

# East Asian Regional Cooperation in the Fight against HIV/AIDS, Tuberculosis, and Malaria



# **East Asian Regional Cooperation in the Fight against HIV/AIDS, Tuberculosis, and Malaria**

Conference Report



Beijing Conference 2006

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# Contents

Introduction	vii
1. Opening Remarks	1
JIEFU HUANG, RICHARD FEACHEM, and ICHIRO AISAWA	
2. Cross-Border Cooperation and the Global Fight against Communicable Diseases	11
CHRISTOPH BENN	
3. Human Security Approaches: Health as a Global Public Good	16
MELY CABALLERO-ANTHONY	
4. Common Regional Challenges in Responding to Communicable Diseases	21
<i>Summary of Discussion</i>	
5. Fighting AIDS and Other Communicable Diseases in China	25
<i>Summary of Discussion</i>	
6. Building Effective Cross-Border and Regional Cooperation in East Asia	30
<i>Summary of Discussion</i>	
Agenda	38
Participant List	41



## Introduction

This publication reports on the discussions at a July 10–11, 2006, conference on East Asian Regional Cooperation in the Fight against HIV/AIDS, Tuberculosis, and Malaria. More than 100 government, business, NGO, and philanthropic leaders from around the world gathered in Beijing, China, for the event, which was jointly organized by the Friends of the Global Fund, Japan (FGFJ), the Chinese Center for Disease Control and Prevention (China CDC), and the Global Fund to Fight AIDS, Tuberculosis and Malaria. This conference was designed to build upon the English and Chinese publication of *Fighting a Rising Tide: The Response to AIDS in East Asia*, and it included many of the experts who began cooperating with one another through the study that culminated in this book.

The stories and experiences shared at this conference provide compelling evidence of just how indispensable regional and cross-border cooperation is in the fight against communicable diseases. Germs and viruses need no passports to cross borders, and conventional responses that stop at national boundaries are bound to fall short in this era of growing mobility and interdependence. The ways in which disease spreads, the porous nature of national borders, and the realities of life for the most vulnerable people among us increasingly mean that responses must be cooperative in order to work. In addition, regional cooperation has the potential to make domestic responses more effective. For example, regional cooperation encourages policymakers and frontline responders in different countries to share best practices, and it has the capacity to crystallize the focus of national leaders, mobilize political support, and reinforce domestic leadership to fight communicable diseases.

However, there is clearly less of a foundation for regional cooperation in East Asia than in other areas such as Europe and North America. The incredible diversity in the region in terms of culture, history, language, and politics is compounded by the relative lack of strong regional institutions and networks. Organizations often run into problems at the starting gate in just identifying whom they should be working with on the other side of the border, and there are few established patterns of cooperation to ease the difficulties in dealing with the complex issues that inevitably arise in collaborative efforts. Despite these challenges, however, there are numerous

## East Asian Regional Cooperation

exemplary cases of emerging regional and cross-border cooperation in the region, ranging from joint harm reduction initiatives on the China-Vietnam border to efforts by NGOs to ensure continued access to antiretroviral (ARV) treatment for migrant workers when they cross borders. These projects, some of which were presented at this conference, can serve as models for deeper and more meaningful regional cooperation.

Drawing on their personal experiences, the conference participants recommended a number of steps to help increase regional and cross-border cooperation and make it more effective. The first thing that is needed is greater information sharing—between counterparts engaged in cooperative initiatives and, in a more general sense, at the regional level about the epidemiology of communicable diseases, the state of responses, and ongoing cooperative initiatives in individual countries and localities. A heightened degree of flexibility is also crucial so that regional and cross-border approaches can be tailored to local conditions. Responses should not just involve foreign ministries or health ministries; rather they also need to be cross-sectoral, cross-agency, and cross-disciplinary in order to be most effective. For example, the case of an innovative HIV prevention effort targeting migrant construction workers employed on the Second Mekong International Bridge project illustrates the importance of involving construction and labor ministries, development agencies, local businesses, and NGOs in responses to communicable diseases. The role of NGOs, in particular, was stressed by conference participants as especially vital in regional and cross-border cooperation, because they are often best placed to reach the mobile populations, ethnic minorities, and vulnerable groups that national and local governments struggle to engage. Finally, there is a pressing need to strengthen the sense of East Asia community and build up regional organizations, forums, and networks in order to create an institutional framework to tackle communicable diseases.

We would like to thank the speakers and participants who shared their expertise and vision, notably including Jiefu Huang, China's vice minister of health, and Ichiro Aisawa, acting secretary-general of Japan's ruling Liberal Democratic Party and former senior vice minister for foreign affairs. We also want to extend our deep gratitude to the Global Fund, represented by Richard Feachem and Christoph Benn, and to the supporters who made this extraordinary collaboration possible, especially the Bill & Melinda Gates Foundation, the Open Society Institute, and the United Nations Foundation. And finally, we would like to note the hard work of our colleagues at the China CDC, especially Zunyou Wu, Zhengfu Qiang,



## *Introduction*

Jiangping Sun, and Lin Feng; and at the Japan Center for International Exchange, which operates the FGFJ, including Hideko Katsumata, Satoko Itoh, Tomoko Suzuki, and Tomone Kozen; James Gannon for compiling and authoring this report; and Susan Hubbard, Naoko Fitzgerald, Kimberly Ashizawa, and Pat Ishiyama for their contributions to the publication process.

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## Opening Remarks

*The conference was opened by Jiefu Huang, China's vice minister of health; Richard Feachem, executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria; and Ichiro Aisawa, former senior vice-minister for foreign affairs of Japan and acting secretary-general of the ruling Liberal Democratic Party. Condensed versions of their remarks are presented below.*

### JIEFU HUANG

We all know that infectious diseases respect no national boundaries, and this “Beijing Conference on East Asian Regional Cooperation in the Fight against HIV/AIDS, Tuberculosis, and Malaria” is a landmark in regional cooperation in the fight against these diseases. This shows there is an objective demand for regional cooperation in this fight, and, at the same time, this also represents the fruit of regional cooperation. This conference demonstrates the latest developments in regional cooperation. I am sure that it will promote regional cooperation in an extensive and intensive manner. So, on behalf of the Ministry of Health of the People's Republic of China, I would like to extend our warm congratulations to the conveners of the conference and a warm welcome to all of the participants from home and abroad.

HIV/AIDS, tuberculosis, and malaria are rampant around the world. The three diseases take about six million lives every year, and this number is increasing year on year. They are threatening the existence and the development of human society, and they have become common public health issues for all of the world's countries. Take HIV/AIDS as an example. Asia has followed Africa and has become the region with the most rapidly increasing number of infections. In recent years, we have seen these rapid increases. Starting from 1985 and through to 2005, the number of accu-

## East Asian Regional Cooperation

mulated reported cases has been large, and now we have about 650,000 people living with HIV/AIDS in China. Among them, AIDS patients number about 75,000, and new infections are mainly dominated by cases of sexual transmission and injecting drug users (IDUs). Now we find that the infection is expanding from high-risk groups to the general population, and it is becoming more and more serious. Faced with the challenge of HIV/AIDS, the Chinese government adopted a series of measures to implement throughout the country by the end of 2005. The government is taking the lead, while the relevant agencies are taking responsibility, and the whole society has been mobilized to fight against HIV/AIDS. The central budget for HIV/AIDS reached 800 million yuan in 2005, and local budget allocations for HIV/AIDS are also increasing. We have now provided ARV treatment, are preventing mother-to-child transmission, and are actively promoting condom use, as well as methadone treatment and clean needle exchange programs. We have special policies to provide AIDS orphans with free education. Also, NGOs are playing a very important role in this process.

As with our measures to control HIV/AIDS, China is accelerating efforts to control tuberculosis and malaria and we are making sound progress. In controlling the three diseases, the Chinese government has paid attention to international exchange and cooperation. International organizations—both bilateral and multilateral like the Global Fund—have all rendered great support to the Chinese government. So, I would like to take this opportunity to express our sincere appreciation to all of you on behalf of the Chinese government.

While fighting against HIV/AIDS, tuberculosis, and malaria, the Chinese government is fully aware of the importance of regional cooperation. With the economic development of recent years, the movement of people and the movement of goods in the region have accelerated, so regional cooperation has become more important than ever. However, regional efforts also face many challenges. In particular, we have a large drug market in our region, and the abuse of injection drugs has caused serious problems in terms of disease control. At the same time, most of the countries in the eastern part of the region are developing countries, and most of them are also faced with common challenges such as insufficient funding and a high disease burden. In addition to many other difficulties, the poor coverage of HIV/AIDS, tuberculosis, and malaria treatment among high-risk populations has become a barrier in our fight against the diseases.

To address this, the Chinese government has worked actively with the countries in the region to improve regional cooperation. For instance, the Chinese government has received support from the Japanese government, and we have initiated the East Asia Laboratory Network, training laboratory staff and also promoting the exchange of experiences. At the same time, with Myanmar, we have accomplished our action plan in Yunnan Province. And, with the support of the United Nations Development Programme (UNDP) and AusAID, China and ASEAN countries have conducted a series of activities targeted at migrant populations. At the same time, together with Thailand and Vietnam, China has strengthened its efforts in promoting the exchange of knowledge and lessons learned.

HIV/AIDS, tuberculosis, and malaria are common enemies of mankind. To control the spread of the three diseases is our common duty. We are fully aware that the prevention and treatment of HIV/AIDS, tuberculosis, and malaria are long-term tasks, and we look forward to further cooperation with countries around the world. We hope that we can share common resources and exchange our experiences. This conference is a very good platform, and so we hope that, with this platform, we can enhance mutual trust and achieve progress together so that we can contribute to the fight against HIV/AIDS, tuberculosis, and malaria.

## RICHARD FEACHEM

It is particularly appropriate that we are gathered in this region because, of course, this region is where the Global Fund originated. It was in the summer of 2000, in Okinawa at the G8 Summit hosted by Prime Minister Mori, that the idea of the Global Fund was really born. And a year and a half later, in January 2002, the Global Fund came into existence. And we have grown very rapidly. The Global Fund now has total assets of around US\$9 billion and is already supporting 386 programs in 131 countries. And those numbers continue to grow as the portfolio of investments of the Global Fund expands and the income of the Global Fund continues to increase year by year.

Not surprisingly, approximately 60 percent of the investments of the Global Fund go to Africa, the continent where HIV/AIDS is most catastrophic and where tuberculosis and malaria are also running at very high levels. But we also have very substantial investments in this region, which we regard to be of great importance to the global effort. We are, in fact,

## East Asian Regional Cooperation

investing in 58 programs in Cambodia, China, East Timor, Indonesia, Lao PDR, Mongolia, the Pacific Islands, Papua New Guinea, the Philippines, Thailand, and Vietnam—in other words, in every country in the region that is not a wealthy country. And the total value of those investments today is US\$1.3 billion, of which US\$350 million has already been disbursed. Those programs are spread across the three challenges: 23 programs for HIV, 18 programs for tuberculosis, 16 programs for malaria, and one very innovative program for strengthening health systems. And, of course, those numbers will grow again this year.

Now, this region is not only important in the fight against HIV/AIDS and the investments that the Global Fund is making. This region is also important as a donor to the Global Fund. And, indeed, Australia, China, Japan, New Zealand, Singapore, South Korea, and Thailand are all donors to the Global Fund. And this is important because it sends a message of global solidarity. It sends a message that all of humankind is facing the tragedy and the scourge of HIV/AIDS and tuberculosis and malaria together, and that all countries should contribute according to their means. And I look forward to a day when every country in this region is a donor to the Global Fund, every country. Even if the sums of money are small, the political significance of those investments in the Global Fund is immense, and the message of regional and global solidarity that it sends is a very important message.

As everybody here knows, the challenges that we face in this region for HIV/AIDS, tuberculosis, and malaria are very large, and we must go forward with a mixture of optimism but also realism about the scale and nature of the challenges. If we look at HIV/AIDS in this region, we see mature epidemics such as Thailand; we see epidemics growing steadily in very large populations, such as in China and in Indonesia; and we also see young and explosive epidemics, epidemics that are newer but growing very rapidly—Papua New Guinea is perhaps the best example of this kind of epidemic. So the region is diverse, but the scale is very large, and we have to join together in implementing effective programs if we are to turn the tide of HIV/AIDS in the region. And today the tide is not turned. I think we are all very clear about that. HIV/AIDS in the region is continuing to expand and to worsen, and we must overcome that.

I mentioned joining together, and I would like to emphasize two different aspects of joining together. The first is the joining together among governments, NGOs, faith-based organizations, private sector organizations, and communities directly affected by HIV/AIDS—the joining together of those

different partners, each of whom can make and is making a substantial contribution. And I want to congratulate the region. As I visit country after country, I see many good examples of government, NGO, faith-based, community, and private sector programs scaling up and working together, but I think we can do more in this arena. I think there is more potential to mobilize the skills and the assets and the talents of each sector in the fight against HIV/AIDS. No one can do this alone. Governments cannot do this alone. Civil society cannot do this alone. We have to join hands.

The second aspect of coming together is the regional or multi-country aspect. HIV is a cross-border issue. Addressing it is a regional public good. Countries must work together, and countries will not be successful if they do not work together. I think this conference symbolizes that need for multi-country and regional efforts. And I hope that the recommendations from this conference will be vigorously implemented in order to achieve that togetherness in the region among countries.

Coming briefly to tuberculosis, despite substantial successes in TB control programs in some countries in the region, tuberculosis continues to worsen and will continue to worsen as long as HIV worsens. Tuberculosis rides on the back of HIV. If HIV is getting worse, then tuberculosis is also getting worse. And along with the frequency of tuberculosis and the expanding use of first-line drugs against tuberculosis, we will see inexorably the development of more and more multidrug-resistant tuberculosis, which is a matter of extreme concern. So I obviously want to encourage everyone—and the Global Fund will be your partner in this—to expand vigorously the programs that are combating tuberculosis, to see tuberculosis and HIV together, to make sure the HIV and tuberculosis programs are working hand in hand, and to prepare for and be ready to counter an increasing load—an increasing burden—of multidrug-resistant tuberculosis.

And finally, malaria is the “quick win” for the Global Fund and the global health community. It is the thing we can conquer quickly if only we implement the programs vigorously and on a large scale. The Global Fund is investing in malaria in every country in this region. In every country in this region, malaria is worsening or at best not improving. In some countries in this region, malaria is worsening quite rapidly, and there is no good reason for this. We have the technologies to fight malaria; we have the money to fight malaria; and increasingly we have the political will to fight malaria. And there is no excuse to see anything other than malaria declining.

Coming to the technologies, we have excellent new diagnostic tests—rapid, easy to use, reliable diagnostic tests. We are not using them widely

## East Asian Regional Cooperation

enough or sufficiently. We have new drugs to deal with drug-resistant malaria, particularly the artemisinin combination therapy, the ACT, which has its origins in China, based on a Chinese herbal remedy that has been used for hundreds, perhaps thousands, of years. We now have the new third generation of ACT malaria drugs, which are highly effective and can create a complete cure in a child in a three-day period. Again, we should be using this new drug much more widely and getting it to the patients, particularly the children, who need it.

And finally, we have the new insecticide-treated bed nets. Not the old kind which you have to dip and soak and re-impregnate every six months, but the new kind, in which the insecticide is built into the fabric before the net is made and the insecticidal properties of the net last for five or six years, by which time you have to buy a new net anyway because your net has fallen to pieces. They cost about five or six dollars—that's a dollar per year—to protect your family against malaria. That has got to be a very good purchase for any family. And that technology comes from this region; the technology of incorporating the insecticide into the fabric of the net was discovered by Sumitomo Chemical of Japan and is now being increasingly used around the world.

So we need to scale up; we need to scale up rapidly and massively and apply these technologies widely. And we need to raise our ambitions. We have become a little apathetic about malaria. We have become a little resigned to malaria. We need to regain our ambition and our zeal in the field of malaria, and for many parts of the region we should look for no less than malaria eradication. Tomorrow afternoon I will be signing a new Round Five grant agreement for malaria with China, and within that agreement is the goal of malaria eradication on the island of Hainan in southern China. This is a wonderful goal. It can be achieved. I am sure it will be achieved. And if we can eradicate malaria in Hainan we can then go on to eradicate malaria in the whole of China, and this will send a message of hope across the region that malaria need not be tolerated and malaria can indeed be eradicated. We will match that with some programs in the Pacific Islands—Vanuatu and the Solomon Islands—where island by island we will also be eradicating malaria. It can be done, and we should set our sights high in the field of malaria.



ICHIRO AISAWA

I am excited to have this opportunity to make the opening statement as a representative of the FGFJ. The FGFJ has created a Diet Task Force, a bipartisan group of roughly 25 Diet members. I hope that “friends” groups in other countries will do as we have done and create a kind of cheering section or task force among members of their own parliaments. The chair of the FGFJ, former Prime Minister Yoshiro Mori, was supposed to be here today. But, there has been some turmoil in Japanese politics and he was not able to come to Beijing. He asked me to come here in his place and talk about Japan’s stance and thoughts, so that is why I am here today. I sincerely hope that all of the experts in this field who are gathered here today from China and other countries in East Asia—including representatives of the Global Fund, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and many other international organizations; NGOs; and other participants—will use this opportunity for an open exchange of opinions on ways of dealing with this global challenge facing all of us.

I went to South Africa for the first time just one week ago, with the support of the M•A•C AIDS Fund and along with another Diet member and with FGFJ Director Tadashi Yamamoto. In one sense, South Africa is one of Africa’s strongest economies—an economic power—but it has also been invaded by AIDS. We had the opportunity to fully observe this side of the country. The Global Fund Partnership Forum that took place in Durban offered a forum for an active exchange of ideas among more than 500 participants. In addition, we also took part in a special site visit program. We visited several areas on the outskirts of Durban, where the HIV infection rate is said to be more than 30 percent—the highest in the world. We also encountered the doctors and nurses, as well as the devoted volunteers who, with support from the Global Fund and other sources, are working heroically in the fight against AIDS, tuberculosis, and malaria. This had an enormous impact on me and left a deep impression.

I would like to offer a couple of examples. We visited an area outside of Durban with a high concentration of poor people. There, we saw a four-week-old baby in a family of four or five. Her mother is 28 years old, and her mother’s mother—the baby’s grandmother—is in her 40s. That 40-year-old grandmother is also taking care of an 18-month-old child left behind when her other daughter died. That is the family. Aside from the newborn baby, everyone in the household is infected with HIV. The baby has not had an AIDS test yet, so they do not know if she is positive

## East Asian Regional Cooperation

or negative. The baby's mother has to feed her powdered milk to keep her from becoming infected with HIV. She has to be raised on powdered milk. If she is raised on breast milk, the chances that she will become infected are very high. Her mother was somehow able to secure four weeks' worth of powdered milk, but she cannot secure the funds to buy more powdered milk or to pay for transportation to get to the center where she could get the powdered milk.

We visited another house in the same area. Actually, it could not really be called a house. It was a structure built from mud, scrap wood, and discarded sheet metal from the surrounding area. A 28-year-old HIV-positive man lives there by himself. A woman was living there with him until several months earlier, but she died. She had AIDS. The man had come to the city from the countryside, looking for work, but he was not able to find any. Then, he realized that he also had AIDS. He is young, still in his 20s, but—to be blunt—he has no dreams, no desires, and no future. He passes every idle day in those conditions. We saw several such miserable situations. However, in some of the areas, thanks to support from the Global Fund, ARV treatment is becoming relatively more widely distributed. I want to report to you that it is producing huge results and is giving people hope.

Still, given the extent to which infection has spread, I could not ignore the fact that no matter how hard families worked or how hard various communities worked, they were still limited in what they could achieve. In order to effectively address communicable diseases, which spread across national borders, we need to build broad cooperative relationships that also cross national borders, such as those that are being discussed at this conference. Fortunately, with the resolve and goodwill of people around the world, we have begun to realize and act on the recognition that, even on the vast continent of Africa, we need the kinds of policies that supersede national boundaries. I want to offer my praise for that development.

An FGFJ symposium held in Tokyo on June 30, 2005, to commemorate the fifth anniversary of the Kyushu-Okinawa Summit took up the theme of "East Asian Regional Responses to HIV/AIDS, Tuberculosis, and Malaria," with the discussion based on research done by 12 experts from throughout East Asia. This conference here in Beijing is meant to be a follow-up to last year's symposium. The English-language report that came out of last year's symposium has been translated into Chinese in time for this conference and serves as material for discussion, and I think it is valuable. Roughly half of this conference's participants are from China and half from other parts of East Asia. I feel strongly that this is very significant considering, as I

already mentioned, our goal of creating mechanisms for regional cooperation. In addition, at this conference we will hear about a large number of concrete examples of cross-border regional cooperation in the fight against the major communicable diseases in East Asia. We should be able to learn from those achievements, but I also believe that it is important for us to learn lessons from our failures.

I think it is simply amazing—and vitally important—that, envisioning the unfortunate wide spread of AIDS, tuberculosis, and malaria in East Asia and attempting to bring about regional cooperation in the response, it was possible to develop this conference together and create a network of cooperation. Right now, we are witnessing a deepening of mutual interdependence among the countries of East Asia. For example, economic interdependence is so advanced that the level of trade within the region is not all that different from that of the EU. And this trend toward stronger regional ties is one factor contributing to East Asian regional cooperation in the fight against communicable diseases. At the same time, I think that the kind of regional cooperation among various sectors on concrete issues such as communicable diseases will further deepen regional solidarity in East Asia. As a politician, I am aware of this. Last year, heads of state from East Asia—from the ASEAN countries plus China, Japan, Korea, India, Australia, and New Zealand—gathered in Kuala Lumpur for the first East Asia Summit. I would like to appeal to these leaders to take up the important theme of communicable diseases at future East Asia Summits.

I would like to touch on one more aspect of my visit to South Africa. Perhaps this is something that comes from my position as a politician, but I do believe strongly that it will be extremely important to secure political leadership in this area. Political leadership will be an important theme in the years to come as we strengthen cooperation in this field in East Asia. Of course, the efforts of central governments are not enough. We will need cooperation among people from multiple sectors, including local governments, those in the medical field, and corporations. Corporate involvement will require the cooperation of both management and labor. We will also need the cooperation of NGOs and volunteers with various points of view. The participation of people from various sectors is indispensable. I would also like to emphasize that developing stable mechanisms for cooperation requires political leadership in every sense of that term. Of course, when I talk about political leadership, I am doing so from the point of view of a politician who was chosen through an election. But it is not something that belongs only to elected politicians. That is an obvious point, but I

## East Asian Regional Cooperation

wanted to make it all the same. We need the kind of political leadership that brings together people from different backgrounds and with different abilities to play catalytic roles.

As politicians, we have a responsibility to guarantee the safety and security of our country's citizens to create a prosperous country. In dealing with large-scale, global challenges, such as major communicable diseases, we need to approach the challenges as problems in our own region. I would also like to emphasize that it is incredibly important that we politicians in East Asia, who find ourselves in a region that is aiming to build some kind of an economic community in the future, will need to develop cooperative relationships with other politicians and people in positions of leadership from many countries around the region. I would like to point out that this conference, where we are building a network through dialogue with people from China and many other countries, is important to the process through which we will exhibit political leadership in the future.

One important thing is that people now know how AIDS, malaria, and tuberculosis are spreading around the world. And people recognize the dire circumstances facing humanity if we do not take adequate steps to stop the spread. But, for example, if I dare say something that sounds a bit critical, one might say that the greatest obstacle to China's growth will not be a financial crisis as some predicted or bad loan problems, but rather the spread of AIDS. That is just one example that I dare to offer up, but that is something that we must acknowledge. So, we need to raise the necessary resources and we have to figure out how to further improve our judgment and our systems so that we will use these resources accurately and effectively.

## **Cross-Border Cooperation in the Global Fight against Communicable Diseases**

*The following is a condensed version of the presentation made by Christoph Benn, the Global Fund's director of external relations, as part of a session on "Exploring Effective Cross-Border Cooperation in the East Asian Context."*

### CHRISTOPH BENN

Why is cross-border cooperation so important? I want to try to address this question by first broadening the perspective and putting it into a more historic and global context and then by focusing on cross-border collaboration in this particular region.

This year, 2006, we are commemorating 25 years of HIV/AIDS. It was exactly 25 years ago that a new, previously unknown disease was identified by a young physician in Los Angeles. It is very easy to overlook how short in historical terms this story is—just 25 years.

Imagine what happened in those 25 years. I would like to divide the response to this particular epidemic—and I will widen this later to tuberculosis and malaria as well—into four stages. The first stage was the discovery of the scientific foundations of the disease. First of all, scientists had to establish the cause of this new disease—the virus that was discovered in 1983—and then they had to find the methods to detect this virus and its antibodies and understand the relationship between the virus and the disease. Within a very short period of time, the world had to understand that this virus spreads in a completely unprecedented way. Within a few years, this virus spread from the very small group of patients in Los Angeles in 1981 to every continent and to almost every country in the world. That is a unique story completely different from other epidemics. SARS, for example, was worrying the world a few years

## East Asian Regional Cooperation

ago, but it has not spread globally in the same way as HIV has over the last 25 years. This really was a new phenomenon. We have to recall that the spread of the virus across countries, across borders, and across regions is one of the reasons why it is so important in our response to focus on cross-border approaches.

The second stage was discovering the right methods to address this disease in terms of prevention and treatment. Within a few years we had to learn how to prevent the transmission of the virus and the appropriate method to inform people about the right behavior to avoid transmission. We had to promote the use of condoms; learn about harm reduction methods, needle exchange, and other methods to address the problem of transmission among IDUs; and devise methods of voluntary testing and counseling so that people could become aware of their status. Many different, new methods had to be learned.

Another very important development was the discovery of ARV combination therapy exactly 10 years ago. It was at the international AIDS conference in Vancouver in 1996 that the world first learned about the possibility of effective treatment. These new drugs were not a cure—we do not have a cure—but they provide effective treatment that can prevent the replication of the virus in the human body. That was a major scientific breakthrough. So, within a few years, we learned about the methods of prevention and treatment. Basically we could say then that we knew what needed to be done. But there was also a great awareness that we did not have the means to implement those discoveries across the world.

Then the third and very important stage was to mobilize the financial resources to implement what the world had learned to do, to provide the resources for prevention, care, and treatment. We realized very quickly not only that prevention was not affordable in many countries but that treatment was completely out of reach for 95 percent of all of the people worldwide who were affected by the disease. That was the particular challenge about 10 years ago. Although we have made progress, this situation has not changed completely. As Michel Sidibe from UNAIDS has mentioned, US\$1.6 billion is expected to be available for HIV/AIDS in Asia in 2007, but the actual need is US\$5.1 billion. So there is a significant resource gap just for HIV/AIDS and just for Asia, not to speak about many of the other regions. The Global Fund has certainly had an impact on the availability of resources, but the Global Fund itself faces a shortfall for 2006 and 2007 of about US\$2.1 billion for the three diseases—AIDS, tuberculosis, and malaria. So there is a lot to be done.

Nevertheless, this is an area in which the world has made a lot of progress. There is no question about that. A couple of weeks ago, we had a huge summit meeting in New York on HIV/AIDS organized by the United Nations. And one of the indications of progress that was reported was that available financial resources had quadrupled from 2001, when Kofi Annan called for a UN general assembly on HIV/AIDS for the first time. In 2001, about US\$2 billion was available worldwide for the fight against HIV/AIDS; now there is about US\$8 billion. That is a huge increase and also quite unprecedented compared with any other disease. Nevertheless, it is not sufficient and more needs to be done.

The first three issues that I mentioned—the scientific foundations, the methods, and the financial resources—have been addressed to a certain degree. But now in the fourth stage we are facing a particular challenge and a very significant gap. That stage is characterized by the question of how to reach the people who are in greatest need. We are now talking about universal access to prevention, care, and treatment by the year 2010. That is a commitment made by the United Nations and by the G8 leaders last year. But implementing this commitment requires extraordinary efforts particularly because we have to reach the people who are hard to reach. And with this, I am now coming back to the regional approach.

People are hard to reach, for example, because of geographic location. People are very hard to reach because of stigma and discrimination. They are hard to reach because the people we need to reach very often belong to particularly vulnerable groups. They belong to ethnic minorities and groups that face discrimination like IDUs and men who have sex with men (MSM). In this region, it is estimated that only 4 percent of all IDUs are reached by appropriate services; 7 percent of MSM are reached by appropriate services. That is a very small proportion and it tells us something about the task ahead of us.

In terms of the future course of this pandemic, young people are maybe the most important group and the group that has been neglected too much so far. For HIV/AIDS in particular, we need to reach young people. The UN study that was published for the summit in New York said that actually less than 10 percent of young people from the age of 14 to 25 worldwide have appropriate information about HIV/AIDS and can correctly name the methods to protect themselves. That is a shocking figure. About 22 percent of young people in this region have access to and regularly use condoms. So here is a particular challenge: how do we reach the young people? In spite of all the methods we know and all of our resources, it seems that

## East Asian Regional Cooperation

we are not getting to them. There are certainly cultural barriers. There are language barriers. There is a lack of education.

There is also the problem of migrants who are difficult to reach. You cannot locate them in one place where they will stay and you can reach them. You have to reach them where they migrate—in different places. For this reason, we need NGOs and civil society. Why is this so important? Because it is often very difficult for governments to reach precisely the groups we are talking about. Civil society has a particular capacity to reach out to them because of the multitude of NGOs, because of their specialized nature, and because of the importance of peer education. It is much easier for peers—those who belong to the same group and understand the culture and the language—to reach them. And these peers are usually not represented among government authorities. They are often represented by NGOs that these groups have formed. All of this is a particular challenge for the East Asian region.

Let me briefly come to the questions of tuberculosis and malaria as well. You will have recognized that it is a particular concern of mine that we do not focus only on HIV/AIDS. Going back to the four stages that I just described, tuberculosis and malaria are well known and much has been known about them for a long, long time. We know most of the factors that drive these diseases. Interventions to address tuberculosis and malaria are largely available. We know how to treat tuberculosis; we also know how to treat malaria. Yes, there have been new and exciting developments: tuberculosis drugs, new malaria treatment in the form of ACT originating from China, and long-lasting impregnated mosquito nets. These are new developments, but basically all these are interventions that are known and they are even cheap. A mosquito net costs only a few dollars. A complete course of malaria treatment with ACTs costs about one to two dollars. So it is not the money in this case. It is not the availability of the methods. But the problem is precisely what I tried to describe for HIV/AIDS. It is reaching the people. How do you get the mosquito nets to families and to children, to the pregnant women in border areas or among migrants in poor rural areas? That is the challenge. Tuberculosis treatment is relatively straightforward and it is a cure. It is not just a temporary measure. But the case detection rate is low and the challenge is how to get to the people who need the treatment so that you can address them appropriately.

So these are the challenges that I see in terms of the three diseases. Part of the response to reach people is through cross-border programs because they overcome some of the challenges that we are facing when we only



look at mainstream populations in urban centers and places that are easy to reach. In particular, it is important to have cross-border programs that are aimed at vulnerable groups, such as minorities, migrants, and stigmatized groups.

Let me just give you a few examples from the portfolio of the Global Fund in this region. We are already supporting a few regional, multicountry, proposals, and the Global Fund would like to support more in the future. We have a few very interesting proposals in the Pacific, combining a number of Pacific islands for malaria, HIV/AIDS, and tuberculosis. These are coordinated together and they have an exchange program to learn from each other. They are harmonizing their indicators and their monitoring and evaluation systems, and they also have a joint coordinating mechanism. We also have a very interesting malaria grant in China from Round One that is focusing on migrant and mobile populations on the borders with Myanmar, Laos, and Vietnam. We have a number of programs in Thailand that also look at cross-border populations, with voluntary counseling and testing methods, and we have programs that focus on fishermen and seafaring migrants who are working in Thailand but originate from other countries. We are also supporting malaria programs there, on the borders of Cambodia, Laos, and Myanmar, as well as a tuberculosis program. In Cambodia, we have the same. And in Indonesia, we are looking at some very important programs, particularly on the border between Irian Jaya Province of Indonesia and Papua New Guinea. One of the hotspots, Papua New Guinea, probably has the fastest-growing HIV epidemic here in Asia and the Pacific, and it is very important to link their response to activities just across the border in Indonesia, especially in the Papua Province, where there is the highest prevalence in all of Indonesia. Also, we are looking at some cross-border programs between West Timor and East Timor, particularly in terms of malaria but also focusing on the other diseases. And finally, we have some interesting work going on with Mongolia, looking at cross-border programs between Mongolia and Russia on the one hand and Mongolia and China on the other hand.

I think these are early beginnings, but this conference will explore how we can collaborate to expand and enhance these very important initiatives. In that sense this conference will be a great step toward achieving universal access in this region of the world.

## **Human Security Approaches: Health as a Global Public Good**

*The following is a condensed version of the remarks by Mely Caballero-Anthony from Singapore's Nanyang Technological University as part of a session on "Exploring Effective Cross-Border Cooperation in the East Asian Context."*

MELY CABALLERO-ANTHONY

It used to be that security was seen as unidimensional, that security was only about protecting the states, protecting its borders from external attacks. But many countries, particularly developing countries in Asia, have argued otherwise. So even before security analysts talked about the reconceptualization of security as such, many countries in Asia have already said that our notion of security has always been comprehensive. Hence, the evolution of the concept of "comprehensive security." This has been an integral part of the security lexicon that we hear in this part of the world. "Comprehensive" is used in the sense that security issues are wide ranging—threats such as economic underdevelopment, the threat of implosion because of political instability, secession, or ethnic disharmony that could lead to internal conflict.

This whole notion of comprehensive security became very popular following the Asian financial crisis in 1997 and the SARS crisis of 2003. The 1997 crisis was very instructive in that, inasmuch as the notion of security had been comprehensive and not many people would argue with it, there has always been a preoccupation with just securing the security of the state but not looking at the security of individuals. There is a UNDP study that listened to the voices of the poor, and when it asked the poor, for example, "What is security to you?" some of the answers that came up were very instructive. One was that security is, of course, having a roof over my head,

having food on my table, and being able to seek medical treatment when sick. Hence came the notion of “human security,” i.e., that it is no longer enough to secure the state, but we have to secure the people by first looking at their security needs—including the provision of medical care and the provision of jobs, for example. This is so that you can secure the state and prevent it from imploding.

The lesson from Indonesia was very instructive about the importance of human security and how we should, from whatever vocation from which we come, focus on issues of basic human needs. The whole story there changed dramatically after 1997, when after 32 years of relative peace and when the government had been credited by the UNDP as having achieved remarkable progress in its human development index, the government collapsed and ethnic conflict and violence erupted. The lessons from the Asian financial crisis challenged the old traditional approaches to comprehensive security and raised questions as to new ways of addressing emerging security challenges.

We now have, for example, an increasing tendency for a number of actors—whether they are from the policy community, the academic community, NGOs, or even donor agencies—to use the language of security to frame almost every issue which they think endangers the well-being of states and societies. We have environmental security, for example, economic security, and now health security. The reason why the notion of security is appropriated is because people really want to highlight the need for quick and immediate action.

In 2003, it was very interesting to note that suddenly state leaders talked of SARS as a national security threat. One could argue that the SARS crisis was a watershed event in the region in that it raised the question of how best to address the threats of infectious diseases. Should we go beyond the medical approach, and should we in fact then securitize it—securitize it in the sense that this allows the state to take emergency measures, allows for the allocation of necessary resources, and allows other countries to help states that are not able to prevent possible outbreaks of medical emergencies?

So, the debate is whether to go beyond medicalizing to securitizing. One problem is that some medical doctors are not very happy when you talk about securitization because it is an alien concept to them. But to look at how this is now being addressed, we can take AIDS as one example and examine how it has been securitized. The United Nations has agreed to consider it as a security issue. But what about the other diseases like

## East Asian Regional Cooperation

tuberculosis and malaria? And if you put AIDS against SARS or the looming threat of the avian flu pandemic then AIDS becomes second or third in the pecking order. So what happens is perhaps that if you securitize a particular disease and do not complement it with other approaches, there could be uneven treatment of infectious diseases.

Nevertheless, the importance of being able to securitize has become more urgent for at least four reasons. One is that, as we already know, the threat and burden of diseases have changed. We now have multiple disease multipliers. Among these, for example, are the rapid growth of megacities with poor sanitation and water supplies that are breeders of infectious diseases. There is also, of course, climate change and the impact of modern medical practices, which sometimes quickly make antibiotics redundant. And, particularly if one is a security specialist, the potential of viruses being used as weapons of bioterrorism has highlighted the need to look at the security implications of infectious diseases.

Now going back to the point about whether it is enough to just medicalize or should we securitize. I think a middle ground can be taken, and this is my main point. Beyond securitization, there is the need to apply a human security framework in which we can direct our attention to adopting more comprehensive approaches. In this case, we need to revisit the concept of health as a global public good. If it is seen as a global public good, then it allows other countries and other stakeholders to promote it and to provide the necessary interventions that are needed to promote and secure this global public good.

What is the global public goods approach? This is not a new approach. The UNDP, through the work of Ms. Inge Kaul, has been promoting this approach. This highlights the needs for countries and other actors to work together to obtain public goods—which include, of course, good health—fight infectious disease, and help countries that face constraints in securing these goods on their own. And, as a necessary approach, it therefore involves multiple actors and multiple stakeholders.

Why is this a useful approach to look at, especially if we are looking at the promotion of regional cooperation? We have to convince not just our governments, not just our NGOs, but even those who are sick to overcome stigma and not to be afraid of seeking treatment because they have an infectious disease. We have to be able to do this in order to ensure the protection of global public goods. In view of the increasing regionalization of diseases, we need to understand how “your health becomes my health, too.” As we all know, diseases travel. As one security analyst said, viruses do

not carry passports. This raises the importance of regional cooperation to maintain this global public good of good health for the overall objective of human security.

How can we take this forward? If we agree that we need to be able to combat infectious diseases, then we need to allow for external intervention, either from other governments or donor agencies. And the fact is that a global public goods approach also allows for innovative approaches. Our discussions at this meeting on the need to look at innovative approaches have highlighted the fact that if we leave it only to state actors to use only usual approaches to handle infectious diseases, sometimes we do not think outside the box. But if we allow NGOs and local actors to take ownership of some of the major problems but give them the necessary support—financial and other resources—then we are actually opening various opportunities and various avenues for actors to come together to work through existing difficulties and work around existing difficulties. The global public goods approach actually refutes the thinking that health is a domestic problem alone and that we cannot go beyond the domestic jurisdiction of states in managing and combating infectious diseases because of concerns about internal interference. As we have seen in the case studies prepared for this meeting, there is a way around this problem of internal interference by actually working around problems and pooling together resources from different actors in different states.

If one looks at a global public goods approach to fighting infectious diseases, it also helps to strengthen regional mechanisms that are in need of revival or in need of rejuvenation. In particular, I am thinking of the regional mechanisms we have. Within ASEAN, there are emerging mechanisms to address infectious diseases and, because of SARS, there is now greater consciousness of the need for more surveillance mechanisms within the region. Singapore and Malaysia are talking about the possibility of building a center for disease control, and there is information sharing about disease surveillance that, perhaps, can be promoted and taken forward in building up a more credible regional disease surveillance mechanism. There is actually the Micro-Basin Development Surveillance system as well. We can link all of these regional mechanisms together and see how they can best be utilized to build a more effective health system in the region. It also highlights, therefore, the need to look into improving the very poor health infrastructure in other developing countries in Southeast Asia, especially in the less developed states in the region like Cambodia, Laos, and Myanmar.

## East Asian Regional Cooperation

So, with that as a proposition, I would just like to end on the note of actors. I have been struck during this conference by the emphasis on the role of NGOs in the fight against infectious diseases. The whole discussion about NGOs helping migrant workers—whether in Japan or in Thailand—raises one very important aspect about NGOs that needs to be appreciated. NGOs work toward the protection of the human rights of workers—particularly the right to good health, the right to have immediate medical attention, the right not to be repatriated, and the right to be able to have a sense of dignity, even in the face of very serious and critical illnesses. This shows that there is a large constituency out there of NGOs that are actually promoting the norm of the protection of migrant workers. In a way, there is a great deal of capital that needs to be tapped. The NGOs are “norms entrepreneurs” and this is something that must be highlighted in trying to bring together their contribution and then mainstreaming the need to protect workers, both at the national and at the regional level. This is one area that needs to be looked at if we want to enhance regional cooperation in fighting infectious diseases.

In conclusion, the approach of looking at security through the broader perspective of the security of states and societies—or through a human security approach—allows us to look at health issues in a more comprehensive way. It also allows for the participation of a number of actors—the medical community and representatives from other agencies, whether focusing on agriculture, immigration, labor, or veterinary issues—who need to talk to one another and look at various ways to address the problem of infectious diseases. And that is a good example of not only cross-country but also cross-agency collaboration underpinned by this whole notion of health as a global public good.

## **Common Regional Challenges in Responding to Communicable Diseases**

*The following is a summary of conference presentations and discussions on the nature of the threat posed by communicable diseases in East Asia and the challenges inherent in crafting an effective response.*

Conference discussions reflected a sense that Asia is at a crucial inflection point in the fight against communicable diseases, at risk of a major disaster but still with a window of opportunity for effective responses. As Michel Sidibe of UNAIDS pointed out, the sheer magnitude of the numbers involved with the spread of HIV/AIDS in the region is daunting. According to UNAIDS statistics, there were an estimated 2.3 million people living with HIV/AIDS in East Asia in 2005, and this number rises to 8.3 million people when South Asian countries are included. Still, while these numbers are high, prevalence rates remain low relative to Africa, providing a rare chance to succeed in beating back the disease. All the same, there is the potential for an explosion of HIV/infections: South Africa had a prevalence rate of only 2 percent 10 years ago, but now rates are 24 percent.

The region is also plagued by two of the other major infectious killers, tuberculosis and malaria, and in impoverished communities these epidemics often overlap with the HIV/AIDS epidemic. Tuberculosis continues to be widespread in the region. The World Health Organization (WHO) estimates that 55 percent of all new cases of tuberculosis reported worldwide in 2004 were in East Asia and South Asia. Meanwhile, malaria remains a persistent problem, and the world's highest rates of drug-resistant malaria are in Southeast Asia.

### CHARACTERISTICS OF THE REGION'S HIV/AIDS EPIDEMICS

The discussions focused primarily on the regional spread of HIV/AIDS, and the participants were quick to note the diversity among the epidemics in the region. Some countries, such as South Korea, have very low prevalence rates, while prevalence rates are high or accelerating rapidly in other parts of the region. The path of the epidemics have also varied widely from location to location. For example, Japan has not yet experienced a significant outbreak among IDUs or commercial sex workers, but the disease was initially concentrated in these populations in Cambodia and Thailand.

Masahiro Kihara, a leading epidemiologist from Kyoto University, noted how the spread of the HIV epidemic can typically be broken down into two phases. In the first phase infections tend to be concentrated in high-risk populations such as commercial sex workers, IDUs, and MSM, while the second phase is characterized by the spread of the disease in the general population and through heterosexual transmission. Unlike Africa, East Asian countries are still only experiencing the first phase, which accounts for this degree of diversity among countries. However, he warned, every country typically enters into a second phase in which the infections will be focused more in young heterosexual populations.

Given this likelihood, it is particularly worrisome that the spread of AIDS in East Asia seems to be coinciding with changes in sexual behavior that have the potential to drive explosive growth in infection rates. Studies carried out by teams led by Dr. Kihara have found that, in the last 10 years, Japanese and Chinese university and high school students are becoming sexually active at a younger age and these younger students have been considerably less likely to use condoms. In 2003, for example, 2.9 percent of Chinese males in their fourth year of university reported having been sexually active before entering university, but 8.9 percent of first-year male students had already engaged in sex by this point. Similar trends were found in Japan, where sexual experience rates among high school girls in Tokyo had jumped from roughly 20 percent to 46 percent from 1993 to 2002, and there are indications that sexual behavior is evolving in a similar fashion in other East Asian countries as well.



## THE STATE OF REGIONAL RESPONSES

Richard Feachem, executive director of the Global Fund, reminded the participants of the need to recognize the good news in the fight against AIDS, namely that five years ago there was a great deal of denial in Asia about the spread of the epidemic, and this is now gone. However, he and other participants made it clear that the region still faces great challenges in responding effectively to the spread of HIV/AIDS.

For one, the coverage of prevention and treatment programs in Asia remains insufficient. Michel Sidibe related how, according to UNAIDS estimates, HIV prevention programs and services only reach 25 percent of commercial sex workers, 7 percent of MSM, and 4 percent of IDUs in the region. As a result, many of the region's epidemics are transitioning into the general population. Also, despite the progress that has been made, there is still poor coverage of ARV treatment for people with advanced HIV infections. WHO/UNAIDS statistics indicate that these treatments reach less than 10 percent of those with AIDS in Myanmar and the Philippines, and coverage is only slightly better in places such as Vietnam.

Meanwhile, the region faces a growing resource gap. Given the projected course of the epidemic, UNAIDS estimates that US\$2.2 billion was needed for AIDS prevention and treatment in Asia in 2005. In the end, roughly US\$1.3 billion was made available for this purpose. However, by 2007 this need will have risen to roughly US\$5.1 billion, while available resources are likely to have only grown to US\$1.6 billion.

## CHALLENGES FACING THE REGION

Countries throughout East Asia are undergoing significant societal and economic transitions, and at the same time regional interactions and interdependency are rapidly increasing. In this environment, there are a number of particular challenges facing the region as it moves to stem the spread of HIV/AIDS

Several participants stressed that large-scale movements of people in the region, both internally and across borders, have proven to be a key issue in dealing with the regional spread of HIV/AIDS. There are a large number of migrant workers in the region who travel back and forth between rural and urban areas, and they tend to be an important conduit for the spread of the disease. However, participants cautioned that in East Asia,

## East Asian Regional Cooperation

patterns of migration are not carefully monitored, often because they are not officially sanctioned, so a deeper understanding of the realities on the ground is critical. For example, in China, many people who are considered migrants are really those who are living in places that are not their official residences—although they may be doing this for their entire lives—while the true risk group for HIV/AIDS is really a subset of migrants, such as truck drivers. Another participant noted that commercial sex workers in Laos have to move from district to district every three months, which has significant implications for the design of effective interventions.

Multisectoral cooperation is also a key ingredient in the fight against HIV/AIDS. However, the patterns of governance in the region mean that this is often difficult to develop. Governments have a critical role to play, and participants agreed that greater political mobilization and leadership is needed in order to effectively respond to the disease. Wiwat Rojanapithayakorn of the WHO noted that China's progress in the past two years has been extremely striking relative to other countries, and China has been able to move so quickly against HIV/AIDS primarily because the central government has more discipline than any other government in East Asia. However, even Chinese government officials pointed out that there are limitations to what central and local governments can do and that there is a need for greater cooperation with NGOs.

In general, promoting cooperation with NGOs has proven particularly challenging in most places in East Asia, where civil society still lacks a strong infrastructure. In order to enable effective responses, participants urged governmental and private donors to provide more funding for NGOs. One foundation official also remarked on the importance of nurturing coalitions or intermediary organizations, partly because these make it possible for NGOs to obtain funding from the government and elsewhere, even if they have not gone through the official registration process.

It is also important to mobilize corporate involvement in the fight against HIV/AIDS. While there are important differences by country, there has tended to be less business collaboration in AIDS-related efforts in Asia than in countries such as the United States. In light of this, several participants stressed the importance of making corporate executives one target of regional cooperation and of more clearly demonstrating to them that their interests are at stake in the fight against this epidemic.

## **Fighting AIDS and Other Communicable Diseases in China**

*The challenges of fighting the HIV/AIDS epidemic in China were taken up in a number of conference presentations and also featured prominently in all of the conference discussions. Key speakers included Zunyou Wu and Jiangping Sun of the China CDC National Center for AIDS/STD Control and Prevention (NCAIDS), Wiwat Rojanapithayakorn from the China office of the WHO, and Martin Taylor of the China office of the United Kingdom's Department for International Development (DFID). The key points of their presentations and the subsequent discussions are summarized below.*

As the conference participants discussed the state of the HIV/AIDS epidemic in China, it quickly became clear that the sheer size of the country poses special challenges. In 2005, out of a population of 1.3 billion, an estimated 650,000 people were living with HIV/AIDS, translating into the relatively low prevalence rate of 0.05 percent. However, in a country the size of China, a small change in the prevalence rate can rapidly result in a huge number of new infections. Some experts cautioned that, despite strong leadership and early successes, the prevalence rate still has the potential to quickly jump to 1 percent if momentum wanes in the campaign against the disease.

In 2005, there were 70,000 new infections recorded. Zunyou Wu, director of NCAIDS, explained that an estimated 49.8 percent of these came from sexual contact, 48.6 percent from injecting drug use, and 1.6 percent from mother-to-child transmission. The government's current target is to keep the caseload under 1.5 million people by 2010, up from 650,000 in 2005. However, as other participants pointed out, this target already incorporates expectations that new infections will increase beyond the current 70,000 per year.

## East Asian Regional Cooperation

For one, the sheer numbers of people in danger of becoming infected are extraordinarily large. According to the estimate of Wiwat Rojanapithayakorn of the WHO, there are 30–50 million people in high-risk groups. The number of “registered” drug users is officially 1.1 million people, and the likely number is closer to 3.5 million. Meanwhile, the sex industry is growing and commercial sex workers still have low levels of condom usage. According to rough estimates, there may be 6 million sex workers nationwide and more than 10 million men who frequent them. In addition, there are roughly 120 million people who can be classified as migrants, and this population also tends to be at risk for HIV/AIDS.

It is no surprise, given the size of China, that there is a high level of diversity in the characteristics of HIV epidemics in different parts of the country. The population of some single provinces are larger than that of many mid-size countries. Most provinces currently experience relatively low prevalence rates, with outbreaks concentrated among high-risk groups such as IDUs and commercial sex workers. However, other areas, such as the Dehong area on the border with Myanmar or parts of Henan Province, have generalized epidemics with rates over 1 percent. The differences by region are exacerbated by wide economic gaps between urban and rural areas, leading to substantial disparities in the capacity of local governments to implement effective interventions.

### CHINA'S NATIONAL RESPONSE

China's national response to HIV/AIDS has accelerated dramatically since 2003, when the SARS outbreak focused the government's attention on the threat of communicable diseases. While the country's size, the diversity of epidemics, and disparities between individual provinces have complicated the task of fighting the disease, numerous conference participants admitted to being impressed by China's rapid response in the past several years.

A wide range of commentators were quick to praise the strong political backing for AIDS initiatives at the highest levels of government and the way in which this has been accompanied by an enthusiastic response at the local level. This political commitment has come to be symbolized by a series of new national and local government policies and edicts, and it has been reflected in the central government's AIDS budget, which was increased eightfold, from RMB100 million in 2002 to more than RMB800 million two years later. It also has led to important legislative changes,

notably including the March 2006 promulgation of China's first AIDS law outlawing discrimination against people living with HIV/AIDS.

One important initial step in the national response was the government's launch of a comprehensive educational campaign to help raise awareness about HIV/AIDS and combat stigma. Celebrities such as basketball star Yao Ming were mobilized to educate the public about HIV/AIDS through the media, and mass events have been held around the country.

In conjunction with these educational initiatives, a major effort has been undertaken to expand disease surveillance and testing. Since 2003, the number of national HIV/AIDS sentinel surveillance sites has increased from 194 sites to 329 sites, while more than 400 provincial sites have been established as well. In 2004, a major campaign was carried out to test individuals in certain high-risk groups, which resulted in a substantial increase in the identification of infections. Nevertheless, most people nationwide have not yet been tested, and it appears that the majority of people living with HIV/AIDS continue to be unaware of their status.

A wide range of prevention and treatment initiatives have also been launched around the country, although numerous Chinese and foreign participants remarked that these programs' coverage is still insufficient. Also, since the epidemic is concentrated among high-risk groups in most places, emphasis has started to be placed on harm reduction for IDUs. So far, 128 methadone clinics have been opened, mainly in urban areas, and another 1,500 are planned in the next three years. Meanwhile, 91 needle-exchange programs have been launched, primarily in rural areas, with 1,400 more planned.

## INTERNATIONAL CONTRIBUTIONS TO CHINA'S AIDS INITIATIVES

Since 2003, China's domestic mobilization has been accompanied by a dramatic upswing in international involvement in the fight against HIV/AIDS. Historically, China has striven to be self-dependent, but Chinese participants insisted that a major factor in its success to date in battling AIDS has been its willingness to encourage international support and work with overseas donors.

This involvement has come in the form of both multilateral and bilateral initiatives, with the Global Fund taking a leading role. Jiangping Sun, deputy director of the China CDC's NCAIDS, explained that the Global Fund has

## East Asian Regional Cooperation

carried out three rounds of funding in China so far. Starting in September 2004, the first round of US\$98 million in funding targeted community-based programs and was designed to mitigate and reduce the spread of AIDS from seven highly affected provinces in central China; the second round of US\$64 million focused on IDUs and commercial sex workers; and the third round of US\$29 million aims to prevent sexual transmission among high-risk groups and to thus forestall the spread of the epidemic into the general population.

As public and private international organizations have hiked their support for programs in China, it has become increasingly critical for them to coordinate their activities in order not to overburden the organizations working on the ground. Martin Taylor of DFID explained how aid agencies from the United Kingdom, Norway, and Australia have begun to coordinate their activities in China, putting resources into the same projects and working together to harmonize documentation, reporting, and monitoring requirements to reduce the overhead costs of these programs. DFID is now working with Chinese officials to reduce the number of reports and meetings needed to operate projects in the region by moving to use the Global Fund framework for the projects, even sharing the same project management office.

### THE CHALLENGES AHEAD

Despite the Chinese government's strong leadership and the progress of recent years, there are still numerous significant challenges that need to be overcome in order to stem the spread of HIV/AIDS.

Chinese and foreign experts alike agreed that there has been a rapid initiation of effective programs, particularly prevention interventions, but these urgently need to be scaled up. Many of these initiatives have tended to be small-scale programs, which has meant that they have had low coverage and limited impact. As one Chinese participant remarked, still only a small proportion of individuals in high-risk groups have access to prevention services, and those not in high-risk groups tend to have even less access. Meanwhile, testing initiatives have targeted plasma donors and IDUs, but testing is still limited among people at risk of being infected through heterosexual contact. Treatment coverage in particular remains low, and this is exacerbated by the challenges of working in the context of a weak healthcare system. For example, as of December 2005, an estimated

73 percent of the 75,000 people diagnosed with clinical AIDS were not receiving ARV treatment, although this was a significant improvement relative to the percentage a few years earlier.

Of course, as several participants noted, China has a greater capacity to scale up coverage than many countries. Its central government–led system continues to allow a rapid and comprehensive national mobilization, and there clearly is a strong political commitment to stemming the spread of communicable diseases. However, once directives are issued from above, care needs to be taken that programs are not just implemented in a pro forma fashion but that they are done so in the most effective manner possible.

A major obstacle that has continued to make prevention, testing, and treatment more difficult has been widespread stigma against high-risk populations and those affected by HIV/AIDS. One Chinese official related how even when free ARV treatment is provided, some patients still decline it due to stigma and fear that their privacy might be compromised. The new antidiscrimination law may be useful as one step in diminishing this stigma, but there is still a long way to go.

This persistent stigma is one reason cited by several Chinese officials who argued that there is a critical need to improve multisectoral cooperation in China. For example, the government has found it particularly difficult to reach out to MSMs, a highly stigmatized group which government officials have had little experience working with in the past. Government agencies are realizing that they have to rely more on NGOs in this effort and they are now engaged in consultations with NGO representatives.

Nevertheless, it is still proving challenging for government agencies—particularly local governments—to work with NGOs, which operate in an uncertain environment and which are a new phenomenon at the grassroots level. In this context, international involvement appears to have been particularly beneficial. NGOs have been involved in the first three rounds of Global Fund–supported activities to some extent, for example through the establishment of an NGO advisory group, and this has started to give them a platform for broader participation in the fight against AIDS. In order to encourage greater NGO participation, conference participants recommended that priority be placed on more funding for Chinese NGOs, the creation of coalitions that will allow NGOs to receive government funds even when they are not registered with the government, and a greater acceptance of advocacy groups for people living with HIV/AIDS.

## **Building Effective Cross-Border and Regional Cooperation in East Asia**

*The final two sessions of the conference focused specifically on models of cross-border and regional cooperation on communicable diseases. Six practitioners with firsthand experience operating joint initiatives described their work, and a wide-ranging discussion ensued about effective ways of building cooperation. The following is a summary of those discussions.*

In East Asia, it is becoming increasingly evident that greater cross-border and regional cooperation is direly needed. Economic development has accelerated the movement of people and goods, and the accompanying societal changes have often added to the complexity of preventing and treating HIV/AIDS, malaria, and tuberculosis. Unfortunately, there seems to be less of a foundation for regional cooperation in East Asia than in Europe or North America. Regional institutions are relatively underdeveloped, and there tends to be greater diversity from country to country in terms of culture, language, economic development, and political systems.

### **CASE STUDIES OF CROSS-BORDER AND REGIONAL INITIATIVES**

Despite the paucity of regional institutions, a number of cross-border initiatives have been undertaken in response to the spread of communicable diseases, and they have been bearing considerable fruit. Six exemplary cases were described by speakers at the conference, and each sheds light on the various challenges and benefits of cross-border responses.



China-Vietnam Cross-Border Harm Reduction Program  
(JIE CHEN, *Guangxi Center for Disease Control and Prevention*)

A strain of HIV that originated in Southeast Asia has spread extensively among IDUs living on both sides of the China-Vietnam border in the Guangxi Autonomous Region in China and Lang Son Province in Vietnam, which are situated on a major heroin trafficking route. In response, in 2002, Chinese and Vietnamese authorities launched coordinated harm reduction programs that have included needle exchanges designed to take into account the mobility of IDUs across the border and on both sides of it.

Japan-China Joint Research on Emerging and Re-emerging  
Infectious Diseases (AIKICHI IWAMOTO, *University of Tokyo*)

With Japanese government funding, Japanese and Chinese researchers have started establishing joint China-Japan laboratories in China to focus on the spread of HIV/AIDS, avian influenza, hepatitis, and other infectious diseases. The Institute of Medical Sciences at the University of Tokyo has teamed up with the Institute of Biophysics and the Institute of Microbiology at the Chinese Academy of Sciences to establish two joint laboratories, and it is also engaged in a joint research program with the Harbin Veterinary Research Institute at the Chinese Academy of Agricultural Sciences.

Funding for Cross-Border Health Issues in the Greater Mekong  
Subregion (KATHERINE BOND, *Rockefeller Foundation*)

Over the last five years, the Rockefeller Foundation has provided more than US\$7.2 million in interconnected grants addressing the cross-border spread of infectious diseases in the Greater Mekong Subregion, including Yunnan, China; Myanmar; Laos; Thailand; Cambodia; and Vietnam. Particular focus has been placed on migrants and refugees moving across borders and upland ethnic communities living in border areas that are especially vulnerable to disease. The cross-border health efforts draw on capacity from within the region to support poor, vulnerable communities and countries and to build institutions and human resources better able to respond to the challenges accompanying regional integration.

## East Asian Regional Cooperation

### Cross-Border HIV/AIDS Cooperation in the Philippines (EUGENIO CACCAM)

More than one-third of reported HIV/AIDS cases in the Philippines involve overseas foreign workers who have been employed in other countries in the region, some without proper legal documentation. The government of the Philippines has carried out pre-departure training sessions on HIV prevention for these workers and its embassies and a variety of NGOs have been providing prevention and treatment services to workers in their destination countries, although the capacity to do this in a robust manner has varied depending on the local environment of each host country.

### HIV/AIDS Program for the Second Mekong International Bridge Construction Project (EMI INAOKA, *Japan Bank for International Cooperation, JBIC*)

JBIC, Japan's development aid agency, is funding the construction of the Second Mekong International Bridge between Thailand and Laos as part of an effort to create a 1,450 kilometer transportation corridor through the Greater Mekong Subregion. Because the construction project employs a large number of migrant workers in a border area, JBIC included the implementation of an HIV prevention program in the construction contracts. As a result, the Planned Parenthood Association of Thailand has been carrying out the "Bridge of Hope" project to raise awareness of sexually transmitted infections and provide testing services to construction workers and commercial sex workers in the area.

### SHARE (Services for the Health in Asian and African Regions)—Supporting HIV/AIDS Treatment Access for Thai People Living in Japan (SANGNIM LEE, *SHARE*)

SHARE, a Japanese NGO that operates in Thailand and elsewhere around the world, has long worked to provide information on HIV/AIDS prevention and improve medical access for non-Japanese nationals residing in Japan. Nearly one-fourth of all reported AIDS cases in Japan are among non-Japanese nationals, many of whom cannot obtain medical insurance due to their undocumented status and who face the risk of being deported

to their home countries, where access to ARV treatment may be highly limited. Taking advantage of its experience in Thailand, SHARE launched a special program in 2004 to help provide access to ARV treatment for Thai people diagnosed with AIDS after their return to Thailand from Japan.

## RATIONALES FOR CROSS-BORDER AND REGIONAL COOPERATION

These cross-border and regional efforts were launched for a variety of reasons. Participants noted that by building personal networks, cross-border collaboration facilitates the sharing of information and knowledge, in a sense creating an economy of scale in terms of expertise. Of course, information sharing in terms of disease surveillance is also critical so that neighboring countries can implement appropriate strategies to head off spreading epidemics. Other participants point out the importance of institutional learning, describing how regional cooperation encourages practitioners and policymakers in different countries to adopt effective approaches that they learn from one another. Meanwhile, another stressed the capacity of bilateral and multilateral cooperation to deepen the political commitment of each of the participating countries to respond to communicable diseases.

The bottom line, however, is that conventional responses that stop at a country's borders cannot adequately cope with the spread of communicable diseases. Conference participants cited a number of serious shortcomings of unilateral and country-based responses as rationales for their efforts to build cross-border and regional cooperation. Some of the major ones included the following:

- 1) There are sizeable populations that fall through the cracks with conventional national responses. Migrant workers and other legal and illegal immigrants are often not covered or only partially covered by national disease surveillance, prevention, and treatment systems. As Sangnim Lee explained in outlining the activities of SHARE, undocumented Thai migrants in Japan often avoid seeking testing and treatment for HIV/AIDS until the illness has reached its final stages due to fears of forcible repatriation and their inability to obtain public health insurance to cover the formidable costs of treatment. Moreover, these "hidden" populations tend to include the very people who are at the greatest risk of infection—commercial sex workers, young laborers who are far from their families and thus have a greater propensity

## East Asian Regional Cooperation

to engage in risky activities, victims of trafficking, and those on the lower rungs of the socioeconomic ladder.

- 2) There are questions as to which entities have responsibility for protecting and caring for certain populations and even as to who has jurisdiction over them. Eugenio Caccam noted that, despite the efforts of the government of the Philippines to raise awareness about HIV/AIDS among workers departing for employment overseas, it is difficult to continue these efforts once they reach their destinations. Meanwhile, national and local governments in destination countries are often hesitant or unable to take on the burden of prevention and treatment for non-citizens. The issue of jurisdiction and responsibility becomes even more acute with refugees and stateless populations, such as the official and unofficial refugee communities in Thailand or among ethnic groups in Myanmar who oppose the central government.
- 3) Even when local and national authorities make a conscious effort, it is difficult for them to reach out to immigrant communities and build up the level of trust that is needed for effective prevention and treatment initiatives. These difficulties tend to be aggravated by linguistic and ethnic differences as well as by stigma and discrimination, and they are even greater for a variety of political and logistical reasons when dealing with immigrants who are undocumented or engaged in illegal activities.
- 4) Border areas, which are often remote and impoverished, pose a particular challenge in East Asia. This is especially true where minority ethnic groups straddle the border and their socioeconomic conditions and cross-border networks make them more vulnerable to disease and more likely to have frequent interactions across the border. Malaria remains endemic in a number of border areas in Southeast Asia, particularly in remote regions that are home to ethnic minorities, and it spreads without regard for the location of borders. Meanwhile, HIV/AIDS can be a pressing problem where the commercial sex industry and the drug trade draw people back and forth across borders. It is not just prevention initiatives that are likely to be fruitless when implemented only on one side of the border, but also other efforts. For example, one participant noted that people living in many border areas often cross into neighboring countries in order to obtain treatment, placing a greater burden on the country with the stronger health system.

- 5) It is particularly difficult to ensure the continuity of prevention and treatment programs for mobile populations that cross borders. Chinese and Vietnamese authorities began cooperating because they realized that HIV/AIDS prevention initiatives had a limited impact when IDUs had ready access to clean needles in one country but would share needles whenever they crossed the border. Meanwhile, it is counterproductive to start people who have been diagnosed with HIV/AIDS on ARV treatment if they will not have access to these drugs when they cross borders for work, to return home, or for other reasons.

## BUILDING EFFECTIVE COOPERATION

While clearly needed, cross-border and regional initiatives tend, by their nature, to be more difficult to launch and implement than conventional responses. In addition to linguistic, cultural, and political barriers, these efforts are often hampered by a lack of personal and institutional networks, differing priorities, a lack of mutual understanding, and geopolitics. There is also significant diversity in the nature of communicable diseases around the region. In light of these challenges, participants recommended several steps that are key to the efficacy of cross-border and regional responses.

The linguistic and cultural differences within the region are one of the greatest barriers to cross-border initiatives, so one element that needs to be stressed is information sharing between counterparts. Since they typically do not share the same social networks, policymakers and practitioners in different countries who are formulating and implementing joint responses tend to have lower levels of familiarity with one another and further to go in building a foundation of trust. This means it is important to make greater efforts to increase transparency at all stages of the cooperative process and to cultivate a sense of shared ownership. In some instances this may necessitate operating in three, four, or more different languages and local dialects. This may also require special efforts to promote exchanges of leaders from different sectors of society or to build personal networks. For example, Jie Chen of the Guangxi Center for Disease Control and Prevention noted that China-Vietnam harm reduction programs have been aided by an active exchange of public health officials from both countries.

Participants with extensive experience implementing cross-border and regional responses also counseled that it is important to build flexibility

## East Asian Regional Cooperation

into programs so that they can incorporate approaches that are appropriate given the local culture. For example, the participation of peer educators has been increasingly instrumental on the China side of the China-Vietnam needle exchanges because the stigma connected to drug use and HIV/AIDS is so strong in China. Financial inducements are also being used, and 0.1 yuan (roughly US\$0.01) was paid per needle collected. Meanwhile, on the Vietnam side, where vouchers remain relatively popular, program organizers have relied more on a system of vouchers to allow users to obtain clean needles from different distribution points. One participant also mentioned that the need to take flexible and sometimes differing approaches as part of the same initiative underscores the importance of involving private foundations and other private funders on the donor side, since the accountability requirements of governments and international agencies often make them more rigid in terms of what they can support.

The movement of people touches many different aspects of government and society, so participants also stressed that it is critical to elicit broad multisectoral and multi-agency cooperation in order to carry out effective cross-border responses. For example, the implementation of an HIV/AIDS prevention program during the construction of the Second Mekong International Bridge demonstrates that bilateral and multilateral cooperation on communicable diseases works best when it involves not just health ministries and foreign ministries but also development banks, construction ministries, and labor ministries. In this case, a task force was formed to bring together representatives from the transportation sector, the health sector, NGOs, and private businesses, and this group met monthly to coordinate and monitor the program. The participation and support of private businesses, primarily construction companies and other contractors, also turned out to be indispensable, because they stood on the front lines as the employers of the construction workers who were at risk of infection and they were the institutions with the best access to these workers.

One particular element of multisectoral participation on which a wide range of participants placed special emphasis is the need to involve and empower NGOs, which usually have the expertise and flexibility to respond more adeptly to evolving circumstances than other actors. Government officials tend to find it very difficult to reach out to vulnerable populations who are often the targets of cross-border initiatives—including commercial sex workers, IDUs, MSM, and immigrant communities—sometimes for linguistic and cultural reasons, sometimes because they cannot deal openly

with them for political reasons, and often because it is difficult for them to build up the requisite level of trust. In these cases, NGOs, including those staffed by people who are considered peers of these vulnerable populations, play an integral role as a bridge between the government and vulnerable groups, in representing and voicing these groups' concerns, and in providing the firsthand knowledge and flexibility to devise and implement effective prevention and treatment schemes. A wide range of participants from various countries added a caveat, however, stressing that NGOs in the region direly need a stronger financial base and a more amenable legal environment if they are to live up to their full potential.

Finally, there is a need to build up institutional frameworks to implement cross-border and regional interventions. As one participant noted, there is no shortage of political commitment and agreements on cross-border cooperation, but "people simply do not know who to deal with on the other side of the border." The relative lack of regional organizations and arrangements means that there are few established patterns of cooperation to ease the difficulties of dealing with the complex issues that arise in any collaboration. Institutional and personal networks often have to be built from the ground up in launching cooperative initiatives, and funding for multi-country initiatives often has to be done through individual, country-based institutions rather than in a more comprehensive manner. Some participants identified ASEAN as a potentially important player in building regional cooperation, particularly because its mandate already covers communicable diseases, and others noted that the East Asia Summit and other East Asia community-building efforts might be helpful in creating mechanisms for joint action. There was a general consensus, however, that much more work is needed in this area.

# Agenda

## Monday, July 10, 2006

### 9:00–10:00 Opening Session

#### *Moderators*

Tadashi Yamamoto, *Director, Friends of the Global Fund, Japan (FGFJ); President, Japan Center for International Exchange (JCIE)*

Yu Wang, *Director, Chinese Center for Disease Control and Prevention (China CDC)*

#### *Speakers*

Jiefu Huang, *Vice Minister, Ministry of Health, China*

Ichiro Aisawa, *Acting Secretary-General, Liberal Democratic Party; former Senior Vice-Minister for Foreign Affairs; Director, FGFJ Diet Task Force*

Richard Feachem, *Executive Director, Global Fund to Fight AIDS, Tuberculosis and Malaria*

### 10:15–12:00 Session 1: Responses to Major Communicable Diseases in East Asia—Commonalities and Diversities in Challenges Faced

#### *Moderator*

William Bowtell, *Director, HIV/AIDS Project, Lowy Institute for International Policy*

#### *Panelists*

Zunyou Wu, *Director, National Center for AIDS/STD Control and Prevention (NCAIDS), China CDC*

Masahiro Kihara, *Professor in the Department of Global Health and Socio-epidemiology, Kyoto University School of Public Health; Advisory Board Member, FGFJ*

Michel Sidibe, *Director, Country and Regional Support Department, Joint United Nations Programme on HIV/AIDS (UNAIDS)*

### 13:00–15:00 Session 2: China's Challenges and Domestic and International Responses

#### *Moderator*

Joel Rehnstrom, *China Director, UNAIDS China Office*

#### *Panelists*

Jiangping Sun, *Deputy Director, NCAIDS, China CDC*

Wiwat Rojanapithayakorn, *Officer-in-Charge, World Health Organization (WHO), China Office*



Martin Taylor, *Health Team Manager, UK Department for International Development (DFID) China Office*

15:15–17:45 **Session 3: Recent Developments in Regional Cooperation in the Fight against Major Communicable Diseases**

*Moderator*

Christoph Benn, *Director, External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria*

*Case presenters*

“Cross-Border Harm Reduction Project in China and Vietnam”

Jie Chen, *Deputy Director, Guangxi Center for Disease Control and Prevention (CDC)*

“Japan-China Joint Research on Emerging and Re-emerging Infectious Diseases”

Aikichi Iwamoto, *Professor of Infectious Diseases, Advanced Clinical Research Center, Institute of Medical Science, University of Tokyo*

“Cross-Border Cooperation on HIV/AIDS: Some Initiatives from the Philippines”

Eugenio Caccam, *Former Associate Director for Training, Philippine Business for Social Progress*

“Health Equity Network for the Greater Mekong Subregion”

Katherine Bond, *Associate Director, Southeast Asia Regional Office, Rockefeller Foundation*

“HIV Prevention Program for Mobile Workers at the Construction Sites and Surrounding Communities in Cross Border Areas”

Emi Inaoka, *Social Development Specialist (Health), Social Development Division, Sector Strategy Development, Japan Bank for International Cooperation (JBIC)*

“Supporting Treatment Access for Foreign Nationals Living with HIV/AIDS: A Case Study of Thailand”

Sangnim Lee, *Program Officer, Health Program in Japan, Services for the Health in Asian & African Regions (SHARE), Japan*

## **Tuesday, July 11, 2006**

9:00–11:30 **Session 4: Exploring Effective Cross-Border Cooperation in the East Asian Context**

*Moderator*

Tadashi Yamamoto, *Director, FGFJ; President, JCIE*

## East Asian Regional Cooperation

### *Panelists*

Christoph Benn, *Director, External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria*

Mely Caballero-Anthony, *Assistant Professor, Institute of Defence and Strategic Studies (IDSS), Nanyang Technological University, Singapore*

Zunyou Wu, *Director, NCAIDS, China CDC*

11:30–12:00 **Concluding Session**

## Participant List

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Christoph BENN	Director, External Relations, Global Fund to Fight AIDS, Tuberculosis and Malaria
Katherine C. BOND	Associate Director, Southeast Asia Regional Office, Rockefeller Foundation
William BOWTELL	Director, HIV/AIDS Project, Lowy Institute for International Policy, Australia
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## East Asian Regional Cooperation

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## East Asian Regional Cooperation

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