countries of East Asia. Another key participant in the fight against HIV/AIDS is the business community, which has much to gain or lose from the outcome of regional cooperation in this field.

This brief analysis has shown that there is growing consensus that regional cooperation is an essential part of the fight against HIV/AIDS. Cooperation within East Asia is characterized

by uneven levels of institutionalization, with Southeast Asian governments showing greater willingness than their Northeast Asian counterparts to develop and utilize multilateral mechanisms for information sharing, capacity building, mutual aid, joint programming, and even policy cooperation. The ASEAN members' greater readiness to resort to institutionalized cooperation is to a large extent attributable to the now decades-old experience and practice in multilateral cooperation within the region, which dates back to the establishment of ASEAN in 1967. It is also due to the more limited capacity and, hence, the greater need of capacity building that requires mutual aid in the ASEAN region.

Notes

[1] For the concept of "human security" generally, see, among others: William Ernest Blatz, Human Security: Some Reflections, London: University of London Press, 1967; Barry Buzan, Ole Wæver, and Jaap de Wilde, Security: A New Framework for Analysis, Boulder: Lynne Rienner, 1998; Commission on Human Security, Human Security Now, New York: United Nations, 2003; David T. Graham and Nana K. Poku, eds., Migration, Globalization and Human Security, London: Routledge Research in Population and Migration, 2000; Human Security Report 2005, War and Peace in the 21st Century, New York and Oxford: Oxford University Press, 2005; Stephen C. Lonergan, Aaron Wolf, and Chris Cocklin, eds., Water and Human Security in Southeast Asia, Tokyo: UNU Press, 2002; Carla Koppel with Anita Sharma, Preventing the Next Wave of Conflict: Understanding Nontraditional Security Threats to the Global Security, Washington, D.C.: The Woodrow Wilson International Center for Scholars, 2003; Sean M. Lynn-Jones and Steven E. Miller, eds., Global Dangers: Changing Dimensions of International Security, Cambridge, MA: MIT Press, 1995; Rob McRae and Don Hubert, eds., Human Security and the New Diplomacy: Protecting People, Promoting Peace, Montreal: McGill-Queen's University Press, 2001; Nana K. Poku and David T. Graham, eds., Redefining Security: Population Movements and National Security, Westport, CT: Praeger, 1998; Thomas Risse, Stephen C. Ropp, and Kathryn Sikkink, eds., The Power of Human Rights: International Norms and Domestic Change, New York: Cambridge University Press, 1999; Peter Stoett, Human and Global Security: An Exploration of Terms, Toronto: University of Toronto Press, 1999; Majid Tehranian, ed., Asian Peace: Security and Governance in the Asia Pacific Region, New York: I.B. Tauris, 1999; Ramesh Thakur and Edward Newman, eds., New Millennium, New Perspectives The United Nations, Security, and Governance, Tokyo: United Nations University Press, 2000; Caroline Thomas, Global Governance, Development and Human Security: The Challenge of Poverty and Inequality, London: Pluto Press, 2000.

[2] For recent studies on public health as a non-traditional security issue, see: Lincoln C. Chen and Vasant Narasimhan, "Health and Human Security: Pointing a Way Forward," May 30, 2002, <www.fas.harvard.edu/~acgei/Publications/Chen/LCC_Health_and_HS_way_forward.pdf> (Accessed February 25, 2008); Lincoln C. Chen, Jennifer Leaning, and Vasant Narasimhan, eds.,

Global Health Challenges for Human Security, Cambridge, MA: Harvard University Press, 2003; Paula Gutlove and Gordon Thompson, "Human Security: Expanding the Scope of Public Health," Medicine, Conflict & Survival, vol. 19, no. 1 (2003), pp. 17-34; G. MacQueen, J. Santa-Barbara, V. Neufeld, S. Yusuf, R. Horton, "Health and Peace: Time for a New Discipline," *Lancet* 2001, no. 357 (2001), pp. 1460-1461; J. Shiffman J., "Orchestrating Collaboration among Contending States: the World Health Organization and Infectious Disease Control in Southeast Asia," JD Montgomery and N. Glazer, eds., Sovereignty under Challenge, New Brunswick, NJ: Transaction Publishers, 2002, pp. 143-163; and Lynn Thiesmeyer, "Gender, Public Health, and Human Security Policy in Asia," Division for the Advancement of Women (DAW) Expert Group Meeting Enhancing Participation of Women in Development through an Enabling Environment for Achieving Gender Equality and the Advancement of Women, Bangkok, Thailand, 8-11 November 2005.

[3] Chen and Narasimhan, "Health and Human Security," p. 3.

[4] UNAIDS, Fact Sheet 11/07, UNAIDS, New York, November 2007, p. 1.

[5] "ASEAN's Efforts in Combating HIV/AIDS," ASEAN Secretariat homepage, http://www.aseansec.org/8561.htm (Accessed February 22, 2008).

[6] UNAIDS homepage, http://www.unaids.org/en/AboutUNAIDS/Goals/UNGASS/ (Accessed February 22, 2008).

[7] "7th ASEAN Summit Declaration on HIV/AIDS
5 November 2001, Brunei Darussalam," ASEAN Secretariat homepage, http://www.aseansec.org/8582.htm (Accessed February 22, 2008).

[8] "ASEAN's Efforts in Combating HIV/AIDS," ASEAN Secretariat homepage, http://www.aseansec.org/8561.htm (Accessed February 22, 2008).

[9] "ASEAN's Efforts in Combating HIV/AIDS."

[10] "ASEAN Commitments on HIV and AIDS, 13 January 2007, Cebu, Philippines," ASEAN Secretariat homepage, http://www.12thaseansummit.org.ph/innertemplate3.asp?category=docs&docid=37 (Accessed February 22, 2008).

[11] Other commitments of the ASEAN summit leaders included: removal of obstacles in access to quality HIV and AIDS prevention products, medicines, and treatment commodities; mobilization

of technical, financial, and human resources to implement HIV programmes and policies; involvement of HIV-infected persons, civil society organizations, and the private sector in responses to the HIV epidemic; strengthening of the role of the ASEAN Task Force on AIDS in the implementation of regional responses to HIV; participation of all key stakeholders in HIV/AIDS; and implementation of the Third ASEAN Work Programme on HIV (AWPIII) (2006-2010). (Ibid.)

[12] Coalition of Asia Pacific Regional Networks on HIV/AIDS homepage, http://www.7sisters.org/ (Accessed February 22, 2008).

[13] Ibid.

[14] International Congress on AIDS in Asia and the Pacific homepage, http://www.icaap8.lk/ (Accessed February 22, 2008).

[15] APEC is composed of 21 members: Australia, Brunei, Canada, Chile, China, Hong Kong, Indonesia, Japan, Malaysia, Mexico, New Zealand, Papua New Guinea, Peru, the Philippines, Russia, Singapore, South Korea, Taiwan, Thailand, the United States, and Vietnam.

[16] "2001 13th APEC Ministerial Meeting, Shanghai, People's Republic of China, 17-18 October 2001, Joint Statement," APEC Secretariat webpage, <http://www.apec.org/apec/ministerial_statements/annual_ministerial/2001_annual_ministerial.html> (Accessed February 25, 2008).

[17] "Infectious Diseases in the Asia Pacific Region: A Reason to Act and Acting with Reason, Report on a Strategy to Fight HIV/AIDS and Other Infectious Diseases, September 2001" (Leaders2001_ID_Paper_Sept21), p. 5.

[18] The APEC Ministers' joint statement following the 15th APEC Ministerial Meeting in 2003, noted, "Ministers agreed that APEC must be ready to respond to other threats to regional prosperity such as the re-emergence of Severe Acute Respiratory Syndrome (SARS). They emphasized the need for continued vigilance and preparedness to implement the APEC Action Plan on SARS and the APEC Infectious Disease Strategy." (2003 15th APEC Ministerial Meeting, Joint Statement, Summary of Key Issues," APEC Secretariat webpage, <http://www.apec.org/apec/ministerial_statements/annual_ministerial/2003_15th_apec_ministerial.html>) (Accessed February 25, 2008).

[19] "The Eighteenth APEC Ministerial Meeting, Hanoi, Vietnam, 15-16 November 2006, Joint Statement," APEC Secretariat webpage, < http://www.apec.org/apec/ministerial_statements/annual_ministerial/2006_18th_apec_ministerial.html> (Accessed February 25, 2008).

[20] "APEC Statement for the XVI International AIDS Conference," downloaded from APEC Secretariat webpage (February 25, 2008).

[21] Report of the APEC Workshop on "HIV/AIDS and Migrant/Mobile Workers, 5-6 December 2005 Manila, Philippines," APEC Health Task Force.

[22] Ibid.

[23] "The Seventeenth APEC Ministerial Meeting, Busan, Republic of Korea, 15-16 November 2005, Joint Statement," APEC Secretariat webpage, <http://www.apec.org/apec/ministerial_statements/annual_ministerial/2005_17th_apec_ministerial.html> (Accessed February 25, 2008). For information on the Global Fund, go to <http://www.theglobalfund.org/en/>.

[24] For information on the XVI International AIDS Conference, go to the conference webpage at <http://www.aids2006.org/>.

[25] "Guidelines for APEC Member Economies for Creating an Enabling Environment for Employers to Implement Effective Workplace Practices for People Living with HIV/AIDS and Prevention in Workplace Settings," Third Senior Officials' Meeting, Cairns, Australia, 3 July 2007 (2007/SOM3/013, Agenda Item: VII ii), downloadable at the APEC Secretariat homepage, <aimp.apec.org/Documents/2007/SOM/SOM3/07_som3_013.doc> (Accessed February 25, 2008).

[26] The ASEAN-ILO collaborative work had produced in 2005 "HIV and AIDS and the World of Work in ASEAN," documenting the initiatives in Brunei Darussalam, Indonesia, Malaysia, Philippines, Singapore, Thailand, and Vietnam. ("HIV and AIDS and the World of Work in ASEAN: Report of ILO-ASEAN Study on Initiatives on HIV and AIDS and the World of Work in the ASEAN Region," December 2005, downloadable at the International Labor Organization homepage, <http://www.ilo.org/public/english/protection/trav/aids/publ/jointpubs.htm>.)

[27] "Guidelines for APEC Member Economies for Creating an Enabling Environment for Employers to Implement Effective Workplace Practices for People Living with HIV/AIDS and Prevention in Workplace Settings," pp. 1-2.

[28] 2007 AIDS Epidemic Update, UNAIDS, WHO (UNAIDS/07.27E/JC1322E), December 2007, p. 21.

[29] "HIV Infections Hit Record High in '07," Japan Times, February 13, 2008.

GIARI Working Paper Vol. 2007-E-6,

Feb. 29, 2008

Published by Waseda University Global COE Program
Global Institute for Asian Regional Integration (GIARI),
Waseda University, Nishiwaseda Bldg. 5F#507 1-21-1
Nishi-waseda, Shinjuku-ku, Tokyo 169-0051 Japan
E-mail: affairs@waseda-giari.jp
http://www.waseda-giari.jp
Printed in Japan by International Academic Printing Co.Ltd