Revitalizing US-Japan Collaboration on Global Health

Eriko Sase and Susan Hubbard

US-Japan Papers

December 2011

Japan Center for International Exchange

Printed in the United States.

Japan Center for International Exchange
4-9-17 Minami Azabu, Minato-ku, Tokyo 106-0047 Japan
URL: www.jcie.or.jp

Japan Center for International Exchange (JCIE/USA)
274 Madison Ave, Suite 1102, New York NY 10016 USA
URL: www.jcie.org

Revitalizing US-Japan Collaboration on Global Health

Eriko Sase and Susan Hubbard

MORE THAN 50 YEARS HAVE PASSED since the signing of the US-Japan Treaty of Mutual Cooperation and Security. The treaty forms the basis of an important alliance that "plays an indispensable role in ensuring the security and prosperity of both [countries], as well as regional peace and stability."[1] While collaboration on traditional security in East Asia has always been a major pillar of the relationship, the United States and Japan also work closely together on nontraditional security challenges, and the threats found in the global health field have become a prominent topic in discussions regarding US-Japan collaboration over the past two decades.

The world experienced drastic changes during the latter half of the 20th century as the acceleration of globalization saw goods and people move more fluidly and rapidly across borders, creating increasing contact and interdependence among countries around the world. This trend toward globalization has brought with it many economic and social opportunities, but it has also highlighted some challenges that have been exacerbated by these changes. Global health is one field where the opportunities as well as the challenges globalization presents can be clearly observed, leading global health experts to look for ways to maximize the opportunities while minimizing the impact of the challenges to the extent possible.

Eriko Sase is a lecturer in the Department of Community and Global Health of the University of Tokyo's Graduate School of Medicine. She is also a board member in the Global Health Research Center of Japan, University of Nagasaki, and an overseas researcher in the Japan Medical Association Research Institute. Previously, Dr. Sase served as the director of the Global Health Systems Program at the Center for Global Health Systems, Management, and Policy as well as an assistant professor in the Boonshoft School of Medicine at Wright University. She conducts research on health systems around the world, human rights, infectious disease policies, and human security. Dr. Sase holds a PhD in health science from the Graduate School of Medicine at the University of Tokyo and an MA in comparative culture from the Graduate Program in Global Studies at Sophia University.

Susan Hubbard is a senior associate in JCIE's New York office and former program director for East Asia at Columbia University's Center for International Conflict Resolution. Ms. Hubbard has co-authored Human Security in the United Nations *and* Building Resilience: Human Security Approaches to AIDS in Africa and Asia *and is a co-editor of* Doing Well by Doing Good: Innovative Corporate Responses to Communicable Diseases. *She received her BA in political science and Asian Studies from Northwestern University and her MIA degree in international development from Columbia University's School of International and Public Affairs. She is a member of the editorial board of the journal* Global Health Governance.

As goods and people move across borders more fluidly, communicable diseases move with them. And even those diseases that are not transmitted through human contact—noncommunicable diseases (NCDs) such as hypertension (responsible for 13 percent of deaths worldwide)[2] and diabetes—still affect people in other parts of the world, as markets in one place are now heavily dependent on workforces and consumers elsewhere. Therefore, many industrialized countries are recognizing that they need to contribute to health improvements in other parts of the world, not only because of a sense of moral imperative but also because doing so helps them protect their own interests.

The United States and Japan are among the countries at the forefront of the global health field, so it comes as no surprise that health has been a hot topic in discussions regarding their partnership activities.

While some progress has been made on US-Japan partnership in this field, however, it is time for more concrete, sustainable action. The United States and Japan need to identify some specific actions they can take, not just as one-off activities in limited geographic areas but as a part of a joint strategy to which both countries can commit at all levels.

The State of Global Health

Today, 33.3 million people are infected with HIV, the virus that causes AIDS. Each year, approximately 2 million people die from AIDS, about 0.8 million die from malaria, and 1.4 million die from tuberculosis.[3] At the same time, new communicable diseases continue to emerge. Both severe acute respiratory syndrome (SARS) and H5N1 influenza (avian influenza) have wreaked havoc on economies, particularly in Asia. The 2009 H1N1 pandemic (commonly referred to as "swine flu") demonstrated that developing and industrialized countries alike are still vulnerable to the rapid spread of emerging infectious diseases. Although it proved to be less lethal than anticipated, it caused significant illness and fear around the world. The H1N1 pandemic also highlighted the importance of solidarity in strategic planning for public health emergencies at the global level.[4]

At the same time, NCDs pose similar threats. They cause an estimated 35 million deaths per year (60 percent of all deaths worldwide) and kill approximately 8 million people worldwide before their 60th birthday.[5] While NCDs were once considered diseases only of the wealthy world, their numbers have been increasing rapidly in low- and middle-income countries as well. This is the first time in history that these countries have experienced a double burden of disease, in which they have to deal with both communicable diseases and NCDs simultaneously. The percent of global mortality caused by NCDs is projected to rise to as high as 73 percent by 2020.[6] In addition to the public health impact, this situation is also troubling from an economic perspective: as manufacturers are constantly looking for new labor and consumer markets, any increase in acute or chronic disease reduces the productivity of workers as well as the disposable income of a population. According to the NCD Alliance, three major NCDs alone—heart disease, stroke, and diabetes—will cost US$84 billion in lost economic production in 23 high-burden developing countries between 2006 and 2015.[7]

While everyone around the world is vulnerable to ill health, the reality is that there are still significant disparities in health status between the richest and poorest segments of the world's population. Approximately 83 percent of all deaths of children under the age of five occur in low-income countries.[8] In 2010, Somalia's under-five mortality rate (probability of dying by age five per 1,000 live births) was 180, while the rate in Japan and in Scandinavian countries was only 3.[9] Complications of pregnancy

and childbirth together continue to be leading causes of death, claiming the lives of both infants and mothers in low-income countries. These disparities are increasingly cited as contributing to civil unrest around the world, opening the door to violent conflict within and across borders.

To respond to these disparities, the international community agreed in 2000 on the Millennium Development Goals (MDGs), concrete targets for addressing some of the most prevalent threats facing developing countries. Tellingly, three of the eight MDGs are directly related to health.

US-Japan Global Health Collaboration

With the end of the Cold War in 1989 and the growing economic friction between the United States and Japan, collaboration on nontraditional security challenges took on new urgency in bilateral relations. The two countries thus set out to cooperate more closely in the development field. The United States and Japan have both made significant contributions to some of the world's poorest countries. Both countries have made major contributions through their official development assistance (ODA) programs, with the United States contributing US$30.2 billion and Japan contributing US$11.0 billion in 2010.[10] Combined, the two countries' contributions accounted for approximately 32 percent of the total contribution made by the 24 members of the Organisation for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC).[11]

Formal cooperation between the United States and Japan in international aid began in 1993, when they agreed upon the Common Agenda for Cooperation in Global Perspective (Common Agenda), one pillar of which was "promoting health and human development."[12] The two governments pledged a total of US$12 billion for the Common Agenda and have since attempted to collaborate on health projects and programs implemented in more than 30 countries.[13]

With the initiation by Japan of the Global Issue Initiative on Population and AIDS in 1994, the health sector became a priority for Japan's foreign policy. This commitment has continued to grow since then, with Japan making notable contributions to the global health field, particularly since the turn of the century.

When the Bush administration came into office in January 2001, it naturally looked to develop its own approaches that were distinct from those of the previous administration. In June 2001, shortly prior to the terrorist attacks of September 11, the United States and Japan announced the "Partnership for Security and Prosperity" as a replacement for the Common Agenda. Under the agreement, the two countries focused on health, Afghanistan, water, the environment, and collaboration with civil society, including local communities, charities, and nongovernmental organizations (NGOs). Overall, US-Japan collaboration in development has targeted five areas:

1. Health systems and health workers
2. Maternal, newborn, and child health
3. Family planning and reproductive health
4. Infectious diseases (e.g., HIV/AIDS, malaria, tuberculosis, polio, neglected tropical diseases, and avian and pandemic influenza)
5. Water and sanitation

The main vehicle for this has been the US-Japan Partnership for Global Health, which was launched in 2002. But there have been other initiatives, such as the US-Japan Clean Water for People, which dealt specifically with the fifth target on clean water and sanitation.

Mechanisms of Collaboration

US-Japan collaboration in global health over the past two decades has established an indispensable foundation for future collaboration at the intergovernmental and field levels. Looking back over this experience, several mechanisms of collaboration can be observed.

Reinforcement of Shared Goals: "Like-minded partners" is a common description used by officials who have played a role in US-Japan collaboration in global health.[14] One shared goal that was reinforced is the centrality of global health in each country's foreign policy and international aid strategy. The sum of the two countries' contributions in the health sector comprises approximately 58 percent of the total of the 24 OECD DAC members' contributions to health from 2005 to 2009.[15] While the percent of total ODA that each country dedicates to health is very different—the United States dedicates 22.7 percent of its bilateral ODA to health and population programs and Japan dedicates only 2.4 percent—global health continues to be central to both countries' foreign policies, with Japan also playing a significant role in recent years in shaping international dialogue about global health priorities and modalities.

Second, both countries have emphasized bilateral ODA, which accounted for 89 percent of ODA by the United States and 71 percent of Japan's ODA in 2008.[16] Third, both countries stress the importance of field operations. Both USAID and JICA have close to 100 overseas offices. The goals of their field support are also similar, with both countries emphasizing capacity building for individuals as well as institutions. To that end, the United States has long worked closely with civil society, and Japan has increasingly been doing the same.[17]

Building a Multilayered Collaborative Structure: The United States and Japan have built a multilayered structure in global health collaboration while working together in more than 30 countries. Agreements on the various partnerships between the United States and Japan are made at the headquarters level, and mid-level and field-level staff are encouraged to meet regularly to develop a smooth process of collaboration. At the agency level, JICA and USAID have worked together to enhance mutual understanding of each country's goals, niches, and resources. For instance, JICA used to assign a resident official from Tokyo to USAID headquarters as a collaboration advisor to both agencies.

At the field level, in the instances in which USAID and JICA officers have committed to meet regularly to discuss joint projects in several recipient countries, this multilayered structure has played an important role in enhancing the collaborative nature of project implementation. As a result, they have been able to promote more joint projects because they understand their respective stakes and the situation in the recipient country. Collaboration at the field level, though, has tended to be ad hoc and depends more on the individual aid officers involved than on any kind of systematic commitment to field-level collaboration and dialogue.

Division of Labor: USAID and JICA were able to achieve a good division of labor between the two countries, utilizing each country's strengths in a way that also compensated for weaknesses. For example, in malaria control, USAID leveraged its experience collaborating with civil society through the President's Malaria Initiative, while JICA created a series of seminars for local health professionals and local leaders and helped increase their capacity through continuous discussions with local authorities. Such a division of labor has been recognized among the officials involved in the collaboration as a best practice to be replicated.

Joint Evaluation: Evaluation is an important tool to measure efficiency, effectiveness, and sustainability of programs and projects. The value of evaluation has been increasingly recognized as many funders have moved toward results-based funding. However, the increasing attention paid to robust evaluation of projects and programs has resulted in an increased burden on aid recipients to facilitate evaluation of

their activities, leading the aid community to commit—at least in principle—to more joint evaluations. The United States and Japan conducted longitudinal joint evaluations of health programs and projects in Zambia. The purpose of the evaluations was to review US-Japan collaboration, assess the benefits and challenges, highlight the key factors of success, identify lessons for future collaboration in Zambia, discuss recommendations, and provide an action plan for the partnership.[18] Further evaluation of this type might be useful in assessing the value of collaboration and building consensus on future efforts.

Challenges

Partnership is not an easy task to execute. As the old African proverb goes, "If you want to go quickly, go alone. If you want to go far, go together." US-Japan collaboration in global health is no exception, and the two countries have experienced some challenges in their quest to develop more effective, efficient, and sustainable means to support developing countries. The challenges may be due to dissimilarities between the two countries' global health and international aid strategies as a whole. Yet many of these challenges can be overcome by utilizing each country's respective strengths.

Differences in Budget Size: The United States gave a total of US$30.2 billion in ODA in 2010, triple the US$10.0 billion it gave in 2000.[19] By contrast, Japan's net ODA was only US$11.0 billion in 2010.[20] The differences in the budget size were naturally reflected in the size of projects implemented by the respective executing agencies.

Differences in Targeted Geopolitical Areas: After the 9/11 terrorist attacks, the Bush administration directly linked diplomacy and development to the national security interests of the United States and stated the importance of elevating both diplomacy and development. Accordingly, US international aid began to focus on the Middle East and South Asia. The leading five recipients in 2009 were Afghanistan, Iraq, Pakistan, Sudan, and the Palestinian Authority, which combined received 26 percent of total US ODA, or roughly US$8.7 billion. While Japan's support for development in the Middle East and South Asia has grown larger relative to earlier periods, its development assistance to neighboring Asian countries has remained quite large. Japan's top five aid recipients in 2009 were Vietnam, Indonesia, India, Thailand, and the Philippines. These five countries received 37.6 percent of Japanese ODA, or roughly US$6.84 billion in 2009.[21]

More recently, there have been reaffirmations at the highest level of government in both countries of their commitment to strengthening US-Japan partnership in responding to global challenges such as global health. The challenge now, though, is to make sure that this is not just lip service and to design a strategy for collaboration that is based on concrete actions that can be implemented systematically across the two countries' aid agencies.

The Changing Context for US-Japan Development Collaboration

Over the past few years, we have witnessed a series of transformations in the milieu of the overall US-Japan relationship and international aid. These changes have potential ramifications for US-Japan collaboration in development and global health and thus warrant a brief review.

In 2009, both the United States and Japan experienced dramatic political changes: President Barack Obama took office in January, and in September of that year the Democratic Party of Japan (DPJ) came to power for the first time, ending the Liberal Democratic Party's 55-year run. Despite growing tensions over the planned relocation of Marine Corps Air

Station Futenma in Okinawa, President Obama and Japan's Prime Minister Yukio Hatoyama shared similar approaches to global challenges, including health. In June 2010, however, Prime Minister Hatoyama resigned and Naoto Kan, also of the DPJ, launched a new cabinet, followed by Prime Minister Yoshihiko Noda's election in September 2011. Despite these changes in leadership in Japan, global health has remained a pillar of the government's foreign policy strategy, as evidenced by the 2010 announcement of Japan's commitment to provide US$5 billion over five years toward achieving the health-related MDGs.

The international aid agencies of both countries have experienced transformations as well. JICA underwent significant reform in 2008, leading it to become the largest bilateral development agency in the world in terms of assets. Some of the activities previously undertaken by the Japan Bank for International Cooperation and some by the Ministry of Foreign Affairs were shifted to JICA to effectively bring Japan's grant, loan, and technical assistance under one roof.

The United States has also been making changes to the way it operates its aid programs. In 2002, the Bush administration's foreign aid reform included the establishment of the Millennium Challenge Corporation, which administers the Millennium Challenge Account as a tool to fight global poverty while giving recipient countries incentives to practice good governance. The President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 as the largest program targeting a single disease and has been largely successful in providing life-saving treatment to people living with HIV/AIDS. In 2009, the Obama administration announced the launch of a new Global Health Initiative with a commitment of US$63 billion over six years for global health to meet the dual goals of fighting specific communicable diseases and strengthening health systems.

With both countries experiencing recent domestic political changes, it is an opportune time to renew ties, bring new players on both sides of the Pacific into the partnership, and explore collaboration in a wide range of fields. At the same time, transformations to both countries' aid agencies have opened a window of opportunity for reinvigorating US-Japan collaboration in various areas related to development, including global health. As two of the world's largest donors, the United States and Japan have the opportunity not only to provide much-needed resources to the global development agenda but also to help drive that agenda in a more effective and equitable direction.

Leveraging Existing Programs to Strengthen Health Systems

Despite a rather heated debate in the global health community over whether disease-specific approaches or health system strengthening should be emphasized, there is growing consensus in the field that this debate represents a false dichotomy. Efforts to aggressively address individual diseases have achieved remarkable success in terms of lives saved over the past decade, particularly programs that deal with HIV/AIDS, tuberculosis, and malaria. The United States and Japan have both played leadership roles in these efforts. The United States is by far the world's largest funder of HIV/AIDS programming in developing countries, both through its financial contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria and through PEPFAR, which has enjoyed wide bipartisan support since its launch in 2003.

Japan, for its part, has been at the forefront of the global fight against communicable diseases since the start of the 21st century as well. Its emphasis on controlling communicable diseases among its own population in the early days after World War II is considered by health experts to have been one important

factor contributing to the rapid improvement in population health in postwar Japan, thus making it a credible role model for developing nations.[22] Japan has since taken the lead, notably by hosting the 2000 G8 Summit in Okinawa, where the idea for creating the Global Fund to Fight AIDS, Tuberculosis and Malaria was first agreed upon.

But both countries have also recognized that fighting communicable diseases is not sufficient if countries lack adequate health systems to deliver these programs or to save their populations from other health challenges, such as maternal death during childbirth, childhood mortality due to easily treatable ailments such as diarrhea, or the growing burden of NCDs. In Japan, this recognition led to a strong focus on health system strengthening in the agenda of the 2008 G8 Summit in Toyako, Hokkaido, and Japan has remained a leader in this area. In the United States, it led to the 2009 announcement by the Obama administration of the new Global Health Initiative, which focuses on both communicable diseases and health systems.

But health systems advocates consistently find that it is harder to mobilize people behind a health system strengthening agenda than it is to get them excited about fighting specific diseases. While the global health community has made considerable progress in determining what kinds of interventions might be needed to strengthen weak health systems, there is still not the same broad base of proven interventions that we have seen to be effective in fighting specific communicable diseases, such as safe sex education and the provision of antiretroviral (ARV) treatment in the case of AIDS and proper widespread use of insecticide-treated bed nets and pharmaceutical treatment in the case of malaria. Providing ARV to a person living with AIDS can generate almost immediate visible positive changes, whereas it can take much longer for the benefits of health system strengthening to yield measurable results. And it is much easier to illustrate to the general public the devastation caused by communicable diseases such as AIDS, malaria, or polio than it is to illustrate the devastation caused by inadequate health systems.

Poorly developed or malfunctioning health systems are a significant barrier to increasing access to essential healthcare in many parts of the world. Strengthening health systems is a complex process that addresses key constraints related to health worker education and employment, physical infrastructure, supply chains (including medical equipment, drugs, and other supplies), information, access, and effective financing. These are all meant to get appropriate preventive, diagnostic, and treatment services to all those who need them in a manner that does not cause a catastrophic disturbance to their daily lives (e.g., because of long distances needed to travel to health facilities or unreasonably long waiting times) or to their household finances (e.g., because of high out-of-pocket expenses).

So the challenge is to find a way to strengthen health systems that does not risk jeopardizing the significant gains that are being made to control specific epidemics or pandemics and to do so with a limited pool of resources. One area where US-Japan partnership might make a valuable contribution is in designing and piloting programs that strengthen health systems in regions where they are weakest by leveraging the efforts that are already demonstrating success in fighting the spread and impact of communicable diseases.

In designing such partnership, the United States and Japan should explore each country's comparative advantages and learn from their past successes in finding an effective division of labor. JICA has long emphasized primary healthcare both at home and abroad, so it is well placed to develop health system interventions aimed at enhancing primary healthcare by targeting vulnerable populations such as pregnant

mothers and children. It could also apply lessons from its own experience developing a strong health system based on universal access and equity during the first half of the 20th century.[23] The United States, for its part, has emphasized large-scale interventions to prevent and treat specific diseases that, without significant financial and technical commitment, would result in millions more lives lost.

The United States and Japan should thus start by focusing on ways to leverage progress that has been made by large-scale disease-specific programs for broader health system strengthening goals. It is important that this be done in a way that does not jeopardize the progress already being made to fight specific diseases. Some of these approaches are already starting to be seen in programs supported by major international disease-specific funders, but a US-Japan commitment to partnership in these areas would bring more attention and needed resources to these efforts. At the same time, given the threats that emerging communicable diseases have posed to countries throughout Asia and other parts of the world in recent years, the United States and Japan should take on the task of strengthening disease surveillance mechanisms and enhancing our health emergency preparedness systems so that we can minimize the negative effect that such emergencies have on lives and livelihoods in affected countries. More specifically, the US-Japan collaborative agenda should focus on the following three priorities:

1. Educate and Train Health Workers

A successful health system requires a capable health work force. Without an appropriate mix of health workers who can prevent, diagnose, and treat ailments, all other efforts to strengthen the health system will be for naught. Several large-scale programs to fight particular diseases, such as HIV/AIDS, malaria, and tuberculosis, have successfully trained, placed, and retained healthcare workers specializing in these specific diseases in hard-to-reach communities. But there is no reason why someone trained to provide treatment for HIV or malaria cannot also be trained and employed to provide treatment for diarrhea or other common childhood illnesses. The United States and Japan should work together to assess the primary health needs in several pilot communities that have benefited from programs to provide healthcare workers for specific diseases and then determine the opportunities in those communities for leveraging these existing human resources to strengthen health systems in the communities where they operate.

For example, community health workers who go door-to-door to encourage families to use bed nets or teach mothers how to recognize and treat malaria can also encourage families to improve household hygiene and teach mothers how to recognize and treat other common causes of childhood morbidity and mortality, such as diarrhea or malnutrition. Similarly, campaigns encouraging testing for communicable diseases such as HIV and tuberculosis can be expanded to include testing for NCDs such as diabetes or hypertension. Combining testing for several diseases might have the added benefit of encouraging more people to get tested for communicable diseases if it is part of a larger package, since that would reduce the likelihood that they will be stigmatized for specifically seeking out testing for AIDS or tuberculosis.

Training should focus on healthcare workers at all levels, including doctors, nurses, midwives, and community health workers. Japan's prewar experience might offer lessons to today's developing countries with high infant and maternal mortality rates. Japanese public health nurses and midwives earned high levels of education and a high social status and were able to gain their communities' trust, which became an incentive for young women to enter the health professions. Their grassroots activities were regarded as an

important factor in the reduction of infant and maternal mortality rates in the first half of the 20th century.[24]

2. Prepare for Public Health Emergencies

Human beings are constantly exposed to emerging infectious diseases (e.g., SARS, avian influenza, and the H1N1 virus) and re-emerging infectious diseases (e.g., drug resistant tuberculosis and the plague). The infectious disease interface between animals, humans, and environmental exposure pathways is now widely recognized.[25] Thus any consideration of public health policies to contain diseases needs to look at not only how diseases pass among human beings but also how they pass between animals and human beings and what role the environment plays in their spread.

The WHO's International Health Regulations aim to prevent, protect against, control, and provide a public health response to the international spread of diseases. Under these regulations, the WHO requires states to notify them of all events that may constitute a public health emergency. By 2012, all 194 member states will have implemented the global rules to enhance national, regional, and global public health security.[26] Despite these commitments, evidence from past epidemics shows that many countries, particularly low-income countries, are not equipped to detect cases of emerging diseases quickly and are therefore delayed in their reporting of the cases.[27]

Moreover, there are other potentially pandemic pathogens (some yet to emerge, yet to be discovered, or yet to be characterized) that are not being tracked through existing surveillance systems. It is in everyone's interest that every country be prepared to recognize the signs of an emerging disease and respond quickly. These areas should be reinforced in a comprehensive pandemic surveillance system as a critical component of preparedness in public health emergencies. To do so, the United States and Japan should collaborate more in supporting economically and technically challenged countries to take part in a global surveillance system on animals, humans, and environments with international agencies, industrialized countries, the private sector, and civil society.

3. Strengthen Existing Mechanisms of Collaboration

US-Japan partnership in these areas should draw on the mechanisms of collaboration that were developed through past experience. These include a reinforcement of shared goals, a commitment to partnership at multiple levels, an effective and efficient division of labor, and a commitment to joint monitoring and evaluation to reduce the burden on partner developing countries. In strengthening these mechanisms, it is important to focus on two areas: Africa and Asia.

Recent years have seen a shift in emphasis of global health aid in general toward sub-Saharan Africa, given the extremely challenging situation in that region (e.g., tremendously high HIV/AIDS prevalence and unacceptable levels of child and maternal mortality), which is likely to prevent many countries there from achieving the MDGs by 2015. The United States has increased the level of ODA it provides to Africa. In 2008–2009, it provided an average of US$8.1 billion each year, or nearly a third of its total ODA, to sub-Saharan Africa, an eight-fold increase over the US$1.1 billion it provided only 10 years earlier.[28]

In the case of Japan, ODA to sub-Saharan Africa accounted for an average of 10.2 percent (US$1.7 billion of total ODA of US$16.9 billion per year) in 2008–2009, representing an 8.6 percent increase over the share of ODA going to sub-Saharan Africa a decade earlier.[29] Since 1993, Japan has hosted the Tokyo International Conference on African Development (TICAD) every five years as a major global framework for promoting the role of Asia-Africa collaboration in sub-Saharan Africa's development. On top of

that, Japan pronounced 2005 the "Year of Africa" to raise awareness in the international community about issues in the region.

While the high prevalence of life-threatening diseases, unstable governance, and poverty will inevitably make aid to Africa—and particularly sub-Saharan Africa—an ongoing priority, the US-Japan partnership should also regard Asia as an important region from a political and public health perspective. President Obama stated in November 2011 that Asia Pacific will be a top priority in US security policy in the coming years given the military's withdrawal from Afghanistan and Iraq.[30] Likewise, US-Japan partnership in global health should place more emphasis on work in Asia. Southeast Asia, which had about 3.3 million new cases of tuberculosis in 2009, accounts for roughly 35 percent of global incidents.[31] HIV infection rates as a percentage of the population are much lower in Asia than in Africa, but given the size of the populations in some Asian countries, the total numbers are similarly staggering. The number of people living with HIV/AIDS is estimated to be 2.7 million in India, which has a total population of 1.2 billion. Similarly, it is estimated that 700,000 of China's roughly 1.3 billion residents are living with HIV/AIDS.[32] In addition, the persistence of several "fragile states" in Asia threatens regional efforts to fight communicable diseases. In December 2009, nine cases of H1N1 were reported in North Korea, which was forced to accept an offer of support from South Korea to provide flu vaccines for its population.[33] Communicable diseases can travel easily across national boundaries, so it only takes one country to jeopardize regional efforts to fight their spread.

Conclusion

During a November 2010 speech, President Obama referred to the two countries' 50-year alliance as an "indestructible partnership" based on "equality and mutual understanding" and called the United States and Japan "partners in Asia and around the world."[34] In today's world, such an alliance cannot be limited to partnership on traditional security. Health challenges have the potential to threaten the lives and livelihoods of large numbers of people throughout the region and around the world. At the same time, the growing threat of emerging infectious diseases drives home the threat of a possible new pandemic devastating lives and economies. Global health is, therefore, an essential area for US-Japan partnership.

Global health has enjoyed increasing prominence in both countries' development agendas, in part because of the growing threat of emerging and re-emerging infectious diseases even in high-income countries, as well as the uncertain impact of the unprecedented double burden of communicable and noncommunicable diseases in low- and middle-income countries. It is now time for the US-Japan partnership to accelerate systematic collaboration and actively promote global health. As the global health community is increasingly recognizing that we need to move beyond a debate between emphasizing either disease-specific initiatives or health system strengthening, there is an opportunity for these two major donor countries to demonstrate how success in one area can be leveraged for success in the other, creating a win-win situation.

The United States and Japan should continue to support the training of health professionals, particularly of those working at the community level, in order to build robust health systems that can deal with both communicable and noncommunicable diseases and provide adequate health services beyond the 2015 target date for achieving the MDGs. By combining their efforts, the United States and Japan can take steps to help prevent the proliferation of serious diseases and public health emergencies at the earliest possible stage.

NOTES

1. Ministry of Foreign Affairs of Japan (MOFA), "Joint Statement of the US-Japan Security Consultative Committee Marking the 50th Anniversary of the Signing of The US-Japan Treaty of Mutual Cooperation and Security by Minister for Foreign Affairs Okada, Minister of Defense Kitazawa, Secretary of State Clinton, and Secretary of Defense Gates," January 19, 2010, http://www.mofa.go.jp/region/n-america/us/security/joint1001.html.
2. World Health Organization (WHO), Global Health Risks (Geneva: WHO, 2009), http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf.
3. Figures are taken from Joint United Nations Programme on HIV/AIDS (UNAIDS), UNAIDS Report on the Global AIDS Epidemic 2010 (Geneva: UNAIDS, 2010), http://www.unaids.org/globalreport/Global_report.htm; WHO, "Malaria," October 2010, http://www.who.int/mediacentre/factsheets/fs094/en/; and WHO, Global Tuberculosis Control 2011 (Geneva: WHO, 2011), http://www.who.int/tb/publications/global_report/2011/gtbr11_full.pdf.
4. See, for example, Christopher Eddy, Eriko Sase, and Richard Schuster, "Pandemic Influenza H1N1 2009: Public Health Emergency Response," Georgetown Public Policy Review 15, no. 1 (2010): 63–75.
5. NCD Alliance, "The Global Burden of NCDs," http://www.ncdalliance.org/globalepidemic.
6. WHO, "NCD Surveillance Strategy," www.who.int/entity/ncd_surveillance/strategy/en/index.html.
7. NCD Alliance, "The Millennium Development Goals and Non-Communicable Diseases (NCDs)," http://www.ncdalliance.org/sites/default/files/rfiles/The%20MDGs%20and%20NCDs_0.pdf.
8. United Nations Department of Economic and Social Affairs, "Population Facts," April 2010, http://www.un.org/esa/population/publications/popfacts/popfacts_2010-3.pdf.
9. WHO, "Child Mortality Indicators" (2010 data), http://apps.who.int/ghodata/?vid=160.
10. Organisation for Economic Co-operation and Development (OECD), "Development Aid: Net Official Aid Assistance (ODA)," April 13, 2011, http://www.oecd-ilibrary.org/development/development-aid-net-official-development-assistance-oda_20743866-table1. Net ODA from the United States was US$22.7 billion, or 0.17 percent of gross national income, in 2006. The United States forgave all its outstanding debt with Iraq in 2005. However, net ODA flows to the least developed countries were at their highest level. US disbursements to sub-Saharan Africa, at US$5.6 billion, reached a record high, not only because of debt relief of US$1.4 billion, but also reflecting increased disbursement for education, HIV/AIDS, and malaria programs. See OECD, "Fact Sheet 2007: Evaluating the Paris Declaration," http://www.oecd.org/dataoecd/0/58/39418473.pdf.
11. OECD, "DAC Members' Net Official Development Assistance in 2009," http://www.oecd.org/document/9/0,3746,en_2649_34447_1893129_1_1_1_1,00.html.
12. The four pillars of the Common Agenda were promoting health and human development, responding to challenges to global stability, protecting the global environment, and advancing science and technology. In addition to these four pillars, three sub-categories were established: women in development, population problems and HIV/AIDS, and children's health. See MOFA, "Common Agenda," http://www.mofa.go.jp/region/n-america/us/q&a/agenda/index.html.
13. Japan International Cooperation Agency (JICA), "US-Japan Partnership for Global Health: Illustrative Collaborative Activities," June 2008, http://www.jica.go.jp/usa/english/activities/pdf/map_0806.pdf.
14. Face-to-face interviews were conducted by Eriko Sase at the JICA USA office and the United States Agency for International Development (USAID) headquarters in Washington DC on February 28, 2008; at the Ministry of Foreign Affairs of Japan on March 14, 2008; and at JICA headquarters in Tokyo on March 19, 2008. A follow-up telephone interview was conducted with USAID headquarters on March 6, 2009.
15. Based on data from the OECD's Query Wizard for International Development Statistics (QWIDS) Database, which includes ODA categorized as either "Health" or "Population Policies/Programs," http://stats.oecd.org/qwids/.
16. OECD, "Aid Statistics: United States," http://www.oecd.org/dataoecd/42/30/44285539.gif; and OECD, "Aid Statistics: Japan," http://www.oecd.org/dataoecd/42/5/44285062.gif.
17. Civil society is playing a growing role in international aid as well. In the case of the United States, ODA comprised 16.8 percent of the total flow of resources to developing countries in 2005, while private resources (remittances, religious organizations, foundations, and NGOs) accounted for 83.2 percent. See USAID, "Guide to the 2005 Resource Flow Analysis: The Private Revolution in Financing Development," June 2007, http://idea.usaid.gov/gp/guide-2005-resource-flows-analysis-private-revolution-financing-development. http://www.usaid.gov/our_work/global_partnerships/gda/pie_chart_guide.html.
18. The first US-Japan partnership in Global Health was launched in Zambia by a joint mission in 1998 under the Common Agenda. Among the early partnership initiatives in eight countries, USAID and JICA both consider Zambia to have been a successful case. See MOFA, "USAID-Japan Partnership for Global Health," June 11, 2002, http://www.mofa.go.jp/region/n-america/us/agenda/health0206.html. Prior to the launch of the US-Japan Partnership in Global Health, the United States, and Japan also conducted joint evaluations of projects launched under the Common Agenda, such as population and health projects in Kenya, Bangladesh, Cambodia, and Tanzania. See JICA, "Summary of the Evaluation Survey: Evaluation on JICA-USAID Collaboration," 2002, http://www.jica.go.jp/english/operations/evaluation/tech_and_grant/program/thematic/pdf/2001_6.pdf.
19. OECD, "ODA by Donor," http://stats.oecd.org/Index.aspx?DataSetCode=ODA_DONOR.

20. OECD, "Development Aid Reaches a historic high in 2010," http://www.oecd.org/document/35/0,3746, en_2649_34447_47515235_1_1_1_1,00.html.
21. OECD, QWIDS Database.
22. Nayu Ikeda et al., "What Has Made the Population of Japan Healthy?" Lancet 378, no. 9796 (2011).
23. Rayden Llano et al., "Re-invigorating Japan's Commitment to Global Health: Challenges and Opportunities," Lancet 378, no. 9798 (2011).
24. JICA, Japan's Experiences in Public Health and Medical Systems (Tokyo: JICA, 2005), http://www.jica.go.jp/english/publications/reports/study/topical/health/index.html.
25. It is estimated that 58 percent of 1,407 known human pathogens are zoonoses that can be transmitted to human from animals. See Mark E. J. Woolhouse and Sonya Gowtage-Sequeria, "Host Range and Emerging and Reemerging Pathogens," Emerging Infectious Diseases 11, no.12 (2005): 1842–7. Seventy-five percent of emerging and re-emerging infectious diseases are supposedly vector-born or zoonotic. See Bruno B. Chomel, Albino Belotto, and François-Xavier Meslin, "Wildlife, Exotic Pets, and Emerging Zoonoses," Emerging Infectious Diseases 13, no. 1 (2007): 1–8.
26. WHO, International Health Regulations (Geneva: WHO, 2005), http://www.who.int/ihr/en/.
27. Richard A. Cash and Vasant Narasimhan, "Impediments to Global Surveillance of Infectious Diseases: Consequences of Open Reporting in a Global Economy," Bulletin of the World Health Organization 78, no.11 (2000): 1358–67.
28. Calculated from the data cited in OECD, " Development Aid," April 13, 2011.
29. Ibid. However, the amount of Japan's ODA to sub-Saharan Africa increased only slightly from US$1.2 billion (1989–1999) to US$1.7 billion (2008–2009).
30. US White House, "Remarks By President Obama to the Australian Parliament," November 17, 2011, http://www.whitehouse.gov/the-press-office/2011/11/17/remarks-president-obama-australian-parliament.
31. WHO, "Tuberculosis," November 2010, http://www.who.int/mediacentre/factsheets/fs104/en/index.html.
32. WHO, UNICEF, and UNAIDS, December 2008, "Epidemiological Fact Sheet on HIV and AIDS: China," http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_CN.pdf; and WHO, UNICEF, and UNAIDS, October 2008, "Epidemiological fact sheet on HIV and AIDS: India," http://www.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_IN.pdf.
33. Agence France-Presse, "N. Korea accepts S. Korea swine flu aid offer," December 10, 2009.
34. In a speech made by President Obama during his second visit to Japan in November 2010. See US White House, "Remarks by President Obama and Prime Minister Kan of Japan in Statements to the Press in Yokohama, Japan," November 13, 2010, http://www.whitehouse.gov/the-press-office/2010/11/13/remarks-president-obama-and-prime-minister-kan-japan-statements-press-yo.

About the Japan Center for International Exchange

Founded in 1970, the Japan Center for International Exchange (JCIE) is one of the few truly independent think tanks in the field of international affairs in Japan. With offices in Tokyo and New York, JCIE conducts political exchange programs for leading American and Japanese policymakers, carries out policy research and dialogue projects on pressing international issues, and works to promote a greater understanding of civil society and philanthropy in Japan and the Asia Pacific region.

About the Project

From 2008 to 2011, JCIE managed a multiyear study on an "Enhanced Agenda for US-Japan Partnership," which explored how revitalized US-Japan cooperation can better address common challenges, strengthen regional and global stability, and ultimately make the bilateral alliance more robust and versatile. The project has brought together a group of promising young policy experts to focus on emerging issue areas where there is the potential for deeper bilateral cooperation between the two countries. The findings of some of the participants are being published as part of this working paper series. This initiative has been made possible by the generous support of the Japan Foundation Center for Global Partnership.

As a rule, JCIE creates opportunities for informed policy discussions and does not take policy positions. In keeping with this, the views expressed in this publication are those of the authors and do not necessarily reflect the policy or position of JCIE.

Japan Center for International Exchange

www.jcie.or.jp
www.jcie.org