博士論文

Global Health and Japan:

G7 presidency in the 2016 Ise-Shima Summit and beyond

グローバルヘルスと日本：
2016 年 G7 伊勢志摩サミット及びその後の展望

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Abstract

Background: Global health is currently at a crossroads. The majority of low- and middle-income countries are now suffering from a double burden of diseases such as co-occurrence of communicable and non-communicable diseases. Compared with the 2000 Millennium Development Goals (MDGs) in which three out of eight goals were directly related to health, less attention has been paid to health challenges in newly adopted post-2015 Sustainable Development Goals (SDGs). There is also a growing number of competing agendas for policy-makers, including terrorism, migration and refugees, and climate change, and the level of Official Development Assistance (ODA) for global health has stagnated in recent years. This is further confounded by new and emerging political and economic actors in this arena. Amid these transformations in global health, Japan hosted the Group of 7 (G7) Ise-Shima Summit in May 2016, where the major focus was on global health architecture (GHA), universal health coverage (UHC), and antimicrobial resistance (AMR). Not only had Japan raised political awareness on these three agendas, but it has also continued to be a major actor in the global health arena. It is clear that becoming an agenda item is important in order for attaining political awareness, but little is known about the mechanism of why some global health agendas receive

political awareness and are given high priority from global and national leaders, whereas some are not.

Objective: My PhD thesis' objectives are two-fold: by choosing three global health agenda items as a case — GHA, UHC, and AMR — it is possible to analyze how these agendas could succeed in raising political momentum. Also, to clarify how Japan used the G7 presidency to support these agendas and give them political weight, in 2016 and beyond. In addition to analyze the usefulness of analytical framework, tuberculosis (TB) was also picked up as a case though Japan did not put it as main agenda item at G7 Ise-Shima Summit and related meetings. Amid decreasing trend of development assistance for health (DAH), a strategy is needed for each global health agenda to increase or even maintain awareness from the international community. By revealing factors why four global health agendas caught higher political attention, this study contributes to other global health agendas to be strategically get political attention. In addition, by also revealing how Japan supported these agenda items to be a political agenda, it also contributes to Japan and other countries to promote any specific health agenda items of their interest.

Method: Several analytical frameworks have been developed in articulating the political dynamics of global health agenda such as Shiffman's 2007 framework, Shiffman's 2016

framework, and Kingdon's three theory. Shiffman's 2007 and 2016 framework was developed to analyze why some global health agenda gets higher attention while others do not. On the other hand, Kingdon's theory is widely used to analyze political economy of any agendas other including health related agenda. This work applies different analytical frameworks for each agenda item in order to analyze political economics of each agenda items; Shiffman's 2007 for GHA and TB, Shiffman's 2016 for UHC, and Kingdon's for AMR. First, I conducted in-depth interviews with government officials from the Ministry of Health, Labour and Welfare and the Ministry of Foreign Affairs; selected participants were 1. those who belongs to the international department/division of each ministry, and 2. Those who participated in the preparatory process of the G7 Ise-Shima Summit and the G7 Kobe Health Ministers' Meeting in 2016. All the interviews were transcribed. The first stage of systematic coding included marking the text with key words and identifying specific sentences that are related to the political economy of each agenda item (GHA, UHC, AMR, and TB). According to the framework especially selected for each case study, each sentences/keyword was categorized following the method of the content analysis. To begin to identify analytic ideas and relationships, descriptive coding categories were again reviewed to highlight repeated ideas and similar words and phrases and to identify unusual responses.

Results: All four case studies showed that Japan has leveraged its role as the G7 president and key global health player, both within and outside of G7 member countries, through G7 related

meetings as well as other international conferences. For example, in the case of UHC, Japan had the highest level of champions like Prime Minister Shinzo Abe, which was a crucial ingredient for raising awareness and pushing the global health agenda to a top global level. This included the highest level of policy-makers attending health-related meetings, picking the health agenda in the meeting agenda, including bi-lateral meetings, and making commitment from the highest echelons visible by publication through internationally recognized journals, and broadcast through mass media and speeches at public events including United Nations (UN) and World Health Organization (WHO) meetings. These visible commitments could be good tools for showing other countries the nation's strong commitment toward the global health agenda. Another key factor was that Japan connected diverse stakeholders through the G7 and its related meetings. Although the G7 had been an influential body on global health, it was not effective enough to raise awareness and move the global health agenda forward. It was important to have "channels" with diverse stakeholders, including non-governmental organizations and civil society organizations. In this regard, Japan found like-minded countries to work together to promote the global health agenda.

Conclusion: All of the four agenda items caught attentions from global leaders through fulfilling each category Shiffman and Kingdon proposed and by taking advantage of the G7 presidency in 2016 and thereafter, the government of Japan has been contributing to strengthen global agenda including GHA, UHC, AMR and TB. Japan's contributions were

mainly through the involvement of notable Japanese political leaders, enhancing community cohesion within and outside of G7 members by hosting several high-level meetings, adopting outcome document which all high-level political leaders including president, prime minister and ministers agreed upon.

Three strong champions came to the fore: prime minister Shinzo Abe, former Minister for Health, Labour and Welfare of Japan, Yasuhisa Shiozaki, and a member of the House of Councilors, Professor Keizo Takemi. As shown in GHA, UHC and AMR case, such strong leadership effectively pushes issues to the top of the political agenda. Moreover, hosting high-level political dialogue is one of the strongest drivers to promote policy agenda: Japan has hosted several such political dialogues and included GHA, UHC and AMR as an agenda item with both G7 members and non-members. Together, all of these efforts are clearly implicated in outcomes such as the G7 leader's Declaration and the G7 Kobe Communique, which are expected to be the basis for future policy making.

Key words: global health, global health governance, global health architecture, universal health coverage, UHC, antimicrobial resistance, tuberculosis, G7, G20, political science**.**

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List of abbreviations

AMR: antimicrobial resistance
CEPI: Coalition for Epidemic Preparedness Innovations
CFE: Contingency Fund for Emergencies
COREQ: consolidated criteria for reporting qualitative research
CSOs: civil society organizations
DAH: development assistance for health
DFID: Department for International Development
EU: European Union
FAO: Food and Agriculture Organization
Gates Foundation: Bill and Melinda Gates Foundation
Gavi: Gavi, the vaccine alliance
GDF: Global Drug Facility
GF: Global Fund to Fight AIDS, Tuberculosis and Malaria
GHA: global health architecture
GHIT Fund: Global Health Innovation Technology Fund
GHP: Department of Global Health Policy
G7: Group of 7
G8: Group of 8
G20: Group of 20
HSS: health system strengthening
IDCA: International Development Cooperation Agency
IDIs: in depth interview
IHP+: International Health Partnership
IHR: International Health Regulation
JATA: Japan Anti-Tuberculosis Association
JICA: Japan International Cooperation Agency
MAFF: Ministry of Agriculture, Forestry and Fisheries
MCH: Maternal and Child Health
MD: Medical Doctor
MDGs: Millennium Development Goals
MDR-TB: multi-drug resistant tuberculosis
M-GTA: Modified Grounded Theory Approach
MHLW: Ministry of Health, Labour and Welfare
MOF: Ministry of Finance
MOFA: Ministry of Foreign Affairs
MPH: Master of Public Health
MSF: Médecins Sans Frontières

NCDs: non-communicable diseases
NCGM: National Center for Global Health and Medicine
NGOs: non-governmental organizations
OIE: World Organization for Animal Health
ODA: Official Development Assistance
PEF: Pandemic Emergency Facility
PPP: public – private partnerships
R&D: research and development
SDGs: Sustainable Development Goals
SEARO: WHO South East Asia Regional Office
SOP: standard operation plan
STBP: Stop TB Partnership
TB: tuberculosis
TICAD: Tokyo International Conference on African Development
UHC: universal health coverage
UHC 2030: IHP+ for UHC 2030
UN: United Nations
UNDP: United Nation Development Programme
UNFPA: United Nations Population Found
UNGA: United Nations General Assembly
UNICEF: United Nation Children's Fund
UNOCHA: UN Office for Coordination of Humanitarian Affairs
USAID: United States Agency for International Development
WB: World Bank
WHA: World Health Assembly
WHO: World Health Organization
WPRO: WHO Western Pacific Regional Office

1. Background

Global health is currently at a crossroads. The majority of low- and middle-income countries are now suffering from a double burden of diseases.[1] Compared with Millennium Development Goals (MDGs), in which three out of eight goals were directly related to health, policy makers are paying less attention to health challenges in the newly adopted Sustainable Development Goals (SDGs).[2] There is also a growing number of competing agendas for policy makers, including terrorism, migration and refugees, and climate change,[3] and the level of Official Development Assistance (ODA) for global health has stagnated in recent years.[4]

This situation is further confounded by new and emerging political and economic actors in this arena. The Bill and Melinda Gates Foundation (Gates Foundation) founded in 2002, is now one of the biggest financial contributors to global health — their annual contribution exceeds 4 billion USD and has strong influence on the decision making of international organizations including the World Health Organization (WHO). At the same time, public – private partnerships (PPP) also emerged in global health. In 2000, under the leadership of the Japanese government at the Group of 8 (G8) Kyushu-Okinawa Summit, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the GF) was created to tackle the global epidemics of HIV/AIDS, Tuberculosis, and Malaria. Dynamic changes — the emergence of private sectors and the creation of PPP — brought significant impact to the political economy of and financing for

global health. In fact, when we look at the trend of development assistance for health (DAH) between 1990 and 2014, about 50% of the assistance came from United Nations (UN) agencies, including the WHO, and the rest came from bilateral donors in 1990, while the WHO shared less than 10% of DAH in 2014. This shows that private foundations, including the Gates Foundation, and PPP, such as the GF and Gavi the vaccine alliance (Gavi), have increased their financial contributions to be larger than that of the WHO.[5]

Another notable changes in global health is the development of emerging economies such as China and India. Although the total amount of China's development aid is still low at 0.04% of total GDP, it has shown a remarkable increase of 21.8% annually.[6,7] China's total development aid was US$7 billion in 2013 and is estimated to reach $21 billion if the country keeps its current increasing trend.[8] In addition, in 2018, China launched a new International Development Cooperation Agency (IDCA) which, like the United States Agency for International Development (USAID) in the USA or the Department for International Development (DFID) in the UK, will be responsible for coordinating and managing the country's foreign aid in low- and middle- income countries. Not only China, but also other emerging economies like India, Brazil, and South Africa are also influencing global health governance and make the governance of global health more complex and political.[9]

Consequently, global health has come to be used as a tool for promoting diplomacy and has been frequently addressed at highly political meetings such as the Group of 7 (G7)/Group of 20 (G20) meetings and UN high-level meetings. Although UN high-level meetings once rarely advanced health-related agenda before 2011 (one exception was the High-Level Meeting on HIV/AIDS in 2001 when the HIV/AIDS epidemic caused a global crises), several health agendas have been discussed in UN high-level meetings since 2011: non-communicable diseases (NCDs) in 2011, 2014, and 2018, antimicrobial resistance (AMR) in 2016, tuberculosis (TB) in 2018, and universal health coverage (UHC) in 2019. In parallel, especially since 2015, the G7 and G20 summit have also started to discuss health challenges, together with launching its Health Ministers' Meetings. This increase in overall attention affected financial contributions to global health challenges.

These changing trends of actors in global health also affect its financial situation. DAH has been largely influenced by politics both inside and beyond each country's interest, rather than merely allocating financial resources based on the disease burden in recipient countries (usually, low- and middle- income countries). For example, NCDs now account for almost 70% of all deaths globally, and the majority of this occurs in low- and middle- income countries (80% of all deaths due to NCDs).[10] Despite this, NCDs have received very little DAH: in 2017, only $825.5 million (2.2 % of a total DAH of $37.4 billion) were earmarked for NCD related

interventions. The United States government is the single largest donor for DAH, and they spent $77 million on NCDs (less than 1% of their total contribution to DAH), while they spent $5.9 billion on HIV/AIDS (48% of their total contribution), even though the prevalence of HIV/AIDS is much lower than NCDs in low- and middle- income countries.[4] As it is unlikely that total amount of DAH will increase in the near future (DAH increased at 11.3% annually between 2000 and 2009, while there was just a 1.2% annual increase between 2010 and 2015),[5] a strategy is needed for each global health agenda to increase or even maintain awareness from the international community to keep adequate financing. However, little is known about the mechanism of why some global health agendas receive adequate financing regardless of their disease burden, whereas some do not.

Indeed, the global health agenda that attracts more political attention and receives more development aid has changed from time to time. Back to 2000, when the MDGs adopted at the United Nations, there was a strong emphasis on vertical approach for individual health challenges such as HIV/AIDs, maternal and child health, and malaria. Most of international support, both through multilateral agencies and bi-lateral agencies, went vertical program. This vertical approach was successful in reducing burden attributable to specific diseases while revealed the fundamental challenges for horizontal issues - human resource shortage, inadequate capacity for health care workforce, lack of health infrastructure. At around 2008,

based on success and lessons from a vertical approach, the global community started to focus on a horizontal approach, or in other words, begin to invest in health systems strengthening (HSS). This movement in investing HSS was further supported by the emergence of an idea of UHC in 2012.

However, the Ebola virus outbreak in West African countries in 2014 posed challenges to an entire effort on global health - both for vertical approach and for horizontal approach, as this outbreak revealed the fundamental fragility of health systems in low- and middle- income countries as well as a capacity for dealing with infectious disease control. The global community was forced to rethink the governance of and the fundamental of global health. In the midst of this transformation in global health — several competing agendas, increasing complexity of actors in global health, and stagnated DAH, as well as the need to fundamentally rethink the nature of global health after the Ebola outbreak, Japan hosted the G7 Ise-Shima Summit in May 2016, where the major focus was on global health architecture (GHA), UHC, and AMR.[11] Historically, Japan has promoted the health agenda as a priority at previous G8 summits.[12] At the G8 Kyushu-Okinawa summit in 2000, Japan advocated the importance of combatting infectious diseases and took a leadership role to establish the GF.[13] Subsequently, at the G8 Hokkaido Toyako summit in 2008, Japan moved the agenda on HSS forward with an emphasis on health information, financing, and human resources for health.[14,15] Like other

previous G8 summits, through the G7 Ise-Shima Summit, Japan promoted three agenda items — GHA, UHC, and AMR.

Background of each agenda item – GHA, UHC and AMR

1.1 GHA

Kickbush et al define GHA as "the relationship between the many different actors engaged in global health and the processes through which they work together."[30] GHA debates have been fueled by the complex interactions of health transition, global health priorities, and uncertainties in global governance and economic prospects. In particular, the Ebola outbreak in 2014 was a game-changer for the GHA. This outbreak caused tremendous damage to African countries, not only in terms of human health but also with respect to their socioeconomic status. According to the Ebola situation report by the WHO on June 10, 2016, a total of 28,616 Ebola cases were reported in Guinea, Liberia, and Sierra Leone, with 11,310 deaths.[31] The WB Group estimated that these three countries lost at least US $1.6 billion in forgone economic growth in 2015. Sub-Saharan Africa, as a whole, also lost between US $500 million (low estimate) to US $6.2 billion (high estimate).[32] The initial response of the UN to this tragedy was to set up the UN Mission for Ebola Emergency Response in September 2014. Their aim was to tackle the Ebola outbreak in the three endemic countries. In addition, a UN High-level Panel on the Global Response to Health Crises was established in 2015 and a Global Health Crises Task

Force was also set up to support and monitor the implementation of recommendations developed by the panel. However, creating a new organization caused further confusion to the endemic countries and the fragmentation of responsibility among stakeholders.[15,33,34]

In concurrence with these global initiatives, the WHO, as a health specialist agency, has attempted to play a leading role in tackling the outbreak of the Ebola virus. However, it did not sufficiently handle the Ebola outbreak and has faced severe criticism, evoking a series of debates and controversies on the GHA.[35] Responding to global concerns, the WHO has decided to conduct an organizational reform for better preparation and to respond more appropriately to future public health crises. This reform included the improvement of International Health Regulation (IHR) core capacities as well as the development of a global health emergency taskforce.

The year 2016, when Japan hosted the G7 Ise-Shima Summit, was the first year since after the adoption of SDGs. In addition, the global community was still feeling the aftermath of the outbreaks of the Ebola virus. Even though the global community made immense progress that year, including the adoption of a new WHO emergency program, there were still a lot of public health emergency threats in the present-day world, such as the Zika virus and Yellow

fever. There was an urgent need to reinforce the GHA in order to prepare well for and respond to future public health crises.

1.2 UHC

UHC is defined as health coverage where "all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[45] The 2030 agenda for sustainable development was adopted at the 2015 United Nations General Assembly (UNGA),[46] and its target 3.8 of Goal 3 relates specifically to UHC with the aim of "achieving universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."[46] SDGs started in 2016 and there is now more momentum than ever for achieving UHC by 2030.

Not only the adoption of the SDGs, the Ebola outbreak in West Africa in 2014 also supported the debate regarding UHC. Not only three West African countries – Liberia, Guinea and Sierra Leone, other African countries also experienced the Ebola outbreak at the same time. However, other countries were not affected a lot by the virus and could handle the outbreak promptly, and the reason behind was considered that these countries had a robust health care system

which could well manage public health emergencies. Since then, there were global consensus that if we would like to well prepare for future public health emergencies, pandemic preparedness alone was not enough, and each country also required to strengthen their respective health care system under the notion of UHC.

Historically, Japan has promoted the concept of human security as the core concept of foreign diplomacy. Human security is defined as "protecting the vital core of all human lives in ways that enhance human freedoms and human fulfilment,"[42] and this leads to the maxim "no one left behind," which is the basic principal behind the 2030 Agenda for Sustainable Development and UHC. As a means to promote human security in the area of global health, Japan has been promoting UHC. The Ministry of Foreign Affairs (MOFA) published Japan's global health policy entitled "Basic Design for Peace and Health" in 2016.[47,48] This was developed as a guideline for the Global Health Policy under Japan's Development Cooperation Charter. One of the objectives of this guideline is to establish the seamless utilization of essential health and medical services throughout one's life in order to promote UHC. It also revealed that in order to do so, it is important to utilize Japan's expertise, experience, medical products, and technologies. Taking an advantage of Japan's experience, Japan put UHC as one of the main agenda item at high-level meetings hosted in 2016: G7 Ise-Shima summit, Tokyo International Conference on African Development (TICAD) Ⅵ and G7 Kobe Health Ministers' Meeting.

1.3 AMR

AMR is now a growing global concern and the current situation is such that, if the global community cannot deal with this threat appropriately, an estimated 10 million people will die as a result of AMR by 2050, potentially exceeding the number of annual deaths due to cancer.[80]

The global initiative toward addressing AMR has been gaining more momentum than ever before. In 2015, the 68th World Health Assembly (WHA) chose to unanimously adopt the WHO global action plan on AMR. The 71st UNGA also hosted the UN High-Level Meeting on AMR, which adopted its political declaration on AMR on September 21, 2016.[81,82] This was the fourth health related issue for which the UN had convened a high-level meeting, following HIV/AIDS in 2001, 2006, 2011 and 2016; NCDs in 2011, 2014 and 2018; and Ebola in 2014. Leaders from each country pledged to foster innovative approaches using alternatives to antimicrobials, and new technologies for diagnosis and vaccines.

Based on above-mentioned background, these three items became the major agenda item at the G7 Ise-Shima summit. However, just putting the agenda item at a high-level meeting such as the G7 or G20 is not enough for attaining global attention. Therefore, the objectives of this

study are to analyze the following points by using three global health agenda as case studies — GHA, UHC, and AMR:

1. Why these three global health agenda succeeded in catching political awareness both from global and national leaders;
2. Especially throughout the G7 summit and its related meetings hosted by the government of Japan in 2016, how Japan developed and succeeded in raising political momentum for theses agendas in collaboration with other G7 members and key stakeholders;

1.4 TB

In addition to above-mentioned three agenda items, TB was picked up as a case study. Japan did not promote TB as a main agenda item at the G7 meeting in 2016, but a UN High-Level Meeting on Tuberculosis was held in September 2019, which succeeded in catching wide political awareness.

TB is the leading cause of death from communicable diseases worldwide. Every year, 10.4 million people develop TB and 1.67 million people die from the disease.[101] TB is listed as a major health challenge in the SDGs as stated in Goal 3.3: “by 2030, end the epidemics of HIV/AIDS, TB, Malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases.” The First Global Ministerial Conference on Ending TB in the sustainable development era was held in November 2017, leading to the

adoption of the “Moscow Declaration to End TB.” Consequently, in September 2018, the first UN High-Level Meeting on TB was held. There is clearly a strong political momentum at the global level for ending the TB epidemic by 2030.

Despite significant progress in the past decades, at the current rate of progress, the SDG target on TB will not be achievable.[102] Currently, the annual rate of decline in TB incidence is around 1 – 2 % while the rate would need to be 4 – 5 % by 2020 and over 10% by 2025 in order to achieve the goal of ending the epidemic by 2030.[103] Moreover, new challenges are emerging, including an increase in multi-drug resistant tuberculosis (MDR-TB), a large number of missing cases (in 2015, there was an estimated 10.4 million cases but only 4.3 million cases were registered as TB, leaving 6.1 million TB patients undiagnosed and untreated), and global migration, which impose a huge financial and political burden on TB control.[101] By being picked up at the UN high-level meeting in 2018, TB became one of the top items on the political agenda. Therefore, this study uses TB as a case to analyze the opportunities and challenges it faced to become a global agenda.

Amid decreasing trend of DAH, a strategy is needed for each global health agenda to increase or even maintain awareness from the international community. By revealing factors why four global health agendas caught higher political attention, this study contributes to other global

health agendas to be strategically get political attention. In addition, by also revealing how Japan supported these agenda items to be a political agenda, it also contributes to Japan and other countries to promote any specific health agenda items of their interest.

2. Method

Political analysis framework

Several analytical frameworks have been developed to articulate the political dynamics of global health agenda.[16] Especially, Kingdon's three-stream model of agenda-setting and policy change, which was proposed in 1984, is still widely used when analyzing political science, including health care.[17] This framework proposes that three streams, namely the problem stream, policy stream, and political stream, are equally important and can be a driving force for opening a window of opportunity if they work together. With respect to the problem stream, Kingdon defines conditions as "problems" when we come to believe that we should do something about them, and these usually occur when there are changes in indicators, focusing events and feedback. The "policy stream" is defined as a process of generating policy alternatives in biological natural selection, akin to when some existing or new policies fading while some of them surviving. As part of this process, he proposes criteria for policy survival, as well as the need for policy community cohesion and policy entrepreneurs. Finally, the "political stream" is defined as being composed of several elements such as public mood, ideology, interest group pressure, the media and other influential actors. In his theory, consensus toward the political stream is controlled by national mood, organized political forces, and government.

There are other frameworks for political analysis. Path dependence theory,[18] issue-attention cycle,[19] and the median voter theorem are examples that have commonly been used in analyzing political power in health care since the mid to late 20th century.[20] Path dependence theory is defined as "history matters," or, in other words, a product or practice is based on its historical preference or use. Path dependency occurs because it is easier for human beings to continue along an already set path than to create an entirely new one. The issue-attention cycle is a systematic cycle of heightening public interest and then increasing boredom with major issues — how long public attention is likely to remain sufficiently focused upon any given issue affects its ability to generate enough political pressure to cause effective change.[19] Median Voter Theorem tells that the outcome of majority voting is the option most preferred by the median voter. It assumes that a choice has to be made from a set of alternatives that only differ in one dimension and that if all voters have a single-peaked preference, then the alternative that is the most preferred by the median voter will defeat any other alternative in a pairwise majority vote.[21] In addition to these, the WHO also published "Demonstrating a health in all policies analytic framework for learning from experiences" that emphasizes opportunities for initiation (window of opportunity).[22] It defines that key drivers of implementation, key domains of an equity lens, and key drivers of sustainability are of vital importance to implementing or changing health policy.[22] Christoph et al also analyzed the political power balance toward global health among European nations by using the Kingdon's three stream

theory and identified main barriers to the European Union (EU) further promoting global health agenda.[23] Especially for UHC, UHC is currently one of the top political agendas and several political analysis have been done so far.[49,50] In 2016, V. Gupta et al. analyzed six low and middle income countries about the relationship between progress toward UHC and political situation.[51] They identified social solidarity, economic growth, legislative decorum, public disaffection, and transformative political figures were five key components in determining successful progress, and analyzed the linkage between these five components and the progress of UHC.

In 2007, Jeremy Shiffman proposed a framework for determinants of political priority for the global health initiative.[24] This was based on an analysis of the global motherhood initiative, which was launched in 1987 by the collective efforts of the World Bank (WB), WHO, and the United Nations Population Fund (UNFPA).[25] By analyzing the stakeholders of the global motherhood initiative through interviews and literature reviews, he defined four main categories as key areas of determining political power (Table 1).

Table 1 Analytical framework proposed by Jeremy Shiffman (2007)

	Description	Factors shaping political priority
Actor power	The strength of the individuals and organizations concerned with an issue	1. Policy community cohesion
		2. Leadership
		3. Guiding institutions
		4. Civil Society mobilization
Ideas	The ways in which those involved with an issue understand and portray it	5. Internal frame
		6. External frame
Political contexts	The environments in which actors operate	7. Policy windows
		8. Global governance structure
Issue characteristics	Features of the problem	9. Credible indicators
		10. Severity
		11. Effective interventions

In this framework, the four categories are actor power (the strength of the individuals and organizations concerned with an issue), ideas (the ways in which those involved with an issue understand and portray it), political contexts (the environments in which actors operate), and issue characteristics (features of the problem).[24] Actor power is further divided into 1. Policy community cohesion (the degree of coalescence among the network of individuals and organizations that are centrally involved with the issue at the global level), 2. Leadership (the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause), 3. Guiding institutions (the effectiveness of

organizations or coordinating mechanisms with a mandate to lead the initiative), and 4. Civil society mobilization (the extent to which grassroots organizations have mobilized to press international and national political authorities to address an issue at the global level). If any global health issue has strong policy community cohesion, good leadership, and has any specific institutions that guide health issues and has strong participations in civil society organizations, then this global health issue is likely to have higher political awareness.

Ideas mean the ways in which those involved with the issue understand and portray it, and refers to two small categories namely 5. Internal frame and 6. External frame. Internal frame means the degree to which the policy community agrees on the definition of, causes of, and solutions to a problem, while external frame refers to public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources. If any global health issue has both reasonable internal and external frame, it is then likely to have higher political awareness.

Political context is defined as the environments in which actors operate and has two sub-categories; 7. Policy windows which are political moments when global conditions align favorably for an issue, presenting opportunities for advocates to influence decisionmakers, and

8. Global governance structure, the degree to which norms and institutions operating in a sector provide a platform for effective collective action.

Lastly about issue characteristics, this consists of three categories — 9. Credible indicators (clear measures that show the severity of the problem and that can be used to monitor progress), 10. Severity (the size of the burden relative to other problems, as indicated by objective measures such as mortality levels), and 11. Effective interventions (the extent to which the proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive). If any global health issue has credible indicators, higher severity and effective interventions, it is then likely to be placed high on the political agenda.

It is important to acknowledge that no single category is sufficient to meet the necessary conditions for change. Even health agendas that fulfill majority of categories do not always succeed in capturing political attention and/or gaining adequate financing. For example, NCDs are now the top cause of death globally and had a policy window like the UN high-level meeting in 2011, 2014, and 2018. However, financial contributions from donors to NCDs, compared with its disease burden, remains low.[26]

In 2016, based on original framework proposed in 2007, J. Shiffman et al. proposed a revised framework through an analysis about global health networks.[27] They analyzed why some global health networks succeed in gaining political awareness while others do not, and then identified three categories as a key: actor feature, policy environment, and issue characteristics (Table 2). The main difference between the 2007 framework and the revised 2016 framework is that the 2016 framework includes a financing analysis as well as looking at the factors of opponents. Although the 2016 framework was constructed based on an analysis of global health networks (actors/stakeholders in global health), it is applicable to other issues and has been widely used in the political analysis of global health challenges.

Table 2 analytical framework proposed by Jeremy Shiffman (2016)

Category	Factor	Explanation
Actor Feature	1. Leadership	A network is more likely to emerge and be effective if capable, well-connected, and widely respected champions are available to lead the cause
	2. Governance	Networks are more likely to be effective if they have appropriate governing structures capable of facilitating collective action and resolving disputes
	3. Composition	Networks that link diverse actors are more likely to generate creative solutions to problems, but also to be hampered by disagreements
	4. Framing strategies	Networks are more likely to be effective when their members have discovered ways of positioning issues that resonate with external actors, especially political elites

Policy environment	5. Allies and opponents	Groups with aligned interests will facilitate network expansion and power. Opponents will challenge network legitimacy and issue promotion, but their existence may inspire mobilization
	6. Funding	Donor funding may facilitate network emergence and effectiveness and a dearth in funding may hinder prospects for sustainability, but over reliance on these resources may hamper network legitimacy
	7. Norms	Widely held expectations that global actors address a particular condition facilitate network emergence. Networks that advocate for policies that violate strong social values face obstacles
Issue characteristics	8. Severity	Network emergence and effectiveness are more likely for problems that are perceived to have high mortality, morbidity, or socioeconomic costs
	9. Tractability	Networks are more likely to form and be effective for problems for which solutions are exist or perceived to exist, especially if the proposed solutions are politically uncontroversial
	10. Affected groups	Network emergence and effectiveness are more likely for issues that affected groups that are readily identifiable, that societies view sympathetically, and that are able to advocate for themselves

There are some limitations to this framework proposed by Shiffman, both in the 2007 and the 2016 versions.[28] The framework does not analyze the relative causal weights of the factors, interactions between categories, interaction from entities outside of health sectors, and the additive effect of the combination of different categories.[24] However, previous research shows

that, other conditions being equal, every category added increases the chance of catching political attention.[24]

As Shiffman's 2007 and 2016 frameworks are the most commonly used in political analysis in global health, Shiffman's 2007 framework is employed in this study to analyze GHA and TB, while Shiffamn's 2016 framework is used of UHC. Although the original framework of 2007 does not contain financial assessment, this study also included analysis of financial aspects of the GHA. In addition, in order to compare strengthen and weakness of Sihffman's framework, Kingdon's framework, the most common framework in political analysis for many issues other than the health sector, is employed for analysis of the AMR case.

Data collection and application of the framework: semi-structured interview

All the data collection and analysis were done by the author. The background information of the author was female, holding Medical Doctor (MD) and Master of Public Health (MPH), and a PhD candidate at the Department of Global Health Policy (GHP), Graduate School of Medicine, the University of Tokyo. The author has previous experience of qualitative research on motivation of female physician to keep working after having children. In that study, the author employed ten early- and late-career residents (those who are less than ten years of

working experience as a physician) working at St. Luke's International Hospital, the author's former workplace. The author then asked:

1. Whether they wanted to continue working as full-time doctors after pregnancy and childbirth.
2. What was their motivation (if they wanted to continue working)?
3. What kind of environment they needed to maintain their motivation?
4. What are the barriers to maintaining their motivation?

Semi-structured interviews were conducted to find out answers to the above-mentioned questions. The results were analyzed using the Modified Grounded Theory Approach (M-GTA) method and revealed factors enabling female physicians to keep their motivation for working after pregnancy and childbirth.

Between April and October 2016, one-on-one qualitative in-depth interviews (IDIs) were conducted with a total of 22 officials from the Ministry of Health, Labour and Welfare of Japan (MHLW), MOFA, the Ministry of Finance of Japan (MOF), Japan International Cooperation Agency (JICA), and International Cooperation Bureau, the National Center for Global Health and Medicine (NCGM). 15 out of 22 participants were coworkers of the author and rest of 7 were introduced by participants. All the participants were approached via email and none of them rejected in joining an interview. The interviews are semi-structured format. Most of

qualitative research interview are either semi-structured, lightly structured or in-depth. In semi-structured format, the interview is conducted based on a set of preliminary questions (interview guide), which is a schematic presentation of questions or topics and need to be explored by the interviewer. Interview guide, which consists of list of questionnaires was newly created by the author based on previous research using the same framework (Shiffman's framework and Kingdon's framework). The full set of interview guide (in Japanese) are provided as an Annex 1. The participants from the ministries were of at least deputy director or higher level, and all of them had previous experience of participating in international conferences such as the WHO General Assembly Meetings. Besides, all of them had some level of decision-making authority (i.e., they could participate in the G7 preparatory meetings and its related meetings alone and make some decisions on the spot). Also, some of the participants were at the director-general and assistant minister's level and had departmental decision-making authority in the final decision-making process. All participants from JICA and NCGM had previously been seconded to MHLW, related ministries, WHO, and other organizations involved in the policymaking process. They have also participated in international conferences such as the WHO General Assembly. All of interviewees participated in the preparatory process of the G7 Ise-Shima Summit, the G7 Kobe Health Ministers' Meeting, TICAD VI, the 69th WHA, the 71st UN General Assembly, and other meetings, both official and unofficial, related to GHA,

UHC, and AMR. In addition, two expert meetings were also initiated for the TB case and more details are explained in page 40. The list of interviewees was as below.

Table 3 List of interviewees

Number	sex	Affiliation
#1	Male	Division of International Cooperation, MHLW
#2	Female	Division of International Cooperation, MHLW
#3	Male	Division of International Cooperation, MHLW
#4	Male	Division of International Cooperation, MHLW
#5	Male	Division of International Cooperation, MHLW
#6	Male	Division of International Cooperation, MHLW
#7	Female	Division of International Cooperation, MHLW
#8	Female	Division of International Cooperation, MHLW
#9	Male	Division of International Cooperation, MHLW
#10	Female	Global Health Policy Division, MOFA
#11	Female	G7 summit preparation secretariat, MOFA
#12	Male	Global Health Policy Division, MOFA
#13	Male	Global Health Policy Division, MOFA
#14	Male	International bureau, MOF
#15	Female	International bureau, MOF
#16	Female	International bureau, MOF
#17	Male	International Cooperation Bureau, NCGM
#18	Male	International Cooperation Bureau, NCGM
#19	Female	International Cooperation Bureau, NCGM
#20	Male	Human Development Department, JICA
#21	Male	Human Development Department, JICA
#22	Male	Human Development Department, JICA

As this research does not deal with any human and animal subjects, does not ask any personal issues, ethical committee clearance was not applicable for this research. The previous research

related to political science in global health also did not conduct any ethical committee clearance and this research followed the previous researches.

All interviews were conducted at the office of interviewee, and there was no other attendance other than interviewer and interviewee. The average length of an interview was approximately 30 minutes. All interviews were recorded with participant permission using a voice recorder and the audio recordings were transcribed nearly verbatim. For this process, identifying information was removed and all names used during interview are pseudonyms.

Data analysis

All interview transcriptions were read multiple times before coding began. The first stage of systematic coding included marking the text with key words and identifying specific sentences that are related to the political economy of each agenda item (GHA, UHC, AMR, and TB). According to the framework especially selected for each case study (i.e., Shiffman's 2007 framework for GHA and TB, Shiffman's 2016 framework for UHC, Kingdon's framework for AMR), each sentences/keyword was categorized following the method of the content analysis. To begin to identify analytic ideas and relationships, descriptive coding categories were again reviewed to highlight repeated ideas and similar words and phrases and to identify unusual responses.[29]

To ensure researchers applied codes consistently, the coding process was done by at least two co-authors who coded the same transcripts and discussed discrepancies. According to Lincorn and Guba, “dependabilty” is used for assessing inter-rater reliability. The process of dependability was to send an expert in qualitative research and is familiar with research topic with recorded interview and to ask them for doing the same analysis (there is no clear definition of an expert; however, according to the previous research, usually got PhD in qualitative research, and have several publications using qualitative research either as a first author or corresponding author). In this regard, in order to secure dependability, the coding process and manuscripts were reviewed by two non-Japanese external reviewers who are not involved in any process of the G7 Ise-Shima Summit or its related Health Ministers’ Meeting, TICAD, or other Japanese government led high-level events. One is a professor at one of the graduate schools of Public Health in the United States, specializing in political science in global health. Although he was not involved in the G7 process in 2016, he has an in-depth knowledge of Japan and has published several papers analyzing Japan's global health policy from a political science perspective. The other is an associate professor at one of the graduate schools of Public Health in the United States. He has published several papers on qualitative research using Jeremy Shiffman's framework.

Also, archive research was conducted to find the official reports of relevant UN meetings and the outcomes of each conferences like the G7 Ise-Shima Leaders' Declaration (the detailed method of literature review is described in each section as different review strategies were used for each case study). Keywords for each case study are as below:

GHA: "GHA", "global health architecture", "global health governance" and "health security."

UHC: "UHC," "Universal Coverage," "Health System," and "Health Financing."

AMR: "AMR" and/or "antimicrobial resistance."

TB: "tuberculosis," "TB," "End TB strategy," "Stop TB Partnership," "MDR-TB," "MDGs," "SDGs," "UN High-Level Meeting on Tuberculosis," and "the Global Fund."

For TB case, the author also organized two expert meetings in 2018. The purposes of these meetings were to assess the current situation, to analyze challenges regarding the prevention and control of TB, and to forecast the upcoming UN High-Level Meeting on TB in 2018.

The first meeting was held in April 2018 and was attended by a wide range of experts, including officials from the Japanese government, JICA, NCGM, the Japan Anti-Tuberculosis Association (JATA), the Global Fund, and others. The second meeting was held in May 2018 and open to the public. In addition to the organizations above, the meeting was attended by representatives from non-governmental organizations (NGOs), civil society organizations (CSOs), and the private sector (mainly pharmaceutical and medical device companies).

The resulting draft report was sent to interviewees in order to get their feedback and comments. Because this research largely relied on diplomatic processes which sometimes were not documented for political reasons, some parts of the research evidence is drawn from excerpts from the interviews. Lastly, in order to secure the quality of research, Consolidated criteria for reporting qualitative research (COREQ) was applied.

Table 4 checklist of consolidated criteria for reporting qualitative research (COREQ)

Topic	Item No.	Guide questions/Description	Reporting page
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	34
Credentials	2	What were the researcher's credentials?	34
Occupation	3	What was their occupation at the time of the study?	34
Gender	4	Was the researcher male or female?	34
Experience and training	5	What experience or training did the researcher have?	34
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	35
Participant knowledge of the interviewer	7	What did the participants know about the researcher?	35
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator?	35-37
Domain 2: Study design			
Theoretical framework			

Methodological orientation and theory	9	What methodological orientation was stated to underpin the study?	26 – 34
Participant selection			
Sampling	10	How were participants selected?	35
Method of approach	11	How were participants approached?	35
Sample size	12	How many participants were in the study?	35
Non-participation	13	How many people refused to participate or dropped out? Reasons?	35
Setting			
Setting of data collection	14	Where was the data collected?	38
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	38
Description of sample	16	What are the important characteristics of the sample?	35
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	36
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	38
Field notes	20	Were field notes made during and/or after the interview or focus group?	N/A
Duration	21	What was the duration of the interviews or focus group?	38
Data saturation	22	Was data saturation discussed?	N/A
Transcripts returned	23	Were transcripts returned to participants for comment/or correction?	41
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	39
Description of the coding tree	25	Did authors provide a description of the coding tree?	N/A
Derivation of themes	26	Were themes identified in advance or derived from the data?	39 – 40
Software	27	What software, if applicable, was used to manage the data?	N/A

Participant checking	28	Did participants provide feedback on the findings?	41
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified?	Yes – in each case study
Data and findings consistent	30	Was there consistency between the data presented and the findings?	41
Clarity of major themes	31	Were major themes clearly presented in the findings?	Yes – in each case study
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	N/A

3. Results

Table 5 political mapping of GHA

Actor power	1. Policy community cohesion	• The Cabinet, Keizo Takemi (a member of House of Councilor) and the Health minister initiated policy dialogue and promoted cohesion among stakeholders in Japan • For G7 and non-G7 members, Japan initiated a dialogue related to the GHA at G7 leaders meetings, the G7 Kobe Health Ministers' Meeting, and the 69th WHA and TICAD VI • Both the Prime Minister and the Health Minister have strong interests in the GHA
	2. Leadership	
	3. Guiding institutions	
Ideas	5. Internal frame	• Strongly connected to the human security the Japanese government promoted for decades, which made easier for relevant ministries to share the basic idea of the GHA
	6. External frame	• The GHA has several aspects which could catch the attention of political leaders from several backgrounds; health, security, economy, and so on
Political contexts	7. Policy windows	• The severity of the Ebola outbreak caught the attention of the UN Secretary-General and academia, such as the Institute of Medicine and the London School of Tropical Medicine and Hygiene • Officially published agreed documents; G7 Leaders Declaration, Nairobi Declaration and its implementation measure, G7 Kobe Health Ministers' Communique
	8. Global governance structure	• The Oslo group (Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand) and the GHA related UN resolutions proposed by it
Issue characteristics	9. Severity	• Expose the fundamental weakness of global health architecture. Discuss externalities and public good

	10. Credible indicators 11. Effective interventions	• Not sufficient because a large scale public health emergency is a rare event and there was not enough evidence on credible indicators
Finance	12.Financing mechanisms 13.Actual amount of contribution	• There was not an adequate amount of financial resources at the time of the Ebola endemic; however, there are increasing trends toward new financing mechanisms and collective efforts such as the WHO's CFE and the WB's PEF and CEPI

Note: GHA; global health architecture, G7; group of seven, WHA; world health assembly, TICAD; Tokyo International Conference on African Development, UN; United Nations, CFE; Contingency Fund for Emergencies, WB; World Bank, PEF; Pandemic Emergency Facility, CEPI; Coalition for Epidemic Preparedness Innovations

3-1. Political mapping of GHA

Shiffman's 2007 framework was applied, and the results of political mapping of GHA is summarized in Table 5.

Actor power

Actor power consists of policy community cohesion, leadership, guiding institutions, and civil society mobilization. First, policy community cohesion was analyzed at three levels of actor power: inside Japan, among G7 members and outside of the G7 countries.

For the first time, three ministries – MHLW, MOFA, and MOF, and the cabinet office had a slightly different opinion on GHA, and there was no agreement on how to portray GHA on the G7 summit at an initial stage. "Relevant ministries have slightly different interests on GHA, and it seemed to be difficult to find agreed point among ministries for the first time (#1, #2, #10, #14)". "The MOFA was interested in the relationship between GHA and human security (#10, #13)." "MHLW promotes GHA as public health emergency has a direct impact on the health of the people living in Japan (#6, #9)." "We (=MOF) had a strong concern on public health emergency as it may have a significant impact on Japan's economy. Besides, as the World Bank is now the leading role in public health emergency including the launch of

Pandemic Emergency Facility (PEF), we (=MOF) would like to support the Bank's efforts (#15)."

Though there was no agreement on how to portray GHA at the G7 summit in 2016, the importance of the cabinet office, and then Minister for Health, Labour and Welfare, and Prof. Takemi Keizo was emphasized. "As the prime minister has an interest in health and put it as one of Japan's main growth strategies, the cabinet secretariat also has an interest in health issues including GHA (#3, #7, #11)." "The Cabinet Office often hold meetings together, with participants at the level of director-general of each ministry, which resulted in sharing information and discussion about how to consolidate Japan's commitment as a whole (#4)." For about the then Minister for Health, Labour and Welfare, Mr. Yasuhisa Shiozaki, most of all the interviewee supported his commitment to GHA. "He had an enthusiasm for Japan to lead the GHA at the global level (#6, #9)." "He hosted two "Advisory panel for global health" in August 2015. One of them (= global health architecture working group) published a list of recommendations for the Japanese government, which became the basis for GHA argument (#1, #16)." "Prof. Keizo Takemi already had a strong influence on global health since the G8 summit preparatory process in 2008. Like 2008, he led an argument on global health issues again in G7 Ise-Shima summit preparatory process (#1, #2, #9, #13, #15)." "Prof. Keizo Takemi hosted a series of dialogue not only among the relevant ministries, but also invited

NGOs, CSOs, and private sectors for the meeting, which contributed to increase mutual understanding among all the stakeholders (#5, #8)."

As the cohesion among G7 members, "there was already a basis for including GHA into the G7 agenda in 2016, as the global community has still been traumatized after the Ebola outbreak in the West Africa in 2014 (#4, #11, #17)." In addition, Japan's leadership in increasing political momentum on GHA at several international conferences was emphasized. "In order to increase cohesion among all stakeholders, it was important to have as much dialogue as possible, especially with non-G7 countries. In this regard, Japan prepared several dialogue opportunities with these countries throughout its G7 presidency in 2016 including the 69th WHA, the TICAD Ⅵ, and the G7 Kobe Health Ministers' Meeting (#5, #8)." "Especially as the chair of the meeting's thematic session at the TICAD Ⅵ, the then Minister of Health, Labour and Welfare of Japan, Mr. Yasuhisa Shiozaki, led an intense debate among the African heads of state and ministers, as well as leaders from international organizations (#6, #13)"

Idea

Ideas refer to the ways in which those involved with the issue understand and portray it both for internal and external stakeholders. For an internal frame, an idea of "human security" played an important role. "As the "human security" has been Japan's central tenant of global

cooperation, and its strong linkage between GHA and human security, it was easy for us to find shared value in GHA (#13, #20, #21)." For about external frame, the diverse dimension of GHA was a factor for attracting several stakeholders. "As public health emergency may easy to cause national emergency, it (=GHA) was important agenda item for the prime minister and the cabinet office (#1, #6, #14, #21)." "it (=GHA) could be health issues for health sector including the Ministry of Health, it is also a financial problem and thus important for financial sector including the MOF (#6, #10, #14)."

Political context

A policy window and good global governance structure are two key components in this category. "It was natural for GHA to open the political window as Ebola outbreak in 2014 caused tremendous death and put significant burden on the society as a whole (#1, #4, #8, #14, #22)." "After the Ebola outbreak in 2014, several movements at the UN level happened including the launch of a UN High-Level Panel on Global Response to Health Crises and a Global Health Crises Task Force, which all was an important factor for opening the political window (#7)." "In this regard (=opening political window), Japan contributed a lot for enhancing political momentum, especially through conveying meetings with high-level participants including the G7 Ise-Shima summit, the G7 Kobe Health Ministers' Meeting, and TICAD (#3, #9, #12, #15)." "Agreed documents at high-level meeting such as the G7 Ise-

Shima leaders' declaration also served as the driver for opening the political window. It was one of the strongest ways for support an agenda item that the head of states clearly made a commitment through agreed documents (#9, #12, #16)."

3-2. Political mapping of UHC

Shiffman's 2016 framework was applied, and the results of political mapping of UHC is summarized in Table 6.

Table 6 political mapping of UHC

Category	Factor	Explanation
Actor Feature	1. Leadership	• Three champions, Shinzo Abe (Prime Minister), Yasuhisa Shiozaki (Minister for Health), and Keizo Takemi (Member of House of Councilors)
	2. Governance	• Based on the G7 meeting and its preparatory process, Japan leveraged its G7 presidency outside of G7 members
	3. Composition	• Expand G7 Agenda to other G7 countries: World Health Assembly, TICAD VI, UNGA, International Conference on UHC in the New Development Era
	4. Framing strategies	• The WHO clearly defines UHC, serving to provide a common understanding of UHC among stakeholders
Policy environment	5. Allies and opponents	• Japan is strong promoter. Germany, Canada, and the UK supported Japan to take up the UHC agenda at G7 meetings. No apparent opposition
	6. Funding	• Not enough funding for UHC/HSS • The GF starts to fund UHC/HSS together with a contribution from the WB
	7. Norms	• Transformation from IHP+ to UHC 2030 • UHC in Africa: Framework in Action, launched at TICAD VI
Issue characteristics	8. Severity	• The concept of UHC is the basis for health and severity is not applicable this time
	9. Tractability	• WHO/WB joint monitoring framework

		• UHC in Africa: Framework in Action. The follow-up conference was held in Japan in 2017
	10. Affected groups	• The whole population

Note: UHC; universal health coverage, G7; group of seven, TICAD; Tokyo International Conference on African Development, UNGA; United Nation General Assembly, WHO; World Health Organization, HSS; Health Systems Strengthening, IHP; International Health Partnership, WB; World Bank

Actor

This category consists of leadership, governance, composition, and framing strategies. First, about the leadership, Prime Minister Shinzo Abe, and Mr. Yasuhisa Shiozaki, the Minister of Health, Labour and Welfare at the time were emphasized as two noteworthy champions for this agenda. “Prime Minister Shinzo Abe was strong advocator for UHC (#3).” “He (=prime minister) picked up UHC as Japan’s main agenda item on several occasions (#9, #12, #15, #19, #20).” “He (=prime minister) made publication at the Lancet, which could be a strong political message to the world that Japan would promote UHC (#3, #8, #14, #21).” “Mr. Yasuhisa Shiozaki had a strong interest in UHC, as he thought Japan’s superiority in the health care system, including the universal insurance system (#1, #11, #21).” “As a health minister at that time, he advocated the importance of UHC as well as Japan’s leading role on this agenda item at several international conferences and picked up this at bi-lateral meetings with health ministers of other countries (#5, #13, #19).”

Concerning the governance and composition, high-level meetings hosted by Japan and the outcome documents adopted at these meetings were highlighted. “Japan as a G7 president hosted UHC related event entitled [The Path towards Universal Health Coverage: Promotion of Equitable Global Health and Human Security in the Post-2015 Development Era,] and [International conference on UHC in the New Development Era] during the 70th UNGA in

2016. These conferences were a good opportunity for Japan to show its strong commitment to global leaders, heads of state, and the leaders of international organizations, and to declare Japan's commitment toward UHC in its upcoming G7 presidency in 2016 (#19, #20, #22)." "I would like to emphasize the importance of Mr. Shiozaki's effort for advancing UHC. As a first Japan's health minister attended TICAD conference, together with Dr. Jim Yong Kim, the president of WB, led a debate on UHC among leaders from international organizations and African countries. These preparatory processes contributed to enhance mutual understanding on UHC (#4, #6, #10)."

Policy environment

With regard to policy environment, alley and opponent, funding and the norm were picked up. "Germany was strong advocator for UHC and there was already global momentum on advancing UHC, by the effort of the German government (#5, #14)." "Germany, together with the WHO, launched the new UHC strategy entitled [Healthy Systems – Healthy Lives], which served as a common understanding of UHC (#1, #19)." "There was some concern on which country – Japan or Germany to take a leadership role in UHC. As both the head of states of these two countries has strong interest in UHC, this was dealt with political issues rather than purely health issues (#2, #6, #12, #17)." "Canada and UK were not main actor in promoting UHC, but was strong supporter for advancing UHC (#18, #21)." "The Global Fund 5th

replenishment was planned in Canada in 2016, Canada has an interest in promoting UHC through strengthening efforts on vertical approach such as infectious disease control (#5, #19, #22)."

With regard to financing, "there was not adequate financing for UHC at that time (#1, #2)." "Most donors prefer to invest in vertical programmes, and very little was allocated to UHC and HSS compared with its importance (#7, #12, #19)." "Japan probably made a breakthrough for start funding in UHC and HSS. Not only advocate UHC, but actually pledged for UHC, which encouraged other major donors to further invest in HSS and UHC (#8, #10)." "The positive trend was that the GF, which usually supports vertical programmes, has started to invest in HSS as strong health system was a basis for promoting vertical programmes (#3, #6, #18, #21)."

3-3. Political mapping of AMR

Kingdon's framework was applied, and the results of political mapping of AMR is summarized in Table 7.

Table 7 political mapping of AMR

Problem Stream	• Significance of the problem: 10 million people will die due to AMR by 2050 • The concept of AMR can be defined quite simply • The WHO, FAO, and OIE portray AMR by defining "One Health approach"
Policy Stream	• The Global Action Plan on Antimicrobial Resistance was unanimously adopted the WHA in 2014, which encouraged all the member states to create national action plan. Japan hosted the Tokyo Meeting of Health Ministers on Antimicrobial Resistance, which provided technical supports for low- and middle- income countries in Asia to develop national action plan • GHIT fund provides options for R&D in AMR. By reiterating it at the G7 Leaders Declaration and the G7 Kobe Communique, Japan provided support for GHIT
Political Stream	• Japan's contribution by picking up AMR as major agenda item at three high-level meetings: the G7 Ise-Shima Summit, the G7 Niigata Agriculture Ministers' Meeting, and the G7 Kobe Health Ministers' Meeting • The UK government's strong leadership with two notable champions, Dame Sally Davies, who has contributed as the Chief Medical Officer for England, and Lord Jim O'Neil, who is well known for the seminal "O'Neil Report" • The UN High-Level Meeting on AMR and its political declaration became the strongest political support for AMR

Note: AMR; antimicrobial resistance, WHO; World Health Organization, FAO; Food and Agriculture Organization, OIE; World Organization for Animal Health, UN; United Nations, G7; Group of seven, WHA; World Health Assembly, GHIT fund; Global Health Innovation and Technology fund

The problem stream for AMR

The problem stream defines conditions as "problems" when we come to believe that we should do something about them, and these usually occur when there are changes in indicators, focusing events and feedback. Interviewees emphasized the importance of O'Neil report and the work by the WHO. "O'Neil report played an important role. After publishing the report, the global community was well aware the importance of addressing AMR (#6, #10)." "Together with O'Neil report, WHO soon started to address AMR including picking up AMR as WHA agenda and adopted global strategy on AMR. These efforts by WHO make each member states realize the importance of AMR (#4, #12, #19, #22)." Also, they emphasized the nature of AMR – easy to understand definition. "As the definition of AMR is quite simple, it is easy for everyone to have the common understanding (#15)." "WHO, together with Food and Agriculture Organization (FAO) and World Organization for Animal Health (OIE) proposed "one health" approach. It became a common slogan for tackling AMR (#8)."

The policy stream for AMR

The policy stream refers to solutions that have been developed in response to particular challenges by policy communities. Majority of interviewee picked up the Global Action Plan on Antimicrobial Resistance, the Communique of the Tokyo Meeting of Health Ministers on

AMR in Asia, and the Global Health Innovation Technology Fund (GHIT) as main solutions for AMR.

"In 2015, WHO published the Global Action Plan on Antimicrobial Resistance, which served as a common guiding tool for tackling AMR globally (#1, #3, #7)." "Japan hosted the Tokyo Meeting of Health Ministers on Antimicrobial Resistance in 2016, where health ministers in Asia countries agreed upon common actions required to tackle AMR in the region (#12, #19, #21)." "The communique adopted at the conference (= the Tokyo Meeting of Health Ministers on Antimicrobial Resistance) still serves as a guiding tool in Asian countries to identify what actions are needed for AMR (#7)." "Japan has the GHIT fund, which was unique mechanisms for addressing AMR (#5, #13, #15)." "Both the MHLW and the MOFA invested a lot on GHIT, which may use as a good example of Japan's contribution on AMR (#15, #16)."

<u>The political stream for AMR</u>

The political stream comprises of several elements that contribute to open political window. In this research, interviewees answered the G7 and its related meetings, and the UN High-Level Meeting on AMR were two main contributing factors for opening political window. "AMR was discussed not only at the G7 Health Minister's meeting, but also at the G7 Ise-Shima summit and the G7 Niigata Agriculture Meeting, both of which contributed for AMR to get

higher political attention (#8, #13).” “Due to the leadership by the UK government, AMR was adopted at the UN-High-Level meeting in 2016. Discussion at the UN High-Level meeting was one of the best opportunities to get higher political attention (#6, #13, #15, #21)”

3-4. Political mapping of TB

In the TB case study, in addition to interview and literature review, two stakeholder meeting were conveyed. In total, 77 people attended the meetings; 8 (10%) were public officials, 18 (23%) were from the private sector, 17 (22%) were from NGOs/CSOs, 13 (17%) and 11 (15%) were from academia and development partners, respectively, and the remaining 10 (13%) were from other sectors. Based on the findings from interview, literature review, and stakeholder meetings, the opportunities and challenges for increasing the attention devoted to tuberculosis at the higher political level are summarized in Table 8.

Table 8 political mapping of tuberculosis

Category	Challenges	Opportunities
Actor	- The private sector has not been effectively involved in the control and treatment of TB - Most NGOs are facing a lack of financing, which may weaken their capacity for implementation	- Three key organizations — the WHO, the GF and the Stop TB partnership have been enhancing the policy community - Active engagement of the private sector, NGOs, and community organizations
Ideas	- Need to further promote the health security aspect of TB - Need to pay more attention to the human-rights aspects of TB prevention and treatment	- Clear and well-established models of the causes of TB and of interventions for reducing the TB burden - Well framed as security issues
Political context	- Given the increased number of health issues highlighted at UN high-level meetings in recent years, it is uncertain how much impact such a meeting on TB has on the attention and priorities of the high-level leaders - It is not clear if the meeting could lead to actual commitments from leaders	- The problem is listed in the MDGs and SDGs - Ministerial conference on ending TB in the sustainable development era in Moscow in 2017 - UN High-Level Meeting on TB in 2018
Issue characteristics	- R&D for new drugs and diagnosis are too slow and funding is limited	- Top infectious killer globally - Substantially affects children - Well-known interventions (4-regimens, 6-months)

Note: TB; tuberculosis, NGO; non-governmental organization, WHO; World Health Organization, GF; Global Fund to Fight AIDS, Tuberculosis and Malaria, UN; United Nation, MDGs; Millennium Development Goals, SDGs; Sustainable Development Goals, R&D; research and development

Actor power

Over the past decades, the WHO, together with the GF and the Stop TB partnership (STBP) have been the guiding institutions in the fight against TB. “By publishing several guidelines and action plans including [the End TB Strategy] and [the Global Plan to End TB 2016 – 2020], these organizations have contributed to enhancing policies’ community cohesion (#2, #5, #14).”

In addition to these efforts made by the WHO, the GF, and the STBP, experts at the two meetings and interviewee emphasized the importance of contributions by community health workers, NGOs, and the private sector. “Community health workers, including public health nurses, played a significant role in the efforts to reduce the TB burden in Japan (#1, #9).” “Public health nurses, trained in patient-centered and human-rights based TB control programmes, delivered high-quality care not only at the health facility level but also through an outreach to schools, workplaces, and other community-based facilities (#6, #11, #13).” “Their contribution to the disease detection and management efforts resulted in a rapid decline in TB prevalence in Japan. What was once 700/100,000 cases in 1950s, declined by 10% annually between 1965 and 1978 (which is almost equal to the rate required to reach the global target by 2030) (#20).”

Another important actor is the private sector, which contributed to TB control by developing new treatment and diagnostic tools, particularly for cases of MDR-TB, and also devised a PPP. The GHIT Fund founded in 2012 by the Government of Japan together with pharmaceutical companies, the Gates Foundation, and the Wellcome Trust (joined in 2015), is one such example. The GHIT Fund aims to promote the development of new medical products and support innovation that addresses the needs of developing countries. As of March 2018, the GHIT Fund has invested USD 190 million in 74 partnership projects (12.5% of the fund was allocated to TB), in which the organization aims to address market failures and incentivize research and development (R&D).

The actor category also refers to civil society mobilization. “A large number of NGOs, such as Médecins Sans Frontières (MSF), RESULTS, and community organizations have been actively participating in grassroots activities (#5, #10, #13).” “As of May 2018, about 80% of the partners of STBP are NGOs and CSOs, which indicates an active participation of these organizations in the fight against TB (#15, #16).”

Ideas

“There is a clear and well-established understanding of the causes of TB and models of interventions for reducing the TB burden (#7, #12).” TB is caused by *Mycobacterium*

tuberculosis and the standard treatment includes four antimicrobial drugs during a period of six months. The clear understanding of the cause and the treatment of this disease makes it easy for relevant stakeholders to unite around a common issue and discuss potential solutions for it.

"The emergence of MDR-TB has framed the disease as not only a health issue, but also a security issue (#8, #18)." More than 30% of AMR related deaths occur among MDR-TB patients.[104] "With a global momentum for combating AMR on the rise, framing TB as an AMR-related security issue could well-position TB to capture political attention, especially from heads of state, foreign ministers, finance ministers, and trade and economy ministers (#1, #2, #12)."

"Another issue that makes TB a health security concern is the increasing prevalence of TB among immigrants and migrants (#7, #9)." For example, in Japan, which is an intermediate TB burden country, foreign-born TB cases increased from 842 cases in 2007 to 1,101 cases in 2014, with the most prominent rise occurring among those aged 20 – 29 years old, a change that more than doubled from 21.2% in 2007 to 44.1% in 2014.[105,106] This trend can be seen in many developed countries,[107] and together with general concerns regarding the increasing

transnational movement of people, the idea of TB as a health security issue has now become widely recognized.

Political context

There is already political support for the fight against TB and interviewee emphasized the series of high-level international conferences. “Both the MDGs and SDGs list TB as a priority (#3, #12).” “Moreover, the year of 2018 was a historical year in the combat against TB. At the 71st UNGA in 2016, member states unanimously adopted the resolution A/RES/71/159 entitled “Global health and foreign policy: health employment and economic growth,” in which they decided that a UN High-Level Meeting on TB would be held in 2018. Following this resolution, the global ministerial conference on ending TB in the sustainable development era was held in Moscow in 2017. At that conference, health ministers adopted the Moscow Declaration to End TB, which now constitutes the basis of the efforts to end the TB epidemic. These all were great opportunities for TB to be a top political agenda (#20, #21).”

Issue characteristic

As for the severity of the disease, deaths due to TB now exceed those of HIV/AIDS, and TB is now the top infectious killer globally.[101] Moreover, TB affects children, and the issue of childhood TB has been raised among the international stakeholders, and described in the

"Roadmap for Childhood Tuberculosis" report.[108] In 2016, less than half (43%) of the estimated 1 million children with TB were reported to national TB programmes, indicating that there is a large number of undiagnosed and insufficiently treated children.[101] As a result, 253,000 children died of TB. Unrecorded cases are also of concern among adults. In 2015, only 4.3 million cases of an estimated total of 10.4 million cases were reported, indicating that there are many TB patients who have no access to health care facilities or proper diagnosis and treatment.

As for effective interventions, the standard treatment is to provide a six-month course of four antimicrobial drugs. In addition, great progress has been made in the development of new TB drugs in recent years. There is now a three-month, once-weekly regimen for TB prevention (isoniazid and rifapentine), and a nine-month regimen that cures 80% of MDR-TB.[109] There are also two additional drugs — bedaquiline and delamanid — which have been approved by the regulatory authorities.[109] However, the pace for developing new drugs and diagnostics is slow and fundamental changes in R&D are needed. The WHO Global Tuberculosis Report estimates that during the 2016 – 2020 period, two billion USD per year are needed for global TB R&D, while there was only a maximum of 0.7 billion USD available each year during 2005 – 2015.[101]

Another important aspect of TB is the huge financial burden it places on patients and their families. In addition to treatment costs, TB patients are required to take a leave of absence from work, leading to risk of impoverishment.[110,111,112] Tanimura et al reported in 2014 that the total cost of TB treatment was equivalent to 58% and 39% of reported annual individual and household income, respectively.[113] In the midst of the increasing momentum toward UHC, providing financial risk protection for TB patients and their families is now of great concern.

4. Discussion

GHA

Actor power

Actor power consist of policy community cohesion, leadership, guiding institution, and civil society mobilization. First, policy community cohesion, there are four main actors inside of Japan namely the Cabinet Secretariat, MOFA, MHLW, and MOF. The three ministries have slightly different interests regarding the GHA. For example, the MOFA emphasizes the aspect of human security, while the MOF would like to promote the World Bank initiative of the PEF. However, the cabinet that has the strongest political power in Japan closely coordinates these three ministries, allowing them to share the ultimate goal of reinforcing the GHA. These three ministries and the Cabinet Office often hold meetings together, with participants at the level of director-general of each ministry, in order to share information and discuss about how to consolidate Japan's commitment to GHA as a whole.

The MHLW also made a notable effort to promote policy cohesion between the cabinet and other ministries. Mr. Yasuhisa Shiozaki, then Minister for Health, Labour and Welfare had an enthusiasm for Japan to lead the GHA at the global level.[36] He hosted an "Advisory panel for global health" in august 2015 with two working groups and asked one of them to make recommendations regarding health challenges to the upcoming G7 Ise-Shima Summit. The

global health architecture working group, one of two working groups, created a set of recommendations for the government of Japan.[15] These recommendations not only created a basis for discussion among Japanese stakeholders but allowed other G7 members to articulate GHA agenda at the G7 Ise-Shima Summit.

Also, Professor Keizo Takemi, a member of the House of Councilors and the former State Minister for the Health, Labour and Welfare of Japan, had strong power in the G7 preparatory process. He was the main advocator of global health issues at the previous G8 Kyushu-Okinawa summit in 2001 and the G8 Hokkaido Toyako summit in 2008.[13] Likewise, for the G7 Ise-Shima Summit in 2016, Prof. Keizo Takemi hosted several meetings with relevant governmental institutions and promoted their mutual understanding.

As to cohesion among the G7 members, they had already discussed global governance for future public health emergences at the G7 Elmau Summit in Germany in 2015.[37] Also, in light of the global situation, when the WHO's emergency reform was still underway and the global community was still feeling the aftermath of the outbreaks of the Ebola virus, other G7 countries showed no strong opposition to including global governance for future pandemics in the G7 agenda.

In order to increase cohesion among all stakeholders, it was important to have as much dialogue as possible, especially with non-G7 countries. Japan prepared several dialogue opportunities with these countries throughout its G7 presidency in 2016. First, at the 69th WHA, member states had an intense debate about WHO emergency reform and newly creating WHO emergency programme, which was expected to be a guiding institution of the GHA agenda. Since Japan was the only G7 member from Asia, Japan acted upon member states from the WHO Western Pacific regions. They made a joint statement in order to clearly support WHO emergency reform, which was strong political support for the WHO Director-General. In parallel, the representative of the Japanese delegates attended several side events organized by the WB or the National Academy of Medicine, resulting into enhanced mutual understanding for how the global community promotes the GHA.

The WHA was the place where Japan could disseminate their GHA effort toward health ministers, while TICAD Ⅵ was the place to discuss the GHA with African leaders. In August 2016, the TICAD VI was held in Kenya, the first time it has been held in Africa. The conference was co-sponsored by the governments of Japan and Kenya, the United Nations, the United Nation Development Programme (UNDP), the African Union Commission, and the WB. The cabinet and MOFA placed health as the priority agenda at this conference, and it was certainly a good opportunity for Japan to further discuss the GHA with African leaders and international

organizations. Health was one of the three major themes at the TICAD VI and there was an intense debate with a strong focus on preparation for and response to future public health emergencies.[38]

As the chair of the meeting's thematic session, the then Minister of Health, Labour and Welfare of Japan, Mr. Yasuhisa Shiozaki, led an intense debate among the African heads of state and ministers, as well as leaders from international organizations such as the WHO, the WB, the GF, the GAVI Alliance, the International Committee of the Red Cross, and the International Federation of Red Cross and Red Crescent.

"protecting human security is emerging as a core challenge for political leaders, who are concurrently dealing with refugee and migration crises, climate change, and disease epidemics. The Ebola virus outbreaks in West Africa exposed fundamental fragility in global health architecture as well as in health systems. This is a crucial juncture for the future of global health…. Now the world needs well-balanced and comprehensive strategy more than ever in order to deal with health emergencies, the global community including the World Health Assembly and G7 Ise-Shima Summit this May agreed that the global coordination arrangement is desperately essential for large-scale health emergencies." (Speech made by Mr. Yasuhisa Shiozaki at the TICAD VI, thematic session)

During the preparatory process of the meeting, MHLW had an intense debate with the WB, acting as the co-chair of the thematic session, as to how to raise awareness toward the GHA among the African leaders, international organizations, and civil society organizations (CSOs). Throughout this consulting process, they obtained consensus on what should be done to prepare for and respond to future health crises. These outcomes were summarized in the conference document namely Nairobi Declaration and its implementation measures.[39,40]

Two weeks after the TICAD Ⅵ, on September 11 and 12, 2016, the G7 Kobe Health Ministers' Meeting was held in Japan with ministers from G7 countries and leaders from the WHO, the UN Office for Coordination of Humanitarian Affairs (UNOCHA), and the WB.[41] This meeting aimed to deepen the health-related discussion of the G7 Ise-Shima Summit this May and propose concrete actions to attain the goals described at the G7 Ise-Shima Leaders' Declaration. Together with three official meetings of preparatory for the G7 Kobe Health Ministers' meeting, it contributed to increase GHA policy cohesion among the G7 health ministers.

In this category, by having three strong champion – Mr. Shinzo Abe, Mr. Yasuhisa Shiozaki and Prof. Keizo Takemi as well as efforts by the Cabinet Office and relevant ministries, Japan contributed to increase policy community cohesion mainly by hosting several meetings

in and outside of G7 members. Not only Japan supported the WHO emergency reform and WHO emergency programme that served as guiding institutions of the GHA debate, agreed document by the Government of Japan and conferences such as the G7 Ise-Shima Leaders Declaration also acted as guiding institutions.

Ideas

Ideas refer to the ways in which those involved with the issue understand and portray it both for internal and external stakeholders. For an internal frame among domestic stakeholders, the cabinet and the relevant ministries already shared the idea that human security has been the central tenet of Japan's foreign and health policies, especially as health security is strongly linked with the concept of human security. Human security is defined as "to protect the vital core of all human lives in ways that enhance human freedom and fulfilment."[42] Prime Minister Shinzo Abe, in his comment at the Lancet in 2015, mentioned that addressing basic health needs, especially for women and children was of vital importance in order to attain human security.[43] Since then, health has been one of the top agendas for the Japanese government.

As for external actors, since the GHA is not only about health aspects but also addresses economic and national security aspects, the GHA could portray different images to different political leaders: focusing on national security issues with G7 leaders, economic threats with

finance ministers, humanitarian emergencies with International organizations and CSOs, and severe health burden with health ministers. In summary, in this category, human security and health security acted as an internal frame, while for external frame, diverse dimension of GHA could successfully caught attention from diverse actors.

Political context

A policy window and good global governance structure are two key components in this category. As for the policy window, it is likely to open after major disasters, discoveries, or forums.[24] Since Ebola caused tremendous damages with a total of 28,616 cases and 11,301 deaths,[31] it was quite natural for it to get political attention when convening the UN High-Level Meeting on the Response to the Ebola Virus Disease Outbreak in 2014. Under UN Secretary General, a UN High-Level Panel on Global Response to Health Crises and a Global Health Crises Task Force also worked as the highest level of policy window. Dr. Shigeru Omi, the former WHO Regional Director for the Western Pacific Region participated in this task force with financial contribution from the government of Japan, contributing to enhance the cohesion between the work done by the task force and the preparatory process of the G7 summit. In parallel, the 69th WHA adopted a resolution which decided WHO emergency reform, including a new health emergency program that contributed to creating political momentum toward reinforcing the GHA, especially among health ministers.

Besides these global efforts, Japan also played an important role in creating policy windows: convening high-level political meetings and supporting the adoption of agreed documents as an outcome of these political meetings. These efforts include the G7 Leaders' Declaration and the G7 Vision for Global Health at the G7 Ise-Shima Summit, the Nairobi Declaration and Nairobi Implementation Measures at the TICAD Ⅵ, and the G7 Kobe Communique at the G7 Kobe Health Ministers' Meeting. These agreed documents also served to open policy windows.

Another element of political context is the global governance structure, the degree to which norms and institutions operating in a sector provide a platform for effective collective action. The 70th UN General Assembly adopted the resolution proposed by the Oslo group entitled "Global health and foreign policy: strengthening the management of international health crises."[44] This resolution convened health issues outside of the WHO and has worked as the basis for keeping dialogue regarding the GHA running among UN entities. In order to maintain this momentum, in 2016 at the 71st UNGA, Japan also worked with the Oslo group and inserted sentences related to the GHA into Resolution A/RES/71/159 entitled "Global health and foreign policy: Health Employment and Economic Growth." In addition, Japan contributed to maintaining the political momentum by putting GHA as a major agenda item at the G7 Ise-

Shima Summit and other related meetings, and by continuing to discuss GHA in other high-level forums in cooperation with the Oslo Group.

Issue characteristics

This category consists of a credible indicator, its severity, and effective interventions. At the beginning of Ebola outbreak in 2014, only severity was widely recognized, whereas the other two were not sufficiently addressed. Severity was obvious because of the number of Ebola cases and deaths. Severity also involves an economic aspect. As mentioned on page 18, the WB Group estimated that the three endemic countries lost at least US $1.6 billion in forgone economic growth in 2015. Sub-Saharan Africa, as a whole, also lost from US $500 million (low estimate) to US $6.2 billion (high estimate).

As for credible indicators and effective interventions, because large scale public health emergencies are such a rare event, there was not enough evidence for both monitoring and interventions. Now both the standard operation plan (SOP) proposed by the UN and the WHO Emergency Programme have been adopted and are expected to evaluate feasibility and effectiveness for future outbreaks.

Financial Support

Although the Shiffman's 2007 framework does not mention anything about financial contribution, this is one of the clear ways to show government commitment and thus this study also analyzed the financial aspect of the GHA. The analysis was done based on two key components: the existence of a mechanism directly allocates financial resources to GHA, and actual amounts of financial contributions to GHA.

At the time of Ebola outbreak, the global community did not have adequate funding for outbreaks nor mechanisms of effectively disbursing financial resources. In response to this situation, the WHO's Contingency Fund for Emergencies (CFE) and the WB's PEF were launched. On the occasion of the G7 Ise-Shima Summit, Japanese Prime Minister Shinzo Abe pledged a total of US $11 billion to global health institutes, including US $50 million to the WHO CFE. Also, at the G7 Finance Ministers and Central Bank Governors' Meeting in Japan in 2016, where the PEF was officially launched, the government of Japan announced its financial commitment of US $50 million to this new facility. Though there were no such financing mechanisms for public health emergencies, launch of CFE and PEF as well as these mechanisms raised rich amount of money made GHA likely to have higher political attentions. The government of Japan also committed both CFE and PEF and reiterate the importance of these financing mechanisms at outcome documents of the G7 Ise-Shima Summit and the G7 Kobe Communique, which all supported the GHA to be a top political agenda.

UHC

Actor

This category consists of leadership, governance, composition, and framing strategies. First, about the leadership, Prime Minister Shinzo Abe, and Mr. Yasuhisa Shiozaki, the Minister of Health, Labour and Welfare at the time, were two noteworthy champions for this agenda. As health is one of the pillars of the government's "New Economic Growth Strategy,"[52] the Japanese Prime Minister has shown strong interest in the area of global health, especially toward achieving UHC.[53] He has given strong UHC related messages to the global community on several occasions.

"Universal Health Coverage needs to be achieved in order to ensure all people can receive the health services they need at an affordable cost….To manage diverse health challenges, we need to strengthen health systems with a view to achieving Universal Health Coverage"

(at the 70th UNGA side event entitled "the path towards UHC – promotion of equitable global health and human security in the post-2015 development era"[54]).

"The reason why Japan prioritize health comes from our conviction that it is among the most important elements in the concept of human security, which strives for the protection and empowerment of all individuals, and the fulfillment of their potential….I intend to take up

health as a priority agenda at the G7 Ise-Shima summit, and I would like to lead the discussion on the health challenges that the world faces in close cooperation with the other G7 countries." (at the International Conference on UHC in the New Development Era: toward building resilient and sustainable health systems[55]).

Furthermore, on December 12, 2015, Mr. Abe published an article entitled "Japan's vision for a peaceful and healthier world" for the Lancet.[43] In the article, he explained that Japan has been an advocate of human security and has taken actions in support of this principle. He also introduced that as the G7 president for 2016, Japan's global health priorities would help build resilient and sustainable health systems to promote health throughout life's course, while maintaining a sustainable health system to deal with ageing. He clearly declared that, with the G7 presidency in 2016, Japan was determined to contribute further to global health.

Mr. Shiozaki, at the time, the minister of the MHLW, recognized the superiority of Japan's health system and the need for strong connection and communication within the global community in the era of globalization.[56] In this regard, he was also a strong advocator for global health and UHC.[36]

"Today, we would like to reiterate our belief that providing universal health care for all people around the world is extremely valuable for every nation to enable their citizens to enjoy better health supported by quality health care…. I as Health Minister of Japan, will continue to make every effort to support the global health community in tackling our major challenges today with a clear vision for future. With knowledge, passion and commitment, I am confident that we can altogether make a significant difference in global health." (International conference on UHC in the new development era[57,58]).

Next, regarding governance and composition, in order to enhance cohesion among stakeholders, Japan as the G7 president in 2016, initiated political dialogue and established political milestones, which resulted in increasing political momentum toward UHC.

As preparatory process for the G7 Ise-Shima Summit, Japan hosted two conferences with regard to UHC, entitled "The Path towards Universal Health Coverage: Promotion of Equitable Global Health and Human Security in the Post-2015 Development Era"[59] during the 70th UNGA in 2015 and "International conference on UHC in the New Development Era: Towards Building Resilient and Sustainable Health Systems"[60] in April 2016. These conferences were a good opportunity for Japan to show its strong commitment to global leaders, heads of state,

and the leaders of international organizations, and to declare Japan's strong commitment toward UHC in its upcoming G7 presidency in 2016.

There were two other remarkable efforts: the WHA and the TICAD VI. During the 69th WHA in May 2016, Japan, together with Germany, hosted a side event entitled "G7 Activities for Health Systems Strengthening and Universal Health Coverage.[61]" Dr. Naoko Yamamoto, the then assistant minister for global health from the MHLW of Japan, introduced the G7 Ise-Shima Vision for Global Health, which had been adopted that same day of the event. In addition, like the government of Germany promoted UHC in 2015 as the G7 president, she emphasized that Japan would prioritize UHC agenda throughout 2016.[62]

In addition, the TICAD VI on August 27 – 28, 2016 in Kenya was the first TICAD that focused on health as a major agenda item. One of the three thematic sessions was entitled "Promoting Resilient Health Systems for Quality of Life."[38] Mr. Shiozaki, the first minister for Japan's MHLW to attend a TICAD, was the chair of this session, together with Dr. Jim Yong Kim, the former president of the WB. Through the negotiation process on the conference's outcome, like the Nairobi Declaration and the Nairobi implementation measure, Mr. Shiozaki as a chair, and officials from MHLW, led the debate among African countries and international organizations such as the WHO and the WB.[39,40] By promoting these conferences, Japan was

able to extend the debate related to UHC outside of the G7 members, mainly with health ministers at the WHA and the leaders from African countries and international organizations at the TICAD.

Throughout these efforts, Japan was able to raise political awareness about UHC, which resulted in its greater emphasis on the outcome of both of G7 Ise-Shima Leaders' Declaration and the G7 Kobe Communique. At the G7 Leaders' Communique, health was a core issue and in their declaration, the G7 leaders allocated approximately 4 of 32 pages to the health agenda.[11,41,63]

Policy environment

Policy environment consists of allies and opponents, as well as funding and norms. With regard to allies and opponents, at the time when Japan promoted UHC as the G7 president, Germany was its biggest ally. Germany showed strong interest in including UHC in the G7 agenda. Under the leadership of Chancellor Angela Merkel, together with the WHO, Germany has been promoting a UHC initiative entitled "Healthy Systems – Healthy Lives."[64,65] In 2015, responding to the need for HSS as set forth in the G7 Elmau Summit commitment,[37] Germany started to develop a roadmap. The goal of this map was to facilitate the development of a

comprehensive understanding of HSS and to agree on the principles and approaches that would assist countries in building strong and resilient health systems.[64]

Canada also played an important role by including vertical issues such as Maternal and Child Health (MCH) and infectious disease into UHC at the G7 Ise-Shima Summit. Canada has a history of pursuing MCH agenda. As the president of the G8 summit in 2010, Canada launched the Muskoka Initiative on Maternal, Newborn and Child Health.[66] This initiative aimed to spend a total of $5 billion between 2010 and 2015 to accelerate progress toward the achievement of MDGs 4 and 5 in developing countries.[67] Additionally, as the host country for the Global Fund's 5th Replenishment which was held in September 2016, just a week after the G7 Kobe Health Ministers' Meeting, there was strong motivation to include infectious disease in the leaders' declaration.[68] The commitments to MCH and infectious disease were included in the G7 Ise-Shima Vision for Global Health, which stated that "they agreed to lead maternal and child health, reproductive health, immunization, and polio."[11]

Shiffman also picks sufficient funding as one of the important components of policy environment. He explains that sufficient funding may "facilitate the initiative's emergence and effectiveness and a dearth may hinder prospects for sustainability."[24] Unfortunately, regardless of its importance, an insufficient amount of financing resources has been allocated to UHC or

Health Systems and the majority of donor funding still goes to vertical programs such as HIV/AIDS.[69] However, in 2016, there were some transition in that some organizations, like the GF whose primary interest has been on infectious diseases rather than health systems, started to invest in HSS, including UHC. These transitions began during a side event at the TICAD Ⅵ entitled "UHC in Africa: Framework in Action." During the side event at the TICAD Ⅵ, the new action plan for UHC entitled "UHC in Africa: A Framework for Action (UHC in Africa)" was launched . This was created together by Japan, Kenya, the WB, the WHO, the GF, and the African Union Commission[70,71] and provided useful references for African countries to develop national roadmaps and concrete actions under national ownership. The GF, together with the WB group announced that it would contribute $24 billion to African countries that attempted to achieve UHC by utilizing this framework.[72]

Japan also made financial commitments throughout its G7 presidency year in 2016. During the G7 Ise-Shima Summit, Mr. Shinzo Abe pledged a total of US $1.1 billion to global health institutes, including US $50 million to the WHO.[73] This showed a strong political commitment to addressing global health challenges as well as providing necessary financial support for the actions described in the G7 Ise-Shima Communiqué and its annex.[74]

With regard to "the norm," which is defined as standard of appropriate behavior for actors with a given identity, it also plays an important role in this category. The MDGs and the SDGs are two good examples of "norms" in the area of global health,[75] and have contributed to bundling several stakeholders with clear objectives. As for UHC, these two movements are treated as "the norm": the IHP+ for UHC 2030 (UHC 2030)[76] and the before mentioned UHC in Africa. UHC 2030 started from the International Health Partnership (IHP+) which aims to enhance collaboration among donor agencies. The original purpose of IHP+ was to enhance aid effectiveness and development cooperation in the health sector. Responding to the global momentum toward UHC, IHP+ has been expanding its scope in order to include UHC in general and officially launched in 2016. By referring to these two platforms in the G7 Kobe Health Ministers' Communique, Japan and other G7 members showed political support for these initiatives.

Issue characteristics

Issue characteristics refers to an issue's severity, tractability, and affected groups. Since UHC is a fundamental concept of all health challenges, analyzing severity and affected groups are not applicable at this time. Regarding tractability, several indicators have been developed for monitoring the progress toward UHC.[77,78] In 2014, the WHO and the WB jointly launched a monitoring framework that is now widely used to assess the progress toward UHC.[79] Besides

this, “UHC in Africa” adopted in 2016 at the TICAD Ⅵ is now expected to become a new framework to monitor and evaluate the progress toward UHC, with great financial support from the WB and the GF.

AMR

The problem stream for AMR

The problem stream describes “those conditions or issues that present themselves as problems, and which require serious attention by policy makers.”[17] The wakeup call for AMR to be recognized as a problem was “Antimicrobial Resistance: Tackling a crisis for health and wealth of nations,” known as the “O’Neil Report” written by Lord Jim O’Neil in December 2014.[80] This report estimates that 10 million people will die due to AMR by 2050, potentially exceeding the number of annual deaths due to cancer,[80] and it is therefore timely that AMR should gain greater attention from members of the international community including the WHO, and start to be included as an agenda item at international conferences. According to Kingdon, differences in problem formulation create a significant barrier to accurate problem definition and recognition, as different parties have different preconceptions of the problem. In this regard, compared with other global health challenges, the concept of AMR, as a problem, can be defined quite simply. The WHO defines AMR as follows: AMR occurs when microorganisms (such as bacteria, fungi, viruses, and parasites) mutate when they are exposed to antimicrobial drugs (such as antibiotics, antifungals, antivirals, antimalarials, and antihelmintics).[83] As a

result, medicines become ineffective and infections persist in the body, increasing the risk of spread to others.[83] This concise definition has made it easier for the global community to share the same understanding of AMR.

Moreover, WHO, together with FAO, and OIE have advocated the concept of "One Health approach." One Health is the idea that the health of humans, animals, and ecosystems are mutually connected, and thus require a coordinated, collaborative, multidisciplinary, and cross-sectoral approach so as to address risks coming from the animal – human – ecosystem interface. [84] This multi-faceted description of health has also facilitated a common grounded understanding of AMR across international sectors.

The policy stream for AMR

The policy stream refers to solutions that have been developed in response to particular challenges by policy communities. The linking of solutions to policy problems is thought to increase the chances of gaining political attention and support for an issue.

The Global Action Plan on Antimicrobial Resistance, adopted through resolution WHA 67/20 at the WHA in May 2014 listed up possible policy solutions for tackling AMR.[85] This was the first global action plan relating to AMR and it has served as the common basis for the

understanding of AMR while increasing each government's confidence that there are appropriate policies to combat AMR.

This resolution also urged all member states to create national action plans, which also made possible options for tackling AMR visible in each country's context. In response, the Japanese government provided support mainly for creating national action plans for low- and middle-income countries in Asia. The MHLW and the Ministry of Agriculture, Forestry and Fisheries (MAFF), together with the WHO Western Pacific Regional Office (WPRO), and the WHO South East Asia Regional Office (SEARO) hosted the Tokyo Meeting of Health Ministers on Antimicrobial Resistance on April 16, 2016.[86,87] Twelve countries from Asia and the Pacific region, the FAO, and the OIE participated, and they adopted the Communique of the Tokyo Meeting of Health Ministers on AMR in Asia with ministers from Asian countries, which clearly reaffirmed creating and maintaining national action plans in each country.[88]

Another policy option came from the GHIT Fund founded in 2012 by the Government of Japan together with pharmaceutical industries, the Gates Foundation, and the Wellcome Trust.[89] The GHIT Fund has had a key task of promoting the development of new medical products, and in particular, supporting innovation and providing benefits to patients in developing countries. By addressing market failure and incentivizing R&D, GHIT showed possible options for

addressing AMR especially in the area of drug R&D. The G7 Ise-Shima Leaders' Declaration acknowledged the importance of the GHIT fund. It encouraged G7 countries to support "push (e.g., support to cover R&D cost)" and "pull (e.g., making advance purchase and support creating markets/demands)" incentives and promote well-coordinated PPP to develop new drugs and alternative therapies, exemplified by the GHIT fund and the Innovative Medicines Initiative (IMI).

The political stream for AMR

The political stream comprises of several elements such as public mood, ideology, interest group pressure, the media, and other influential actors. In this stream, the leadership of G7, especially the strong support from the Japanese government as the G7 president in 2016, and the convening of the UN High-Level Meeting on AMR were identified as the two main contributing factors for AMR as a top item of the political agenda.

There were three meetings related to the G7 in 2016: 1. The G7 Ise-Shima Summit; 2. The G7 Niigata Agriculture Ministers' Meeting; and 3. The G7 Kobe Health Ministers' Meeting. Prior to Japan's G7 presidency in 2016, at the 2015 G7 summit hosted by Germany, AMR was already a key element at the G7 Health Ministers' Meeting. In the communique that was produced, G7 members promised to commit to the One Health approach, and to foster the

prudent use of antibiotics.[90] This subsequently resulted in an expectation for Japan's G7 presidency to adopt this agenda, and to continue with an increased momentum towards the UN High-Level Meeting on AMR. Moreover, Mr. Jeremy Hunt, the British Secretary of State for Health at the time, asked Mr. Shiozaki, then Minister for Health, Labour and Welfare of Japan, to include AMR as a major agenda item at the upcoming G7 Ise-Shima Summit and the G7 Kobe Health Ministers' Meeting, which was also strong push for AMR to be included into G7 agenda.

In April 2016, the G7 Niigata Agriculture Ministers' Meeting was held in Japan.[91] The G7 members and the FAO decided to encourage efforts to ensure the prudent use of antibiotics in human and animal sectors, as well as agricultural industries, and to implement strategies to phase out the use of antibiotics for growth promotion in animals, albeit in the absence of a risk analysis.[92] A month after the G7 Niigata Agriculture Ministers' Meeting, the G7 Ise-Shima Summit was held in Japan between the 26th and 27th of May.[93] By elaborating on the discussions from the 2015 G7 Elmau Summit in Germany and the G7 Niigata Agriculture Ministers' Meeting, leaders proposed new approaches for AMR, like data sharing, the strengthening of monitoring systems, and the implementation of surveillance systems.[11,94] This declaration by G7 leaders, together with the G7 Niigata Agriculture Ministers' Meeting Declaration, is likely

to send a strong political message and was undoubtedly a key milestone towards the convening of a UN High-Level Meeting on AMR.

On September 11th to 12th, 2016, the G7 Kobe Health Ministers' Meeting was held in Kobe, Japan.[41] The purpose of this meeting was to deepen discussion of the health agenda arising from the G7 Ise-Shima Summit, held the previous May, and to propose concrete actions to attain the goals described in the G7 Ise-Shima Leaders' Declaration. In the Kobe Communique, the G7 members agreed to promote actions against and to strengthen surveillance of AMR. To do so, it is vital to support the establishment of the development of technical guidelines for regulatory harmonization, and to recognize the challenges in access to medicines and the sustainability of health systems.[95] Since the G7 Kobe Health Ministers' Meeting was held in advance of the UN high-level meeting, Japan, together with its fellow G7 members, attempted to convey a strong political message to the world toward a UN High-Level Meeting on AMR. Though the G7 was not the ultimate influencer for articulating the global health agenda, they still have demonstrated a strong influence on the global health community. Throughout the intensive discussions that were a part of the preparatory processes for the G7 Elmau summit in Germany in 2015 and continuing in the G7 Kobe Health Ministers' Meeting in Japan in 2016, G7 members were able to promote AMR as a top item for the political agenda.

The UN High-Level Meeting on AMR and its preparatory processes also contributed a great deal to creation of the political stream for AMR. Resolution A68/20 adopted at the 68th World Health Assembly in 2015 requested that the WHO Director General "elaborate, in consultation with the United Nations Secretary-General, options for the conduct of a high-level meeting in 2016, on the margins of the UNGA, including potential deliverables, and to report thereon to the Sixty-ninth World Health Assembly through the Executive Board at its 138th session.[96]" In response to the WHO resolution, the 70th UN General Assembly then adopted a resolution requesting a UN High-Level Meeting on AMR.[44] This resulting resolution, "Global health and foreign policy: strengthening the management of international health crises (A/RES/70/183)," was drafted by the Oslo group, that comprised delegates from France, Norway, Thailand, South Africa, Indonesia, Brazil, and Senegal.[97] In this resolution, Member States requested the General Assembly to "hold a high-level meeting in 2016 on antimicrobial resistance" and requested "the Secretary-General, in collaboration with the Director-General of the World Health Organization, and in consultation with Member States, as appropriate, to determine options and modalities for the conduct of such a meeting, including potential deliverables."[44] Since the Oslo group comprised a diverse collection of states, representing all the regions with different socio-economic levels, this resolution made it easier for the WHO to facilitate dialogue with its member states toward convening a UN High-Level Meeting on AMR.

After a year-long consultation process, the UNGA finally convened the UN High-Level Meeting on AMR in September 2016. Leaders have reaffirmed their commitment toward AMR and unanimously adopted the political declaration of the high-level meeting of the General Assembly on antimicrobial resistance.[82] Mr. Yasuhisa Shiozaki, then the Minister for MHLW, attended the UNGA as the first Japanese health minister to attend such an assembly, and reaffirmed Japan's commitment to this area. Mr. Shiozaki also attended several side events related to AMR and conveyed the outcomes through the G7 Ise-Shima Summit and the G7 Kobe Health Ministers' Meeting.[98,99,100]

TB

With regard to actor category, three key organizations — the WHO, the GF and the STBP — have played important roles as guiding institutions in increasing cohesion around TB targets in the policy community. The private sector, NGOs, and CSOs have played significant roles as well. However, challenges remain — especially for the engagement of the private sector, NGOs, and CSOs. Even though several private companies have joined the STBP, these constitute only around 7% of STBP membership, and the STBP lacks a platform for the private sector to engage in the prevention and treatment of TB in an active manner.

During the meetings that were organized in May 2018, several private companies emphasized the complexities behind different countries' varying drug regulatory and procurement systems

that result in difficulties in introducing new medicines and tools for diagnosis to TB endemic countries. As the private sector plays an important role in promoting R&D on new drugs, vaccines, and tools for diagnosis, it is crucial to create an environment that maximizes the benefits of private sector engagement. This would include adequate financing of R&D, simplified procurement systems — by the WHO as well as in each country — and a global framework on drug regulatory and approval.

CSOs engagement is also a key to the continuing and further scaling up of interventions for TB. Several NGOs and CSOs expressed strong concerns regarding inadequate financing for activities at the grassroots level. According to the WHO Global Tuberculosis Report, 9.2 billion USD per year is required for the implementation of TB interventions, while only 6.9 billion USD was available for countries to use in 2016, leaving a funding gap of 2.3 billion USD.[101] It is thus important to raise financial support for the fight against TB and allocate these funds adequately into implementation activities at the grassroots level.

Regarding the idea category, participants of the meetings emphasized that TB should not only be regarded as an infectious disease but also as a health security issue — especially because TB is the only major drug resistant epidemic that is airborne. Moreover, a global increase in migration and immigration accelerates the spread of TB. In comparison, the Ebola disease outbreak was perceived as a health security issue and caught significant political attention.[35] It

is a feasible strategy to also emphasize the security aspect of TB. In addition, unlike HIV/AIDS, TB lacks framework and recognition as a human rights issue.[120] TB requires long treatments and sometimes even the isolation of patients, which can lead to stigmatization.[121] Such stigmatization can delay or hinder patients' treatment seeking behavior. To overcome such social barriers, inclusion of human rights-based and patient-centered approaches in framing the disease is also needed.

As for the political context, it is certain that, compared to the past, TB currently gets more attention at the highest political level since the UN High-Level Meeting on TB. Other health challenges such as HIV/AIDS, NCDs, and AMR, received attention from higher political levels after being subject to UN high-level meetings and ministerial conferences. The UN High-Level Meeting on HIV/AIDS in 2001 was the first-ever high-level meeting dedicated to a health issue. Since then, health issues have appeared more frequently on the agenda of high-level meetings; HIV/AIDS and AMR in 2016, NCDs in 2011, 2014 and 2018, TB in 2018, and UHC in 2019. Given the increasing number of health issues highlighted in recent years, it is uncertain how much impact they have on the attention and priorities of the high-level leaders going forward.

Moreover, just holding UN High-Level Meetings on TB is not enough; such meetings must be followed by actual commitments from heads of state. The fundamental challenge to TB is the lack of financing. Being in the position to greatly influence financial priorities, it is important

for the heads of state from low- and middle-income countries with moderate to high TB burdens to put TB high on their country's agenda and increase domestic financing for TB control. In particular, countries that are transitioning away from the GF's support need to devise strategies for continued efforts using domestic financing. Heads of state from high- income countries also need to raise additional financial support for TB control, including contributing to the GF and to the Global Drug Facility (GDF) operated by the STBP.

Lastly, with regard to issue characteristics, as pointed out during the meetings, childhood TB is now of great concern. When Japan reduced the TB incidence between 1965 and 1978, the overall rate of incidence decline was 10%, while it was 15 – 30% among children.[126] The rate of decline in incidence for childhood TB is typically faster than the overall rate of decline. This metric could be used as an indicator for TB control. The global community is encouraged to set specific targets for childhood TB. Moreover, child-friendly diagnostics and treatments are urgently needed. Although several new diagnostics and drugs have been discovered in recent years, further efforts are needed for developing shorter and more simple drug regimens, especially for children. Experts at the meetings emphasized the importance and uniqueness of GHIT Fund activities and underscored the need for this kind of innovative PPP with a specific focus on R&D.

In Japan, universal health insurance was introduced in 1961, and public subsidy for TB patients (starting in 1951) played an important role in controlling the financial burden of TB patients. With the financial protection offered by health insurance, patients accessed health care facilities for diagnosis, and their treatment cost was fully funded by the government once they were diagnosed with TB.[127] Public subsidy also provided incentives to private health care facilities to enter TB control programs and contributed to enforcing registration and standardization of TB treatment. Researchers have shown that the majority of the patients stop their TB treatment before six months due to financial reasons,[128,129,130] making systems for covering treatment costs important. Currently, the GF supports the provision of TB diagnosis and treatment for free (similar to the public subsidy in Japan), while most countries are now on their way toward creating universal health insurance. This good mixture — public subsidy and health insurance — are keys for TB control. Another remaining issue in the era of the SDGs is to address the missing cases and TB patients in vulnerable populations — "the last one mile." As the population constituting "the last one mile" differs across countries, each country needs to identify its vulnerable populations. Addressing "the last one mile" requires a comprehensive set of efforts, including adequate medicines and diagnostic tools as well as accessible and accurate information.

General discussion

For the GHA, UHC and TB, which used similar analytical frameworks (Shiffman's 2007 framework for GHA and TB, Shiffman's 2016 framework for UHC), all three agendas gained greater political attention by fulfilling each core category set by Shiffman: Actor power, Idea, Political context, and Issue characteristics for 2007 framework, and Actor power, Policy environment, and Issue characteristics for 2016 framework. In the case of mainstreaming the nutrition initiative globally, Pelletier et al introduced that policy community cohesion could contribute to an increase in political awareness toward ending the undernutrition endemic.[114] Similar to the global nutrition initiative case, for the GHA, Japan initiated several policy dialogues through the Cabinet, Keizo Takemi (a member of the House of Councilors), and then Health minister, which all contributed to strengthening collective efforts toward reinforcing the GHA. Also, two political leaders, the Prime Minister and then Health Minister of Japan championed to this agenda. The emergence of strong political leadership helps to generate a high level of political attention.[75] For example, James Grant, the former director of the UN Children's Fund (UNICEF) gathered global attention to child health.[115] One remaining issue in the actor power category of the GHA is CSOs engagement which Shiffman's framework emphasizes s important [24]. HIV/AIDS generated political awareness by effectively developing grassroots activities.[28] Further analysis of CSO engagement for reinforcing the GHA is needed.

About the UHC case, similar to the GHA case, a noteworthy finding was two strong champions for UHC, Prime Minister Shinzo Abe and then Minister for the MHLW Mr. Yasuhisa Shiozaki. Under their leadership, Japan paid the highest attention toward UHC. As shows in a UHC case study conducted by the WB group,[116] previous study already indicated that such strong leadership effectively promotes issues to higher positions on the political agenda.[17,117] Moreover, as with the NCD Ministerial meeting in Moscow, the UN High-Level Meeting for NCD in 2011[118] contributed to enhancing global momentum toward NCDs, by hosting high-level political dialogue and accepting UHC as an agenda both in and outside of G7 events such as at the International Conference on UHC in the New Development Era in Tokyo in 2015, the TICAD Ⅵ in Kenya in 2016, the G7 Ise-Shima Summit, and G7 Kobe Health Ministers' Meeting, Japan leveraged its G7 presidency to promote this issue in 2016. All of these efforts are clearly indicated at each outcome, namely the G7 Leader's Declaration, the G7 Kobe Communique, and UHC in Africa,[11,95] which also contributed UHC to get higher political attention through increasing policy community cohesion. Though, at the time of tbe G7 Ise-Shima Summit in 2016, there was a concern regarding policy environment that the transition of the heads of organizations such as the WHO and UN Secretary-General might not keep high political attention to the GHA. However, both the new UN Secretary-General Antonió Gueterres, and the new WHO Director General, Dr. Tedros Adhanom, have been active

advocators for UHC and there is some expectation that both of them will continue to put strong emphasis on the agenda.

As for the Actor category, the following points have not yet been sufficiently verified, and further research is desirable in the future. As for leadership, in the Japanese case study, the champions were all politicians. However, it does not necessarily have to be a politician; for example, a British singer was the champion for climate change. There is a need to examine what kind of people can become champions and whether it is enough to be celebrities, entertainers, politicians, or other prominent people. The mechanism of why a potential champion chooses a particular issue out of many issues has not yet been fully explained. It would be necessary to examine this area in the future.

As for civil society's mobilization, their participation is essential, as shown in HIV/AIDS and tuberculosis. Still, there are also issues such as lack of sufficient funds for their activities and lack of their voices in policymaking. It is necessary for policymakers to pay special attention to NGOs and civil society. Besides, when considering the allocation of funds, it is also important to consider which areas of NGOs should receive more funding. It will be necessary to examine which areas of NGOs and civil society donors and policymakers pay more attention to and whether this analysis can be tested using Shiffman's framework.

Moving on to the Idea category, Shiffman pointed out that, when applying his framework to the global motherhood initiative, compared with child health, maternal health failed to grab higher political attention because of its vague concept and the difficulty of not having the same understanding among stakeholders.[24] As to the GHA case, for the internal frame, major stakeholders already shared a concept of human security, which relates to GHA and made it easier to get consensus on what the GHA includes. Also, like HIV/AIDS, which can be recognized as public health issue, humanitarian issue, human rights issue, or in many other ways, GHA drew attention from diverse sectors by showing several aspects, such as public health, humanitarian crises, health security, and economic burden. In some cases, the framing was successful because it was simple and straightforward, as in the case of AMR and TB. While the GHA was able to attract many stakeholders' attention through its various interpretations, it may also lead to the dispersal of interest, as in the case of maternal health. In this regard, further study is needed to determine whether diverse aspects cause more stakeholders or more fragmentation.

With regard to the Political context category, in the case of GHA, the severity and externality of the Ebola outbreak itself caused greater political attention, such as a UN high-level meeting after the release of several influential reports by the WHO and academic institutes. As shown with the case of HIV/AIDs and NCDs, UN high-level meetings promote the health

agenda.[122,123] Also, a previous G7/G8 leaders' meeting advanced the global health agenda (for example: maternal and child health in the Muskoka Summit in Canada[66,124]). The GHA was discussed in UN high-level meetings and G7 summit, which in turn led it to be at the top global health agenda. Japan was one of the members leading this process and contributed to opening a political window with the G7 leaders at the G7 Ise-Shima Summit; with health ministers at the 69th WHA; with leaders from African countries and international organizations at the TICAD VI; and with G7 heath ministers, the WHO and UNOCHA at the G7 Kobe Health Ministers' Meeting.

For the UHC case, not only did Japan have many allies in promoting UHC, but there was also no strong opposition to UHC at that time, which was a key success factor (note: in 2020, the current US government is the strong opponent for UHC). However, too many allies also cause fragmentation of the policy-setting.[16] When a country promotes an agenda, especially with commitment from its highest ranks, such as the president, prime minister, or minister, it usually has some expectation toward increasing its presence, rather than for purely humanitarian reasons. This sometimes causes political tension among countries with similar interests. Though UHC 2030 was launched in 2016 as an international framework to coordinate the efforts of relevant stakeholders and various initiatives, there are many initiatives for UHC, and the coordination among these different initiatives are still of concern. [125] UHC 2030 is now on

the transformational period from its former IHP+ to UHC 2030 but is highly expected to be a catalyst for various initiatives as well as to leverage the expertise of all relevant stakeholders.

Lastly, about issue characteristics, in the case of the GHA, new mechanisms for future public health crises have just started under SOP by the WHO and UNOCHA as well as WHO emergency reform, and these new mechanisms should be closely evaluated and monitored. Also, regarding financial contribution to the GHA, tremendous efforts have been made on a global level such as the WHO's CFE and the WB's PEF and Coalition for Epidemic Preparedness Innovations (CEPI). As scarce financial resources may hinder sustainability,[27] effective and efficient use of financial resources are needed.

Though the study applied a different framework for the AMR case (Kingdon's three theory framework), there were similar trends for AMR's rise to the top of the political agenda. About the framing issue, AMR as a problem stream, not only grabbed attention for its severity through the renowned report by Jim O'Neil, it was relatively simple to describe and, thus, a common understanding among the relevant stakeholders was easy to establish with a cross sectoral slogan such as "One Health." Similar to the TB case, the WHO together with the seminal O'Neil report was able to provide a clear framework for the common knowledge and understanding of AMR among stakeholders.

As to policy cohesion and political environment in Shiffman's framework, as in the AMR case where G7 related meetings are the key component of the political stream of Kingdon's framework. It can be said that Japan as G7 president in 2016, contributed to enhancing the political stream by establishing AMR as an agenda item at G7 related meetings on several occasions: the G7 Ise-Shima Summit, the G7 Kobe Health Ministers' Meeting, and the G7 Niigata Agriculture Meeting. Japan also leveraged its G7 presidency role to members external to the G7, in addition to hosting high-level meetings, such as the Tokyo Meeting of Health Ministers on AMR, and related side-events at international conferences. The most noteworthy efforts were made for the adoption of the G7 Leaders' Declaration, the G7 Niigata Agriculture Leaders Communique, and the G7 Kobe Health Ministers' Communique, all of which clearly indicated the importance of AMR.

Support for AMR is now at a higher level than ever before, and the momentum to address this as a global issue is increasing. However, as history shows, many global health agendas are created and then fail. And as such, there is uncertainty regarding how long the momentum and support for AMR will last. Kingdon indicated that, in order for initiatives to survive, technical feasibility, value acceptability, and anticipation of future constrains are essential criteria for survival.[17] Even though these survival criteria where not analyzed in this paper, it is still

essential that the global community bare these survival criteria in mind in promoting the AMR agenda.

There are some limitations in Shiffman's frameworks.[28] First, previous research shows that, other conditions being equal, every category increases the chances of gaining political attention. However, this frameworks do not analyze the relative causal weights of the factors, interaction between categories, interaction from outside the health sector and the additive effect of the combinations of different categories.[24] Secondly, due to the nature of the research, many of the interviews were conducted anonymously, and many of the contents could not be kept as official records. Therefore, it is difficult to ensure objectivity. Although several methods of ensuring objectivity have been proposed for qualitative research in the medical field, they cannot necessarily be applied to political science. How to ensure objectivity in qualitative research in political science, such as conducting interviews with two or more people, is an issue for the future.

Third, in this study, only Japanese people were interviewed. Japan is not the single actor in global health, and many other countries contribute to the improvement of political momentum. Therefore, it is desirable to include the views of not only Japan but also other countries. This

time, I asked non-Japanese to evaluate the content of the analysis, but it would be desirable to include non-Japanese as interviewees in the future.

The fourth point is that the categories used in this study do not prove the effectiveness of inter-sectoral collaboration. It is difficult for the health sector alone to solve health care issues, and it is said that collaboration with other sectors is necessary. For example, in tobacco control, it is necessary to collaborate with tax-related and economic-related sectors. The current category does not include how such sectoral collaboration can contribute to (or negatively impact) the improvement of political momentum. A framework for evaluating this point is needed in the future.

Fifth, the current study only deals with cases that have been successful in increasing political momentum. However, it is not necessarily the case that fulfilling all the elements of a category will attract political attention. To verify this point, it is necessary to examine cases of failure. Therefore, the usefulness of the framework can be examined more comprehensively by analyzing areas that do not necessarily attract political attention compared to the burden of diseases, such as NCDs, surgery, and anesthesia.

Finally, this framework focuses on the analysis of attracting political attention and does not evaluate how much funding was actually obtained as a result or how much progress was made in the relevant area. The ultimate goal of gaining political attention is to improve the area (e.g., in the case of tuberculosis, to eradicate the number of people who are infected or die from tuberculosis). As a result of fulfilling each element of the framework and attracting political attention, the extent to which it has contributed to the ultimate goal of the area in question should be fully examined in the future.

Note that as G7 president in 2016, Japan promoted three health related agenda items: GHA, UHC, and AMR. The promotion of the GHA and UHC were led by Japan in its role as G7 host, while AMR was predominantly influenced by Germany's initiative in 2015 and strong leadership by the UK government. When thinking about consistency in support for a global health agenda, it is fundamentally important for the G7 president to place their own political interest as a top priority agenda, as well as to promote previous G7/G8 agenda. Wherever the primary interest for pushing some item to the G7 agenda came from, the G7 still has great political power in the agenda setting process in the area of global health. Their cooperation is required to progress the global health agenda in a coordinated manner.[131]

5. Conclusion

All of four agenda items caught attention from global leaders through fulfilling each category Shiffman and Kingdon proposed. Also, by taking advantage of the G7 presidency in 2016 and thereafter, the government of Japan has been contributing to strengthen global agenda including GHA, UHC, AMR and TB. Japan's contributions were mainly through the involvement of notable Japanese political leaders, enhancing community cohesion within and outside of G7 members by hosting several high-level meetings, adopting outcome document which all high-level political leaders including president, prime minister and ministers agreed upon.

Three champions came to the fore: prime minister Shinzo Abe, former Minister for Health, Labour and Welfare of Japan, Yasuhisa Shiozaki, and a member of the House of Councilors, Professor Keizo Takemi. As shown in GHA, UHC and AMR case, such leadership pushes issues to the top of the political agenda. Moreover, hosting high-level political dialogue is one of the strongest drivers to promote policy agenda: Japan has hosted several such political dialogues and included GHA, UHC and AMR as an agenda item with both G7 members and non-members. Together, all of these efforts are clearly implicated in outcomes such as the G7 leader's Declaration and the G7 Kobe Communique, which are expected to be the basis for future policy making.

It was quite natural for GHA to get political attention with a total of 28,616 cases and 11,301 deaths with potential of global epidemic, following several UN-led and the WHO-led meetings and task forces (Political context category (7. Policy windows), Issue characteristics category (9. Severity)). GHA also has a good framing strategy especially for non-health sectors such as security issues to foreign ministers and economic threats to finance ministers (Ideas category (6. External frame)). The government of Japan also supported to opening policy window by hosting several high-level meetings such as picking up the GHA as agenda item at the G7 Ise-Shima Summit (Political context category (7. Policy windows)).

By having three leaders in global health – Mr. Shinzo Abe, Mr. Yasuhisa Shiozaki and Prof. Keizo Takemi and hosting several meetings with different stakeholders in and outside of Japan (Actor power category (1. Policy community cohesion and 2. Leadership)), the government of Japan contributed to promote the GHA as a top political agenda.

For UHC, there was already an environment for UHC to get strong political awareness; SDGs clearly mentions UHC as a priority goal, and Germany picked up it as G7 Summit in 2015. By having three champions of UHC and holding several dialogues on UHC, Japan contributed to enhance political momentum toward UHC (Actor Feature category (1. Leadership, 2.

Governance, and 3. Composition)). No oppositions on UHC and strong support coming from Germany and Canada also supported Japan to further promote UHC through the 2016 G7 presidency (Policy Environment category (5. Allies and opponents)). Further monitoring is needed if it can keep higher momentum especially since after several initiatives and norms was created including UHC in Africa, UHC 2030 (Policy environment category and Issue characteristics category)

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Annex 1.

質問紙票 ＃１（Shiffman's framework (2007)）

注）質問中の XX には GHA もしくは TB が入る

<Actor Power>

1. Policy community cohesion: XX の議題に関しては主要な関係者にはどのような組織がありましたか。またそれらの組織の連携度合いはどのような状況でしたか
2. Leadership：XX の議題を推進するに際して、主としてリーダーシップをとっていたのは誰ですか
3. Guiding Institutions: XX の議題を推進するような（XX の議題に特化した）組織はありましたか。仮にあった場合にはそれはどのような組織ですか
4. Civil Society Mobilization: XX の議題には、市民社会はどの程度関与していましたか

＜Ideas＞

5. Internal frame：XX の議題は内部関係者の間ではどのように定義されていましたか。もしくはどのような概念として整理されていましたか
6. External frame：XX の議題は外部の関係者に対してはどのような定義・概念で説明されていましたか

＜Political context＞

7. Policy window：XX の議題について、政治の窓が開いたと思われるタイミングはありましたか。あった場合には、それはどのような場合でしたか
8. Global governance structure：XX の議題に関して、国際的に議論を行ったり活動を行うための基盤になるものや、プラットフォームは存在しましたか。その場合、それはどのようなものでしたか

＜issue characteristics＞

9. Credible indicators：議題 XX に対する取り組みの進捗を評価するために何かしらの指標は存在しますか。
10. Severity：議題 XX の与える影響の重要度はどの程度でしたか
11. Effective interventions：議題 XX を解決するために、効果的な介入方法はありましたか

質問紙票 ＃２（Shiffman’s framework (2016)）

<Actor Power>

12. Leadership: UHC を推進するに際して、主としてリーダーシップをとっていたのは誰ですか
13. Governance: UHC を推進するに際して国際的にはどのような枠組みが存在していましたか。組織構造、ガバナンスはどのようなものでしたか。
14. Composition: UHC に関しては主要な関係者にはどのような組織がありましたか。またそれらの組織の連携度合いはどのような状況でしたか
15. Framing strategy: UHC は内部・外部の関係者の間ではどのように定義されていましたか。もしくはどのような概念として整理されていましたか

＜Policy environment＞

16. Allies and opponents: UHC を推進するに際して、賛同者はいましたか。また、敵対者（UHC の推進を積極的に歓迎しない人）はいましたか。いた場合には、それぞれどのような人・組織でしたか
17. Funding：UHC をめぐる資金の状況はどのような状況でしたか
18. Norms：XX の議題に関して、国際的に議論を行ったり活動を行うための基準・規範は存在していましたか

＜issue characteristics＞

19. Severity：UHC の与える影響の重要度はどの程度でしたか
20. Tractability：UHC に対する取り組みの進捗を評価するために何かしらの指標は存在しますか。
21. Affected groups：UHC に関係する人や集団はどのような人たちでしたか

質問紙票 ＃３（Kingdon’s framework）

<Problem stream>

- AMR の国際的な認識はどのようなものでしたか
- AMR が国際的な課題として認識された経緯はどのようなものでしたか

<Policy stream>

- AMR に対する解決策としてはどのようなものがありますか
- 上記の解決策が生まれた経緯はどのようなものでしたか。それに対して日本を含めた国際社会の取り組みはどのようなものでしたか

<Political stream>

- AMR に関して、政治の窓が開いたタイミングはありましたか。あった場合にはそれはどのようなものでしたか
- AMR の政治の窓を開くために、日本を含めた国際社会はどのような取り組みをしていましたか